The Association Between Acculturation Patterns and Mental Health Symptoms Among Eritrean and Sudanese Asylum Seekers in Israel

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CITATION
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Past research has documented the role acculturation plays in the process of adjustment to new cultures among migrants. Yet little attention has been paid thus far to the role of acculturation in the context of forced migration. In this study we examined the association between acculturation patterns and mental health symptoms among a convenience sample of Eritrean and Sudanese asylum seekers (n = 118) who accessed health services at the Physicians for Human Rights Open-Clinic in Israel. Participants completed measures on sociodemographic information as well as detention history, mental health symptoms, exposure to traumatic events, and acculturation pattern, in their native language upon accessing services. Consistent with our predictions, findings showed that acculturation predicted depressive symptoms among asylum seekers beyond the effect of history of detention and reports of experiences of traumatic events. Assimilated compared with integrated asylum seekers reported higher depressive symptoms. Findings draw attention to the paradox of assimilation, and the mental health risks it poses among those wishing to integrate into the new culture at the expense of their original culture. Asylum seekers may be particularly vulnerable to the risks of assimilation in the restrictive policies that characterize many industrial countries in recent years.

Keywords: acculturation, Africa, anxiety, asylum seeker, depression, forced migration, Israel, mental health

Political tensions, civil unrest, and persecution based on religious affiliation are some of the reasons people are forced to leave their country of origin and flee to safer places where asylum is offered. Section 94(1) of the Immigration and Asylum Act of the United Nations Agency for Refugees defines an asylum seeker as a displaced person who “is not under 18 and has made a claim for asylum which has been recorded by the Secretary of State but which has not been determined” (United Nations High Commissioner for Refugees, 2001). The number of asylum seekers is growing rapidly, and the United Nations High Commissioner for refugees (2011) estimated there are approximately 895,000 asylum seekers worldwide.

Similar to other industrialized countries, Israel has been facing an influx of African asylum seekers in recent years. Currently there are approximately 55,000 asylum seekers in Israel, the majority of whom came from Eritrea and Sudan (Moshe, 2013). Young Eritreans claim asylum based on having escaped from an extremely repressive state and compulsory military service in Eritrea, a country that has long been known for its grave violations of human rights: religious and political persecution, disappearances of citizens, and use of torture by the government (Connell, 2012; Tronvoll, 2009). Men and women from the Darfur region in Sudan flee persecution and mass murder of civilian populations perpetrated by the government and armed militia groups. Israel also hosts a smaller community of asylees who have escaped years of governmental persecution, civil war, insecurity, and a lack of social infrastructure in South Sudan (Furst-Nichols & Jacobsen, 2011; Reynolds, 2013).

African asylum seekers began crossing the Egypt–Israel border in 2006. Reasons for the influx of asylum seekers entering Israel can be traced to the growing restrictions on migration to Europe and the decline of living conditions for African refugees in Libya and Egypt. Most, if not all, asylum seekers arrive in Israel via the Sinai desert in Egypt (Lijnders, 2012).

Since 2007 and up until recently, the number of asylum seekers arriving in Israel through the Sinai desert has dramatically increased and reached a peak of more than two thousands asylees who crossed the border each month in 2010 (Human Rights Watch, 2014; Lijnders, 2012). The political unrest, the state of insecurity, and chaos in North Africa were some of the reasons for this influx. The journeys of African refugees merge in the Northern Sinai, a region that, although under Egyptian governmental control, is characterized by a political vacuum that is demonstrated by growing lawlessness and impunity (Furst-Nichols & Jacobsen, 2011; Reynolds, 2013) since the emergence of the Arab spring in 2010.

Although some fleeing Eritrea and Sudan are able to pay a smuggler who can guide them in relative safety to a refugee camp, a significant number cross the border without help and often fall prey to human traffickers who roam the border region (van Reisen, Estefanos, & Rijken, 2012). Traffickers operate within Ethiopian
and Sudanese refugee camps as well (van Reisen, Estefanos, & Rijken, 2013). A sizable network of smugglers operates across Eritrea, Sudan, Egypt, and Israel to smuggle sub-Saharan asylees to their destination in Israel. The construction of an Egyptian–Israeli border fence and growing restrictive policies have substantially diminished the number of new arrivals since 2013.

African asylum seekers in Israel are densely concentrated in the southern Tel Aviv, one of the city’s poorest neighborhoods. Until recently, Israel’s collective group protection policy, granting Eritrean and Sudanese asylum seekers the right to remain in Israel until their home countries are deemed safe for their return, prevents Eritrean and Sudanese asylum seekers from applying for official refugee status. The provisional status granted to them must be renewed frequently. To this date an exceptionally small number of asylum seekers have received refugee status in Israel (Mundlak, 2008). As a result, African asylum seekers in Israel often remain in an economically and psychologically unstable situation for a prolonged period of time and are excluded from fully participating in Israel’s social, political, and health systems (e.g., many cannot legally work and have limited access to the national health care system; Furst-Nichols & Jacobsen, 2011; Mundlak, 2008; Reynolds, 2013).

## Forced Migration and Mental Health

Though mostly focused on refugees, past research documented that forced migration serves as a risk factor for mental ill health (Ellis, MacDonald, Lincoln, & Cabral, 2008; Kirmayer et al., 2011; Leaman & Gee, 2012; van Willigen, Hovens, & van der Ploeg, 2006). Factors related to premigration experiences (e.g., political and religious persecution, rape, torture, famine, war and ethnic conflicts, poverty; Masocha & Simpson, 2012; Porter & Haslam, 2005; Thomas & Thomas, 2004), process of migration (e.g., loss of family and friends, traumatic experiences during the migration), and postmigration experiences (e.g., discrimination and restrictive policies; Nakash, Nagar, Shoshani, Zubida, & Harper, 2012; Nakash, Wiesent-Brandsma, Reist, & Nagar, 2013; Porter & Haslam, 2005) are all likely to play a role in the increased risk for mental health problems documented among refugees and asylum seekers compared to the general population.

In particular, studies have documented elevated risk for anxiety, depression, and posttraumatic stress disorder (PTSD) among asylum seekers and refugees (Burnett & Peel, 2001; Fazel, Wheeler, & Danesh, 2005; Govaert, Gernaat, Komproe, Schreuders, & De Jong, 2004; Tempany, 2009). For example, 19% of the adult newly arrived African asylum seekers in Australia were reported to have mental health problems (Tiong et al., 2006), and prolonged waiting for refugee status led to severe mental distress (Sultan & O’Sullivan, 2001). Similarly, approximately 30% of asylum seekers who received treatment at a mental health clinic in Israel were diagnosed with PTSD (Lurie, 2009). Rees (2003) suggested that asylum seekers are at high risk of developing psychopathology as a result of the uncertainty that accompanies their legal status and the limited social support.

In a meta-analysis examining pre- and postdisplacement factors associated with mental ill health among refugees and internally displaced persons, Porter and Haslam (2005) identified several factors including age (children and adolescents reported less psychopathology than adults), gender (women have higher prevalence of depression and PTSD than men), and employment status post migration (unemployment was associated with worse mental health than employment). In addition, during migration, family structure is often disrupted and early separation from significant others is common (Chan, Barnes-Holmes, Barnes-Holmes, & Stewart, 2009). Furthermore, a study that examined medical records of refugees from Africa and Asia who participated in the Bellvue Hospital/New York University Program for Survivors of Torture in New York showed that past exposure to multiple traumatic events among participants of the program was common and was associated with mental ill health (Chu, Keller, & Rasmussen, 2013).

Another postmigration stressor that has received a growing attention is detention. To deal with the influx of irregular migrants, some countries have adopted a strategy of restrictionism including establishment of detention centers, where asylum seekers are held for undetermined periods of time while their application for refugee status is evaluated (Robjant, Hassan, & Katona, 2009). Although some, research has suggested that prolonged stay in these centers can contribute to mental ill health especially among individuals who experienced prior traumas before and during migration (Masocha & Simpson, 2012). For example, in a two-year longitudinal study among refugees from Iran and Afghanistan currently living in Australia, Steel et al. (2011) found that detained refugees had higher baseline and follow-up scores on PTSD scales compared with nondetained refugees. Similarly, Keller et al., (2003) interviewed asylum seekers from Africa, Europe, and Asia who lived in the United States and documented that longer periods of detention were associated with worse symptoms of PTSD at follow up and suggested that detention of asylum seekers exacerbates psychological symptoms.

Asylum seekers, like other migrants, often need to adapt to a new cultural environment that can place them at odds with their heritage culture (Berry, 1990), with significant implications to mental health (Heptinstall, Sethna, & Taylor, 2004; Pumariega, Rothe, & Pumariega, 2005).

## Acculturation and Mental Health

The process of learning about and adapting to a new culture is termed “acculturation” (Berry, 1990). Two independent dimensions have been hypothesized to underlie the process of acculturation, namely, heritage-culture retention and receiving-culture acquisition (Berry, 1997). According to this bidimensional approach, four acculturation patterns can possibly emerge as a result of the intersection of the two dimensions: assimilation, whereby limited interest and involvement is made to maintain the heritage culture or rapprochement; separation, in which there is high involvement in maintaining the heritage culture and low involvement with the receiving culture; marginalization, in which there is low involvement in both cultures; and integration, or biculturalism, in which there is high involvement in both heritage and receiving cultures (Berry, Phinney, Sam, & Vedder, 2006). The process of acculturation is acknowledged to be stressful and can be associated with social and psychological problems (Berry, 1997). The extent, pace, and type of cultural changes necessary can all impact the psychological well-being of the immigrating individual. Lack of support, pressure to adapt too quickly, or inability
to follow desired acculturative strategy can lead to emotional problems. Berry argued that the most positive acculturative pattern in societal and psychological terms is integration which results from a situation where new arrivals develop relationships with the receiving culture while maintaining their own cultural heritage. Much research over the past three decades has provided support to the benefits of integrated acculturative pattern and showed that it is associated with improved mental health outcomes compared with other acculturative patterns (Berry, 2006; Chen, Benet Martinez, & Harris Bond, 2008; Sullivan, Schwartz, & Prado, 2007). For example, a study among first- and second-generation irregular migrant youth in Israel (Nakash et al., 2012) showed that acculturation played an important role in predicting the mental health status of the young migrants, with youth characterized by integrated acculturative pattern reporting lower mental health symptoms compared with those characterized by assimilated acculturative pattern.

Although limited, some studies have shown that acculturating to the receiving society proves to be more challenging among those who have been forced to leave their home country, partly because of their temporary status, which inhibits their motivation to adapt to the ways of the receiving society. Furthermore, specific integration policies may be necessary to ensure that the development of intercultural relationships is possible and thus it is important that institutions act to facilitate interaction while at the same time ensure that services can be adapted to meet newcomers’ needs. This is particularly important in the case of forced migrants as they can have a preference for an acculturative strategies (e.g., to mix with the receiving culture), yet they may have little choice about implementing it. In the case of forced migrants, acculturative strategy may be imposed if perhaps members of the receiving culture are reluctant to engage with new arrivals, or if policies are not in place to support integration and institutions do not adapt to meet their needs. In a study among refugees living in England, Phillimore (2011) suggested that in the current restrictive policy environment, many refugees lack choice about acculturation strategy, struggle to integrate, and remain vulnerable to psychosocial stress.

The Current Study

Research to date has provided support to the impact of acculturation pattern on mental health symptoms of migrants. However, little attention has been paid to the association between acculturation and mental health in the context of forced migration in general, and among asylum seekers in particular. In this study, we examined the role of acculturation in predicting mental health symptoms among Eritrean and Sudanese asylum seekers in Israel. The study was conducted among a convenience sample of asylum seekers from Eritrea and Sudan who sought health services in the Physicians for Human Rights (PHR) Open-Clinic in Tel Aviv Israel, which provides services to irregular migrants who do not have access to the national health care system.

We hypothesized that acculturation patterns will be associated with mental health symptoms such that integrated asylum seekers will show lower anxiety and depressive symptoms compared with other acculturation patterns beyond the effects of sociodemographic variables, history of detention, and previous exposure to traumatic events.

Method

Setting

The PHR Open-Clinic provides primary care as well as a range of secondary services to uninsured persons, most of whom are asylum seekers and undocumented migrant workers who lack access to medical care (Physicians for Human Rights, 2013).

Sample

A convenience sample of \( n = 118 \) asylum seekers from Eritrea and Sudan who sought health services at the PHR Open-Clinic in Tel Aviv, Israel between April 2012 and June 2013 participated in the study. Participants included 91 Eritreans (77.1%) and 27 Sudanese (22.9%). Ages ranged from 19 to 48, with a mean age of 31.0 (SD = 7.2). A majority of the participants were men (74.7% of the Eritrean sample, \( n = 68 \) and 92.6% of the Sudanese sample, \( n = 25 \)). A majority of the participants were Christians (74.1%, \( n = 87 \)), and the rest were Muslim; two participants did not state their religion. Approximately half of the participants (50.8%, \( n = 60 \)) were unemployed and searching for a job, and 34.7% (\( n = 41 \)) of participants were employed. The majority of participants (89.4%, \( n = 105 \)) reported earning salary that is lower than the median salary (1,674US$ per month).

Procedure

Upon accessing services at the clinic, research assistants invited service users to participate in the study. Those who agreed to participate completed a list of measures detailed below in their native language (Tigrinya, Arabic) while waiting for the appointment with the health provider. Participation was anonymous and confidentiality was assured. To attain cultural relevance, which includes semantic, content, and technical equivalency, and internal consistency of the measures across languages and ethnic groups we finalized the instruments through a five-step process: (1) identification and prioritization of the constructs we intended to study based on a comprehensive literature review; (2) identification of available measures to study the constructs with prioritization to measures that have been used in previous studies with the targeted population; (3) adaptation and translation- back translation of the identified measures; (4) pretesting of the measures; and (5) testing the internal consistency of the final measures (Alegria et al., 2004). The study was approved by the Ethics Committees of PHR and the Interdisciplinary Center, Herzliya. Data collection was in compliance with human subject protocol.

Measures

Sociodemographic measure. The sociodemographic measure included questions tapping the following information: gender; date of birth, country of origin; religion; family status (single, married-living with partner, married- partner not in Israel, separated, divorced, widowed); employment status (employed, unemployed); income (much below median, below median, median, above median; monthly median income = US$1,580); years of formal
education; and detention history length (up to 1 month, 1–3 months, 3–6 months, more than 6 months).

Hopkins Symptoms Checklist (HSCL25; Parloff, Kelman, & Frank, 1954). The HSCL-25 consists of 25 Likert-type questions ranging from 1 (not at all) to 4 (extremely). The first 10 questions cover anxiety symptoms (total scale score ranges from 10 to 40), and the remaining 15 questions cover depression symptoms (total scale score ranges from 15 to 60). Previous studies have documented valid use of the measure among African migrants as well as asylum seekers (Tang & Fox, 2001; van Willigen et al., 2006). The scales showed high internal consistency (Cronbach’s alpha = .82 and .88, respectively).

Harvard Trauma Questionnaire (HTQ-Part 1; Mollica et al., 1992). The first part of the Harvard Trauma Questionnaire assesses the prevalence of exposure to traumatic events. The 17 items included in the measure depict traumatic events that are rated on a scale indicating whether the respondent experienced, and/or witnessed, and/or heard about the event. Final score includes the total number of events (summary of all items for which response differs from “no”). Previous studies have documented valid use of the measure among African migrants as well as asylum seekers (Tang & Fox, 2001; van Willigen et al., 2006). The scale showed high internal consistency (Cronbach’s alpha = .92).

Bicultural involvement and adjustment scale (Szapocznik, Kurtines, & Fernandez, 1980). This measure assesses the acculturation pattern and includes two scales representing adoption of receiving-culture practices and retention of heritage-culture practices. The measure was adapted to the Israeli context and consists of two separate subscales (Israelism, which captures adoption of Israeli practices and “country of origin,” which includes retention of practices of heritage country). The Israelism scale assesses use of Hebrew and affinity for Israeli food, entertainment, and music. The “country of origin” scale assesses use of native language and affinity for country of origin’s food, entertainment, and music. The scales showed high internal consistency (Cronbach’s alpha = .79 and .76, respectively). Using a bipartite split, the Israelism and country of origin scales rendered a score for each participant that was placed on a 2 × 2 quadrant to determine participant’s acculturation pattern (Nakash et al., 2012; Ward & Rana-Deuba, 1999) resulting in four groups of acculturation patterns: separated (n = 44), assimilated (n = 16), integrated (n = 37), and marginalized (n = 21).

Statistical Analysis

Analyses were performed using SPSS version 18.0 (SPSS Inc., Chicago, IL). Sociodemographic characteristics across the four groups of acculturation patterns (separated, assimilated, integrated, and marginalized) were compared by the χ² test for categorical variables and ANOVA for continuous variables. Bonferroni correction was applied to account for multiple comparisons (α = .005). MANCOVA analysis was used to examine differences among the four groups of acculturation patterns in anxiety and depression symptoms while controlling for exposure to traumatic events. Tukey post hoc analyses were conducted to reveal the source of significant differences.

Bivariate correlations between independent and dependent variables were calculated using Kendall’s tau-Bs for categorical variables (i.e., gender, employment status, family status, country of origin, detention, and separated, assimilated, marginalized, and integrated), Spearman’s r for ordinal variables (i.e., detention length), and Pearson’s r for continuous variables (i.e., age, total number of traumatic events, anxiety and depression).

To examine the effect of acculturation patterns on anxiety and depression while controlling for the possible effect of sociodemographic variables and above the effects of detention and exposure to traumatic events, two hierarchical (three steps) linear regression analyses were computed. Anxiety and depression scores were entered as the dependent variables in each regression. Independent variables included demographic variables (gender, age, employment, family status, and country of origin) in the first block, detention and exposure to traumatic events in the second block, and acculturation pattern in the third block. Bonferroni correction was applied to account for multiple comparisons (α = .005).

Results

Sample Sociodemographic Characteristics

Sociodemographic characteristics of the sample by acculturation patterns are presented in Table 1. The majority of participants were Eritrean men who had up to 12 years of formal education and were unemployed. Most of the respondents were detained up to 3 months on their arrival to Israel. There were no significant differences in sociodemographics characteristics among participants in the four acculturation groups.

Differences in Anxiety and Depression Among the Acculturation Groups

One-way MANCOVA was used to examine the differences among the four acculturation groups in anxiety and depression while controlling for exposure to traumatic events. Results approached significance, F(6, 204) = 1.912, p = .08; Pillai’s Trace = .106, partial η² = .053. One-way ANOVA analyses were used to test for between subjects’ effects. The analyses revealed significant differences between acculturation groups in depression scores, F(3, 102) = 2.829, p < .05, partial η² = .077. Tukey post hoc analyses showed significant differences between marginalized and assimilated acculturation patterns, such that assimilated participants reported higher sum score of depressive symptoms (M = 33.6, SD = 10.5) compared with marginalized participants (M = 24.2, SD = 10.8). Means and standard deviations of anxiety and depressive symptoms are presented in Table 2.

Acculturation Pattern and Outcome Measures Among Asylum Seekers

Bivariate correlations between independent and dependent variables among participants are presented in Table 3. As expected, there was a significant high positive correlation between anxiety and depression and significant small to medium positive correlations between anxiety, depression, and total exposure to traumatic events. Significant small negative correlations were observed between acculturation patterns and sociodemographic characteristic, for example, employment and family status. Additionally, anxiety was negatively correlated with marginalized acculturation pattern, and depression was positively correlated with assimilated accul-
A second hierarchical linear regression analysis using depression scores as the outcome variable and the same predictor variables was also significant, predicting 26% of the variance. Exposure to traumatic events was significantly associated with depression, such that exposure to traumatic events was significantly associated with depression scores even after accounting for sociodemographic variables, detention, and exposure to trauma, with assimilated acculturation being related to higher depression scores (partial \( r = .33, p < .001 \)) predicted higher depression scores. In addition, acculturation patterns were associated with depression scores even after accounting for sociodemographic variables, detention, and exposure to trauma, with assimilated acculturation being related to higher depression scores (partial \( r = .35, p < .001 \)) compared with integrated acculturation pattern. Estimates from the model are presented in Table 4.

### Table 2

<table>
<thead>
<tr>
<th>Condition</th>
<th>Separated (n = 44)</th>
<th>Assimilated (n = 16)</th>
<th>Integrated (n = 37)</th>
<th>Marginalized (n = 14)</th>
<th>Statistic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>19.1 (7.0)</td>
<td>19.6 (7.1)</td>
<td>17.5 (6.8)</td>
<td>14.2 (4.9)</td>
<td>( F(3, 102) = 1.812, ns )</td>
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<tr>
<td>Depression*</td>
<td>30.0 (10.1)</td>
<td>33.6 (10.5)</td>
<td>26.5 (9.6)</td>
<td>24.2 (10.8)</td>
<td>( F(3, 102) = 2.829, p &lt; .05 )</td>
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</tbody>
</table>

Note. ns = not statistically significant.

A second hierarchical linear regression analysis using depression scores as the outcome variable and the same predictor variables was also significant, predicting 26% of the variance. Exposure to traumatic events was significantly associated with depression, such that exposure to traumatic events (partial \( r = .33, p < .001 \)) predicted higher depression scores. In addition, acculturation patterns were associated with depression scores even after accounting for sociodemographic variables, detention, and exposure to trauma, with assimilated acculturation being related to higher depression scores (partial \( r = .35, p < .001 \)) compared with integrated acculturation pattern. Estimates from the model are presented in Table 4.
Discussion

In this study we explored the association between acculturation patterns and mental health symptoms among Eritrean and Sudanese asylum seekers in Israel. Although past research has documented the significant role acculturation plays in the process of adjustment to new cultures among migrants, little attention has been paid, thus far, to the role of acculturation in the context of forced migration in general, and among asylum seekers in particular.

Consistent with our predictions we found that acculturation predicted depressive symptoms among asylum seekers beyond the effect of history of detention and reports of experiences of traumatic events. We did not find similar associations between acculturation and anxiety symptoms. More specifically, assimilated asylum seekers reported higher depressive symptoms compared with integrated asylum seekers. These results are consistent with some previous research (Nakash et al., 2012) showing that the rejection of the heritage culture and adoption of the Israeli culture, as a possible mechanism to improve the likelihood of upward social mobility or local acceptance, may carry heavy mental health consequences. The contrasting outcomes about anxiety and depression suggest that our findings are not merely the result of culturally based response bias.

Rumbaut (1997) called attention to the paradox of assimilation, and the mental health risks it poses among those wishing to integrate into the new culture at the expense of their original culture. Assimilation can be a highly stressful process for migrants (Wang & Freeland, 2004), especially at the beginning stage of relocation, when the newcomer is overwhelmed with daily hassles (Abouguendia & Noels, 2001), poverty (Porter & Haslam, 2005)

Table 3

<table>
<thead>
<tr>
<th>Variable</th>
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<tbody>
<tr>
<td>1. Gender</td>
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<td>- .25**</td>
<td>- .12</td>
<td>.56**</td>
<td>- .18*</td>
<td>- .08</td>
<td>- .07</td>
<td>- .09</td>
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<td>2. Age</td>
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<td>.08</td>
<td>- .22**</td>
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<td>3. Employment</td>
<td></td>
<td>- .03</td>
<td>- .15</td>
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<td>4. Family status</td>
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<td>- .16*</td>
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<td>5. Country of origin</td>
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<td>6. Detention length</td>
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<td>7. Total traumatic events</td>
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<td>8. Anxiety</td>
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<td>9. Depression</td>
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<td>.19**</td>
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<td>10. Separated acculturation</td>
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<td>11. Assimilated acculturation</td>
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<td>12. Integrated acculturation</td>
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<td>13. Marginalized acculturation</td>
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Note. For gender, male = 0, female = 1. For employment, not working = 0, working = 1. For family status, single, married with partner not living in Israel, separated, divorced, widowed = 0, married with partner in Israel = 1. For country of origin, Eritrea = 1, Sudan = 2. For detention length, up to 1 months = 1, 1–3 months = 2, 3–6 months = 3, more than 6 months = 4. For separated, assimilated, marginalized, integrated, no = 0, yes = 1. Kendall’s tau-Bs were calculated for gender, employment, continent, visa status, detention, and separated, assimilated, marginalized, integrated variables. Spearman’s r was calculated for detention length. All other correlation coefficients represent Pearson’s r.

*p < .05.  **p < .01.

Table 4

Hierarchical Multiple Regressions Examining Predictors of Anxiety and Depression Symptoms Among Asylum Seekers (n = 118)

<table>
<thead>
<tr>
<th>Model</th>
<th>Anxiety symptomsa</th>
<th>Depression symptomsb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE B</td>
</tr>
<tr>
<td>Step 1 (Constant)</td>
<td>23.73</td>
<td>4.46</td>
</tr>
<tr>
<td>Gender</td>
<td>-.87</td>
<td>2.04</td>
</tr>
<tr>
<td>Age</td>
<td>-.02</td>
<td>1.00</td>
</tr>
<tr>
<td>Employment</td>
<td>-3.24</td>
<td>1.40</td>
</tr>
<tr>
<td>Family status</td>
<td>-1.78</td>
<td>1.83</td>
</tr>
<tr>
<td>Country of origin</td>
<td>-4.09</td>
<td>1.91</td>
</tr>
<tr>
<td>Step 2 Detention length</td>
<td>-.55</td>
<td>.51</td>
</tr>
<tr>
<td>Total traumatic events</td>
<td>.30</td>
<td>.12</td>
</tr>
<tr>
<td>Step 3 Separated acculturation</td>
<td>.83</td>
<td>1.55</td>
</tr>
<tr>
<td>Assimilated acculturation</td>
<td>3.41</td>
<td>2.25</td>
</tr>
<tr>
<td>Marginalized acculturation</td>
<td>-4.20</td>
<td>2.12</td>
</tr>
</tbody>
</table>

a R² = .185, F(10, 103) = 2.331, p = .02.  b R² = .262, F(10, 104) = 3.698, p < .001.  **p < .001.
and discrimination (Nakash et al., 2012). Based on qualitative analyses of interviews with refugees living in England, Phillimore (2011) examined the experiences that influenced the refugee arrival and resettlement in the new country. Her findings showed how in current restrictive policy environments, many refugees lack choice about acculturation strategy, and are forced into marginalization. They are vulnerable to psychosocial stress and struggle to integrate. Asylum seekers, who are a particularly vulnerable group because of their temporary status, which excludes them from the possibility of integrating into the local social and political spheres, may be especially exposed to the risks of assimilation. The restrictions around employment in particular, and social and civil involvement in general, may push asylum seekers into living in encapsulated ghettos and lead to forced marginalization (Moshe, 2013; Phillimore, 2011; Tempany, 2009).

Interestingly, in the current study, assimilated asylees reported the highest depression symptoms compared with other acculturation patterns, whereas no significant differences emerged between integrated compared with marginalized and separated individuals. Harper and Zubida (2010) suggested that even when forced migrants want to settle in Israel and become part of Israeli society they remain, for the most part, “invisible” to the Israeli public, who perceive them as a cultural monolith and not as individuals with unique personalities and personal histories. Furthermore, these migrants’ reported identity conflicts including the internalization of prevalent Israeli negative stereotypes toward their heritage, culture, and/or the ethnic group. The internalized negative attitudes alongside restrictive policies may intensify this cultural clash and result in rejection of the heritage culture and adoption of the Israeli culture as a mechanism to improve the likelihood of upward social mobility. However, as the results of this study show, the rejection of heritage culture and adoption of the receiving culture may carry heavy mental health consequences. Future longitudinal studies may shed light on the dynamic nature of the adaptive function of acculturation patterns and show whether the assimilated acculturative pattern continues to be most maladaptive for this population if and when they naturalize. In addition, further qualitative studies which will allow more in-depth investigation into the acculturative experience of particularly the marginalized group may shed more light into the possible protective function it serves among African asylees in Israel.

Restrictive policies in many industrial countries (Moshe, 2013; Phillimore, 2011; Tempany, 2009) pose great hardship on the integration of asylum seekers into the new cultures. Miller and Rasmussen (Miller & Rasmussen, 2010; Rasmussen et al., 2010) further suggested stressful social and material conditions (daily stressors) partially mediate the relationship between war exposure and mental ill-health. In a study among Darfuri refugees in Eastern Chad, Rasmussen and colleagues (2010) found that although war-related traumatic events were the initial causes of refugees’ distress, the day to day challenges and concerns in the camps mediated the relationship between exposure to traumatic events and emotional distress.

Our findings provide additional support to the role of exposure to traumatic events on the mental health status of displaced individuals (Porter & Haslam, 2005). Our results expand previous research that documented the high prevalence of exposure to traumas among displaced individuals, including harassment, witnessing violence to others, torture of family members, and living in hiding (Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007; Nakash et al., 2014). Our findings show that past exposure to traumatic events is associated with depressive symptoms among asylum seekers.

Interestingly, despite recent research supporting the effect of prolonged detention on mental health symptoms (Robjant et al., 2009; Steel et al., 2011), our findings showed that detention did not have a significant effect on anxiety and depressive symptoms. Likely, the relatively short detention period that participants in the current study were exposed to (a majority of participants were less than a month in detention) minimized its effect on their well-being. The study has several limitations. First, data were collected among those who sought medical treatment, who may represent a particularly vulnerable, or on the other hand, a resourceful group among asylum seekers, which may limit the generalizability of the findings. Second, our data only included self-report measures, which can be subject to biases (Sonuga-Barke, Minocha, Taylor, & Sandberg, 1993). Reliability of recall of experiences of traumatic events may be particularly vulnerable to these biases because of symptoms of avoidance and dissociation that can develop as a result of the exposure (Herlihy & Turner, 2007). Third, because of statistical power constraints we conducted analyses across country of origin, which may have concealed important differences between migrants from Sudan and Eritrea.

The findings of the study manifest the important effect of the acculturation pattern on mental health symptoms in the integration experiences of asylum seekers. Being forced to flee their countries of origin and integrate into “strange foreign lands, where they can be isolated, ostracized, and impoverished” (Williams & Berry, 1991, p. 632), may result in acculturation risks that will have lingering mental health consequences. Future longitudinal studies that also include in-depth interviews may shed light on the unique risk and protective factors among asylum seekers to guide intervention studies aimed at improving the well-being and adaptive functioning of this vulnerable population.

References


