The Influence of Immigration on the Mental Health of Those Seeking Psychiatric Care in Southern Israel: A Comparison of New Immigrants to Veteran Residents

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Abstract: Objective: The wave of immigration from the countries of the former Soviet Union from 1990 to 2006 brought to Israel over 1,000,000 people. Many of them suffer from different diseases including mental disorders. Although the majority of older persons are free of serious psychopathology, 15–20% of the elderly people may be in need of psychiatric services. The aim of the study is to compare the mental health parameters of two elderly groups living in the southern part of Israel who suffer from severe mental problems: new immigrants from the former USSR (NI) in contrast to veteran Israelis (VR). Method: In this retrospective study we compare two groups of aged inhabitants (NI and VR) from the southern region of Israel who sought psychiatric services (both outpatient and inpatient). The comparison concerns socio-demographic characteristics of people in care in a mental health center, rate of use of these services and diagnoses of the patients. Results: One hundred and fifty-six (1.2%) NI sought psychiatric help versus 584 (2.1%) VR. The major findings include the significantly increased number of adjustment disorders and the significantly lower number of organo-mental diagnoses among psychiatrically hospitalized NI in comparison to VR. No differences were found in the frequency of mood or psychotic disorders between the two groups. Conclusions: Immigration is acknowledged to be a major stressor which may increase the emotional distress of an immigrant and in some cases may even lead to psychopathological reactions. NI are prone not to seek medical aid in outpatient facilities until a real worsening of mental health status compels them to be hospitalized.

Introduction

Israel is a society made up largely of immigrants and their children. The last wave of immigration from the countries of the former Soviet Union brought to Israel more than 1,000,000 people.

Migration is one of the most prominent political, economical and socio-cultural events of the modern era and this phenomenon is considered a significant mental risk factor. Anxiety disorder, depression, dysthymia, and adjustment disorder are the most common mental pathology among immigrants (1–4). Depressed immigrants show more acculturation problems, immigration stress and social isolation than non-depressed ones (5).

Immigration is a process involving significant cultural and psychological changes and, in some cases, may even lead to psychopathological reactions (6). Though the immigrants came from different ethnic communities, the difficulties they face are the same. Problems are substantial and largely interrelated; they pertain to the integration into a new, unfamiliar, culture, acquisition of a new language, creation of new relationships in the new surroundings, reorganization of relationships within the family structure, struggle for social and professional recognition, search for suitable employment and housing, and attainment of an appropriate lifestyle, to name just a few (7–9).

Adaptation to a new environment may be undermined in the case of older people by a career crisis, family problems and the fear of impending old age, along with major mental pathology such as affective disorders and psychosis. Elderly immigrants have a higher risk of cultural shock because they bear more connections with and memories about their past (10).

Cultural expectations and beliefs about health, adaptive health behaviors learned in the former Soviet Union, the stresses of immigration, and the medical realities of aging can result in serious problems in the care and treatment of older Russian im-
migrants (11). Immigration and aging have a synergic deteriorating effect on social networks. Increasing health problems and dependency among the aged coincides with reported less social support available at the time of illness. Thus, the period of rehabilitation for elder immigrants is prolonged (12).

Elderly people form a large group within the recent wave of immigration. Many of them are single, widowed, or alone, having immigrated without their children. Loneliness is a major challenge for aged immigrants (13). A chronic sense of discomfort, disease and distress is known to increase with age. Elderly immigrants are more at risk to become mentally disordered than are younger immigrants. A large number of Soviet immigrants belong to the generation that have either gone through World War II or suffered from the Nazi occupation similar to veteran residents who had immigrated from Europe in the decades prior to 1987. Several studies have demonstrated that persons who underwent these experiences are more vulnerable to subsequent stress (14, 15).

While the majority of older people are free from serious psychopathology, it has been found that 15–20% of the elderly may be in need of psychiatric services (16–18). Studies of immigrants who suffered from mental illnesses have shown that 81% of those who applied for psychiatric help in Israel had been receiving such help in the USSR (19).

Despite a large number of publications about psychological and psychiatric problems connected with immigration, until now there are few studies that have focused specifically on mental problems among elderly immigrants (14, 20).

The purpose of our study is to compare the two groups of elderly subjects requesting psychiatric services: new immigrants from the former USSR and old-time residents.

The following working hypothesis was formulated: New immigrants from the former Soviet Union form a closed community and tend to refrain from seeking psychiatric help, owing to the feared stigmatization. Therefore, we expected that relatively fewer new immigrants would ask for psychiatric help as compared to old-time residents.

Method

This retrospective study was performed in Be’er Sheva Mental Health Center that provides psychiatric aid to the inhabitants of the southern region of Israel. The southern region covers an area extending north from Eilat to Be’er Sheva and Ashkelon, including all towns and settlements situated in this area. The territory of this area covers more than half of Israel and the Jewish population of this territory at the end of December, 1995, was about 661,000 people. Out- and inpatients older than 60 years who sought psychiatric help during 1990–1995 were included in the study. This period was chosen because the largest number of immigrants with distinguishable culture, habits and language (more than 600,000 people) arrived in Israel during this time. This large number of newcomers for such a diminutive country like Israel would be equivalent to 30 million immigrants which the USA would have absorbed. We focused on this age group since in the former Soviet Union the retirement age for women is 55, and for men 60. These people were prepared for retirement and for appropriate changes in their life style and as such were considered to be senior citizens. From this aspect they are similar to Israeli retirees.

The following data was extracted from the standard medical records: age, gender, time of immigration, marital status, years of education, place of treatment and diagnosis according to ICD-10.

According to the date of immigration, the patients were divided into two groups: a group of veteran residents (VR) and a group of new immigrants (NI) from the former USSR. For the purposes of our study, VR were defined as persons who had either been born in Israel or arrived in Israel prior to December 31, 1987 (recommencement of immigration from the USSR to Israel). NI were defined as persons who had arrived in Israel after January 1, 1988. In addition, data regarding the number of new immigrants and old residents living in the southern region of Israel at that time were obtained in the regional bureau of the Ministry of the Interior.

For comparison of demographic and clinical parameters we used χ². Differences were considered statistically significant at p<0.05.
Results

During the years 1990–1995 in our hospital, many fewer aged NI sought help for psychiatric problems compared to aged: 156 subjects (1.2%) of the 12,800, in contrast to 584 (2.1%) patients of 27,400, respectively (p<.0001). There were no differences found between these two groups regarding place of treatment (hospital or outpatient clinic): 91 (58.3%) of NI were inpatients and 65 (41.7%) were outpatients and 312 (53.4%) of VR were inpatients and 272 (46.6%) were outpatients (p>.05). No significant difference in age was observed between the NI and the VR. The socio-demographic data are presented in Table 1.

A significant difference between these groups was observed with regard to marital status: in the VR group, the married subgroup was larger (56.3% vs. 43.6%, χ²=47.7, p<.001). There were significantly more divorcees among the NI group as opposed to the VR group (17.3% vs. 7.2%, p<.0001), and the single’s subgroup in the NI group was almost twice as large as in the VR group (25.0% vs. 12.7%, p<.0003). Women predominated as inpatients among the NI (68.1% vs. 51.3%, p<.05). There were 2.5 times more subjects with a higher level of education among NI than among VR (15.4% vs. 6.0%, p<.001).

The most common diagnoses in both groups were mood disorder (27.9% of VR and 28.9% of NI, respectively) and schizophrenia (20.5% and 21.2%, respectively) with no statistically significant difference found both for proportion of patients and for place of obtaining treatment (Table 2).

As we had assumed, the proportion of patients suffering from adjustment disorders among the NI inpatients was 2.5 times higher than among the VR inpatients (11.0% vs. 4.5%, χ²=3.97, df=1, p=.0472). No difference between the groups was found regarding outpatients with this diagnosis (12.3% vs. 12.5%, respectively).

Table 1. Sociodemographic Characteristics and Place of Treatment the Old Residents (N=584) and the Former Soviet Immigrants (N=156) who Sought Psychiatric Help

<table>
<thead>
<tr>
<th></th>
<th>OLD RESIDENTS N=584</th>
<th></th>
<th>NEW IMMIGRANTS N=156</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatients</td>
<td>Outpatients</td>
<td>Total</td>
<td>Inpatients</td>
</tr>
<tr>
<td></td>
<td>n=312 %</td>
<td>n=272 %</td>
<td>N=584 %</td>
<td>n=91 %</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>male</td>
<td>152 48.7</td>
<td>103 37.9</td>
<td>255 43.7</td>
<td>29 31.9</td>
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<tr>
<td>female</td>
<td>160 51.3</td>
<td>169 62.1</td>
<td>329 56.3</td>
<td>62 68.1</td>
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<tr>
<td>Age:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>55–64</td>
<td>155 49.7</td>
<td>96 35.3</td>
<td>251 43.0</td>
<td>44 48.3</td>
</tr>
<tr>
<td>65–74</td>
<td>92 29.5</td>
<td>95 34.9</td>
<td>187 32.0</td>
<td>34 37.4</td>
</tr>
<tr>
<td>75+</td>
<td>65 20.8</td>
<td>81 29.8</td>
<td>146 25.0</td>
<td>13 14.3</td>
</tr>
<tr>
<td>Marital st:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>married</td>
<td>181 58.0</td>
<td>148 54.4</td>
<td>329 56.3</td>
<td>36 39.6</td>
</tr>
<tr>
<td>divorced</td>
<td>29 9.3</td>
<td>13 4.8</td>
<td>42 7.2</td>
<td>18 19.7</td>
</tr>
<tr>
<td>single</td>
<td>27 8.6</td>
<td>5 1.8</td>
<td>32 5.5</td>
<td>11 12.1</td>
</tr>
<tr>
<td>widow</td>
<td>69 22.1</td>
<td>86 30.5</td>
<td>155 26.5</td>
<td>24 26.4</td>
</tr>
<tr>
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<td>6 1.9</td>
<td>20 7.3</td>
<td>26 4.5</td>
<td>2 2.2</td>
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<tr>
<td>Education:</td>
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<td></td>
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<tr>
<td>0</td>
<td>31 9.9</td>
<td>127 46.7</td>
<td>158 27.1</td>
<td>14 15.4</td>
</tr>
<tr>
<td>1–8</td>
<td>211 67.6</td>
<td>84 30.9</td>
<td>295 50.5</td>
<td>47 57.6</td>
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<tr>
<td>9–12</td>
<td>53 17.0</td>
<td>43 15.8</td>
<td>96 16.4</td>
<td>17 18.7</td>
</tr>
<tr>
<td>13+</td>
<td>17 5.5</td>
<td>18 6.6</td>
<td>35 6.0</td>
<td>13 14.3</td>
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Table 2. Diagnoses* and Treatment’s Place of Old Residents and Former Soviet Immigrants

<table>
<thead>
<tr>
<th></th>
<th>OLD RESIDENTS N=584</th>
<th></th>
<th>NEW IMMIGRANTS N=156</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatients n=312 %</td>
<td>Outpatients n=272 %</td>
<td>Total N=584 %</td>
<td>Inpatients n=91 %</td>
</tr>
<tr>
<td>F00-F03</td>
<td>72 23.1</td>
<td>47 17.3</td>
<td>119 20.4</td>
<td>11 12.1</td>
</tr>
<tr>
<td>F10-F19</td>
<td>13 4.2</td>
<td>2 0.7</td>
<td>15 2.6</td>
<td>4 4.4</td>
</tr>
<tr>
<td>F20, F22, F25</td>
<td>97 31.1</td>
<td>23 8.5</td>
<td>120 20.5</td>
<td>25 27.6</td>
</tr>
<tr>
<td>F30-F39</td>
<td>105 33.6</td>
<td>58 21.3</td>
<td>163 27.9</td>
<td>35 38.5</td>
</tr>
<tr>
<td>F43</td>
<td>14 4.5</td>
<td>34 12.5</td>
<td>48 8.2</td>
<td>10 11.0</td>
</tr>
<tr>
<td>F50-F59</td>
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<tr>
<td>F60-F69</td>
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<td>4 1.5</td>
<td>9 1.5</td>
<td>1 1.0</td>
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<tr>
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<td>1 0.2</td>
<td>1 1.0</td>
</tr>
<tr>
<td>Z03</td>
<td>5 1.6</td>
<td>6 2.2</td>
<td>11 1.9</td>
<td>4 4.4</td>
</tr>
<tr>
<td>Z60</td>
<td>0 0.0</td>
<td>4 1.5</td>
<td>4 0.7</td>
<td>0 0.0</td>
</tr>
<tr>
<td>No data</td>
<td>0 0.0</td>
<td>92 33.8</td>
<td>92 15.7</td>
<td>0 0.0</td>
</tr>
</tbody>
</table>

* Diagnoses according to ICD-10:
F00-F03 — Dementias; F10-F19 — Mental & behavioral disorders due to psychoactive substance use; F20 — Schizophrenia, F22 — Delusional disorders; F25 — Schizoaffective disorders; F30-F39 — Mood disorders; F43 — Reaction to severe stress, and adjustment disorders; F50-F59 — Behavioral syndromes associated with physiological disturbances & physical factors; F60-F69 — Disorders of adult personality & behavior; F70-F79 — Mental Retardation; Z03 — Medical observation & evaluation for suspected diseases and conditions; Z60 — Problems related to social environment.

There was a clear, but not statistically significant, trend between the two groups regarding the proportion of patients suffering from dementias (20.4% in VR group vs. 14.2% in NI group, p=.088). However, we found that twice as many VR patients in this diagnostic group were hospitalized compared to NI (23.1% vs. 12.1% respectively, p<.023). No difference in proportion of subjects with this disorder was observed between the outpatient groups.

Discussion

There are many reports about migration and the psychological and psychiatric problems associated with it, but there are only a few studies specifically dedicated to psychiatric disturbances among aged immigrants (1, 14, 21–23). Many researchers have reported that psychological distress characterizes the first years following immigration, and that mean demoralization scores for immigrants are higher than the scores of native populations (1, 19, 24, 25).

Many post-Soviet immigrants used mental health services for the first time in Israel, preferring primary care physicians rather than mental health specialists, and individual outpatient service rather than group counseling. Our data confirm the findings of Chow et al. (26).

The most important finding of our study is that major psychiatric disturbances were unevenly distributed in the two groups. This holds true for the inpatient groups (Chi-square-10.0, p<.05), but not for the outpatient groups. Our assumption was that relatively fewer NI as opposed to VR would seek psychiatric help and this was confirmed by our findings. The NI are prone not to seek medical aid in outpatient facilities until a real worsening of mental health status compels them to be hospitalized. Older immigrants from the former Soviet Union tend to minimize psychological problems, perceiving defining them as expressions of the natural stresses in life, which can be coped with by obtaining help from one's family. Cultural stigmatization of mental illness remained evident in their views of mental illness as beyond the person's or family's ability to cope as the
person has lost his or her inner strength and moral character (dusha) and is beyond help (27).

Soviet elders often present with more advanced stages of impaired function and numerous somatic complaints (11, 28). They tend to focus on physical discomfort while ignoring or suppressing emotional symptoms, but they also experience higher rates of depression, anxiety, demoralization and somatization than do native-born populations in Israel, the United States and the United Kingdom (28, 29).

Immigration is generally acknowledged to be a major stressor which may increase the emotional distress of an individual immigrant and in some cases may even lead to psychopathological reactions. However, immigration alone does not necessarily lead to psychological disorder; rather it affects individual immigrants via the interaction with external and internal factors (6, 14, 30). A primary external factor specific to immigrants from the former USSR is the significant cultural gap which exists between Soviet and Israeli societies, rendering much of the life long experience of these immigrants inapplicable and inappropriate in Israel (31–33).

Immigration leads to major changes in lifestyle and environment. (34, 35) Depression and loneliness are associated with immigration (23). Soviet immigrants experience separation from their homeland and familiar way of life (36, 37), cultural and psychological stresses related to loss of relatives and friends, language and financial status (38). They need to adapt themselves to a state of dependence on their children (39, 40) and difficulties with the laws and norms of the new country (41, 42).

Even though these immigrants come from different ethnic republics from the former USSR, they have significant difficulties in common, as well as normative stressors such as aging, bereavement, narcissistic injuries during the process of adaptation, retirement and vulnerability to uprooting. These difficulties include enhanced dependency needs, poorly defined boundaries within extended family units, and specific historically and culturally determined relationships with authority figures (43). According to Kleinman (44, 45), culture-bound syndromes express certain cultural ideologies that are not shared across cultures. Symptoms are socially constructed, and the cultural patterning of symptoms produces so-called culture-bound disorders, whereas illness is the personal, interpersonal, and cultural reaction to disease, which is a malfunctioning or maladaptation of biological or psychological processes.

Our results demonstrate that female gender, higher education and marital status (being either single or divorced) in NI were associated with more psychiatric referrals than in VR. These findings correspond to those of other researchers who report that female gender, higher education and single marital status are among those factors that predispose immigrants to a poorer mental health outcome (46–51). Divorced or widowed older women reported significantly more somatic and other symptoms of distress than did men (52). In women stressful conditions more often have a tendency to increase panic and passive behavior, while in the absence of stress, women are more predisposed to stereotyped behavior. Men do not display such a tendency (53).

The demographic data show that in the immigrants' group there is a greater prevalence of indicators considered to be associated with greater vulnerability for worse mental health such as single or divorced status (54, 55).

Our findings also showed that there is no difference in the diagnosis of adjustment disorders in the outpatient groups, while there is a significant difference among admitted inpatients — 11% versus 4% (p<.05). These results are consistent with previous publications (14, 56). Our explanation for these findings is that the immigrants from the former Soviet Union have a higher threshold for sending older family member to psychiatric services due to social and cultural traditions. According to tradition, family does everything to hold onto older family members in the family framework, and will not turn to psychiatric services for what are conceptualized as slight problems. While checking the health seeking behavior of NI for psychological distress, it was found that most of them preferred not to turn to help at all. Only the most severe cases turned to mental health services and this expressed itself in the inpatient category with significant increase in the rates of admission (57).

Our explanation is supported by the Polyakova and Pacquiao study (27) that also found that elders demonstrated a high degree of stoicism. According
to their findings, elders’ facial expressions and behaviors remained unchanged even in situations when they were in pain, sad or lonely. Physical symptoms such as blood pressure and heart rates were more indicative of conditions that may have been precipitated by emotional distress. Elders only presented physical complaints and did not elaborate on feelings even when prompted. They openly discouraged each other from reporting pain or emotional distress to the researchers (practitioners at the clinic). Although elders attended the clinic more consistently once they established relationships with the practitioners, their emotional expressions were limited because of language barriers (27).

We did not find differences between NI and VR groups in proportion of patients suffering from schizophrenia and mood disorders and regarding place of treatment of these disorders. We explain these findings as follows: these patients had often been hospitalized before their immigration and the severity of their illness and the necessity of treatment was well established by family members.

A more surprising and interesting finding was the psychiatric help associated with the diagnostic category of dementias. Examining the results we find that the rate among admitted NI patients is half that of admitted VR patients, while the rate in the outpatient groups was almost identical. How are we to understand this finding? Our explanation is based on the appreciation of socio-cultural factors in this population. We have in mind the importance of the extended family in this culture, especially the importance of the grandmother and grandfather ("Babushka" and "Dedushka") in raising children. The families will make a more considerable effort to hold onto and to take care of the demented or the elder relatives suffering from organic brain syndromes at home as long as possible. They often experience financial burdens and psychological distress in order to keep the sick relatives at home (58). Only the most severe and deteriorated cases are brought to the hospital for admission. According to Kleinman (45), illness and disease occur within a cultural and social context. Culture is the framework within which the meanings of illness and the necessary care or cure are determined. The types of mental illness seen within a given culture reflect the way that culture understands the self and its relationship to society, the way people within the culture understand themselves in the world, and the way they express grief, fear, anxiety and depression.

The lower rate of dementias among NI compared to VR may be explained by their higher educational level. Higher educational level may protect against dementia (49). According to some studies, schooling appears to be an important protective factor against the development of dementia (49–51). Another explanation could be that in those with a higher level of education the symptoms of dementia are recognized later due to a greater degree of cognitive reserve.

Our study has some limitations. For one this was not a planned epidemiological study. In addition, we examined only those elderly patients of both groups who sought psychiatric help. We did not obtain data from the Ministry of Absorption regarding the distribution of gender, age, marital status and education in the entire population. We did not perform an entire catchment-area survey. Proper epidemiological studies would be helpful.

Acknowledgement

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References


