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Cultural and Familial Factors Affecting Mental Health in Immigrant Communities

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ABSTRACT

This study aims to explore how cultural and familial factors influence the mental health experiences of immigrant communities residing in Tehran, with a particular focus on stigma, intergenerational dynamics, and structural stressors. A qualitative design was employed using semi-structured in-depth interviews with 24 immigrants from diverse national backgrounds currently living in Tehran. Participants were recruited using purposive sampling to ensure diversity in gender, age, and migration history. Interviews were conducted until theoretical saturation was reached. Data were transcribed verbatim and analyzed thematically using NVivo software. The study emphasized inductive coding to allow themes to emerge organically from the participants' narratives. Three main themes emerged from the analysis: (1) Cultural Beliefs and Stigma, (2) Familial Dynamics and Expectations, and (3) Structural and Social Stressors. Cultural stigma and religious interpretations of mental illness were identified as major barriers to help-seeking. Families often perpetuated silence and shame around psychological issues, particularly through gendered expectations and the preservation of social reputation. Intergenerational conflict, emotional communication gaps, and pressure related to parental sacrifice narratives were common. Structural challenges such as legal insecurity, language barriers, discrimination, and lack of culturally competent services further exacerbated psychological distress. Despite these challenges, some participants identified community and spiritual resources as protective factors. Mental health among immigrant communities is deeply influenced by cultural norms, family dynamics, and systemic inequalities. Addressing immigrant mental health requires culturally responsive, family-centered, and community-informed strategies that acknowledge the complex socio-cultural realities these individuals navigate.

Keywords: immigrant mental health; cultural stigma; family dynamics; acculturation stress.

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Introduction

The global increase in migration has led to an expanding body of literature examining the multifaceted challenges faced by immigrant populations, particularly in relation to mental health. While migration often holds the promise of economic opportunity, safety, and improved quality of life, it also brings with it significant psychological and social stressors that shape the mental health trajectories of individuals and

families. Among these stressors, cultural dislocation, family role shifts, economic insecurity, discrimination, and legal precarity are frequently identified as critical determinants of psychological well-being among immigrants (1-3).

Immigrant communities are not homogeneous, and their mental health experiences vary widely based on origin, migration history, legal status, and cultural background. However, many immigrants confront a similar core challenge: navigating the intersection of their cultural values and host society norms while managing the emotional toll of uprooting and resettlement (4, 5). This process of adjustment often exacerbates stress levels, disrupts family dynamics, and alters parenting practices and emotional support systems—all of which directly affect mental health outcomes (6, 7).

A prominent aspect of mental health in immigrant communities is the role of cultural belief systems. Mental illness is often conceptualized differently across cultural contexts, and stigmatization rooted in traditional or religious interpretations can limit help-seeking behaviors (8, 9). In many cultures, mental health struggles are interpreted as a sign of personal failure, spiritual weakness, or familial dishonor, leading individuals to suppress symptoms rather than access formal care (10, 11). This cultural stigma, combined with fear of social repercussions such as gossip or reputational damage, discourages disclosure and can exacerbate isolation and psychological distress (12, 13).

Family systems play a central role in mediating mental health experiences among immigrants. On one hand, families can be vital sources of emotional support, resilience, and cultural continuity. On the other, they may become sites of tension when differing levels of acculturation or generational divides arise (14, 15). Adolescents and young adults, in particular, often struggle to reconcile expectations from their family of origin with the sociocultural values of the host country. This intergenerational conflict can result in feelings of guilt, identity confusion, and reduced psychological well-being (13, 16).

Parent-child relationships often undergo considerable change during and after migration. In some cases, children adapt more rapidly to the host society's language and norms, which can reverse traditional family hierarchies and create a sense of parental disempowerment (7, 17). Simultaneously, immigrant parents often carry the emotional burden of sacrifice and the pressure to succeed for their children's sake—narratives that, while grounded in love, may unintentionally convey conditional support or suppress acknowledgment of psychological distress (6, 8).

The sociopolitical environment of the host country also significantly shapes immigrant mental health. Discrimination, xenophobia, and exclusionary policies contribute to heightened stress levels and fear, especially among undocumented or mixed-status families (11, 18, 19). Encounters with immigration enforcement, such as workplace raids or detention threats, have been found to produce long-term psychological harm in both adults and children (10, 19). Moreover, research indicates that immigrant families living with multiple marginalities—such as those related to race, gender, and HIV status—often experience compounded trauma, requiring culturally competent and intersectional responses from health systems (5, 20).

Structural barriers, including lack of access to mental health services, language difficulties, and absence of culturally sensitive providers, often leave immigrant populations underserved (3, 21). Even in countries with publicly funded healthcare systems, immigrant families report difficulties in navigating services due to unfamiliarity with administrative processes, fear of exposure, and insufficient translation or interpretation

services (9, 22). Community-based interventions and culturally embedded models of care have been suggested as more effective alternatives to traditional, individually oriented therapeutic modalities, especially for collectivist cultures (15, 23).

The stress associated with acculturation—the process of adapting to a new culture—has been widely documented as a significant predictor of mental health outcomes in immigrant families (1, 2). Acculturative stress may emerge from conflicting cultural expectations, pressures to assimilate, and systemic exclusion. For parents, it may mean the erosion of traditional parenting practices; for youth, it may involve identity fragmentation or pressure to serve as cultural brokers for their families (13, 16). In both cases, these stressors contribute to a climate of psychological tension that heightens vulnerability to anxiety, depression, and emotional disengagement (12, 24).

Children and adolescents within immigrant families are particularly susceptible to the cumulative effects of these psychosocial stressors. Exposure to trauma, both pre- and post-migration, and lack of access to supportive school environments contribute to emotional and behavioral difficulties (8, 14). Research in diverse settings has shown that family affluence, educational opportunity, and gender all interact with immigrant background to shape adolescent mental health trajectories (14, 21). Moreover, the stigma associated with mental health problems can deter young people from seeking help, especially if parents hold culturally rooted beliefs that equate emotional distress with weakness or failure (9, 15).

Importantly, the emotional well-being of immigrant families cannot be separated from the broader sociocultural and policy context in which they are embedded. Evidence from studies in both urban and rural settings shows that punitive immigration policies, fear of deportation, and anti-immigrant sentiment have tangible mental health repercussions that extend beyond the directly affected individuals to entire communities (1, 10, 19). For example, heightened anxiety, reduced trust in institutions, and social withdrawal are common responses to immigration-related trauma, even among U.S.-born children of undocumented parents (11, 18).

Intersectionality—a framework recognizing the overlapping and interdependent nature of social categorizations such as race, gender, and migration status—is increasingly being applied to understand the diverse mental health experiences of immigrant families (5). Studies focusing on Black, Latinx, and Asian immigrant groups have emphasized how racism, sexism, and cultural alienation intersect to produce unique vulnerabilities (1, 12, 20). Thus, mental health research and interventions must avoid universalizing immigrant experiences and instead recognize the layered identities and contexts that shape emotional well-being.

Despite the documented challenges, many immigrant communities exhibit remarkable resilience, drawing on cultural knowledge, spiritual practices, social networks, and community solidarity to navigate adversity (3, 17). Community-based mental health initiatives, culturally tailored therapy models, and structural interventions that address legal, economic, and educational inequalities show promise in promoting mental well-being among immigrant populations (4, 23). However, to design effective and equitable interventions, it is essential to understand the subjective, culturally specific experiences of immigrant families—a gap that qualitative research is uniquely positioned to address.

In this context, the current study seeks to explore how cultural and familial factors shape mental health experiences in immigrant communities residing in Tehran.

Methods and Materials

Study Design and Participants

This study employed a qualitative research design to explore cultural and familial factors affecting mental health among immigrant communities. The qualitative approach was selected to gain in-depth insights into participants' lived experiences and perceptions. A total of 24 participants were purposefully selected based on their status as immigrants residing in Tehran, Iran. Inclusion criteria included being over the age of 18, having lived in Tehran for at least one year, and willingness to discuss personal and familial experiences related to mental health. Maximum variation sampling was used to ensure a diverse representation in terms of age, gender, country of origin, and socio-economic background.

Data Collection

Data were collected through semi-structured, in-depth interviews conducted between [insert months/year if known]. An interview guide was developed to address key themes such as cultural beliefs about mental health, family dynamics, coping strategies, and perceived barriers to mental health services. Interviews were conducted in participants' preferred language and lasted between 45 to 90 minutes. All interviews were audio-recorded with participants' consent and transcribed verbatim. Data collection continued until theoretical saturation was achieved, meaning no new themes emerged from subsequent interviews.

Data analysis

Thematic analysis was conducted using NVivo software to manage and code the data systematically. Transcripts were first read thoroughly to achieve immersion, followed by open coding to identify initial themes. Codes were then grouped into broader categories and refined through iterative analysis. The analysis process was inductive, allowing themes to emerge from the data without imposing preconceived categories. To enhance trustworthiness, peer debriefing and member checking were utilized at key stages of the analysis.

Findings and Results

A total of 24 participants took part in the study, comprising 13 females and 11 males. Participants ranged in age from 22 to 58 years, with a mean age of 36.7 years. The majority were married (n = 15), while others were single (n = 7) or divorced (n = 2). In terms of educational background, 10 participants held a university degree, 8 had completed secondary education, and 6 had primary education or less. The sample included individuals from diverse countries of origin, including Afghanistan (n = 14), Iraq (n = 5), Syria (n = 3), and Yemen (n = 2), all currently residing in Tehran. The average length of stay in Iran was 9.3 years, ranging from 1 to 22 years. Employment status varied, with 9 participants engaged in informal or day labor, 6 in service-related occupations, 5 unemployed, and 4 homemakers.

Table 1. Themes, Subthemes, and Concepts

Category (Theme)	Subcategory (Subtheme)	Concepts (Open Codes)
1. Cultural Beliefs and Stigma	Mental Illness as Weakness	Shame, fear of judgment, lack of understanding, emotional suppression
	Religious Interpretations	Mental illness as a test from God, reliance on prayer, avoidance of medical help
	Distrust in Western Mental Health Models	Belief in cultural mismatch, fear of misdiagnosis, perception of therapy as foreign

	Silence Culture	Avoiding discussion, “saving face,” family secrecy, emotional isolation
	Role of Traditional Healers	Preference for spiritual healers, herbal remedies, community elders’ advice
	Gendered Perceptions of Mental Health	Women seen as emotional, men discouraged from expressing vulnerability
	Fear of Social Repercussions	Fear of losing community standing, gossip, marriageability concerns
2. Familial Dynamics and Expectations	Intergenerational Conflict	Value clashes, language barriers, parenting stress, youth identity struggle
	Parental Sacrifice Narrative	Guilt, pressure to succeed, financial stress, emotional suppression
	Family Honor and Reputation	Pressure to maintain image, discouraging disclosure, denial of problems
	Communication Barriers	Emotional distance, taboo topics, lack of shared vocabulary for emotions
	Gender Roles Within the Family	Unequal emotional labor, caregiving burden on women, father’s absence in mental dialogue
	Support vs. Control	Overprotectiveness, infantilization, conflict over independence
3. Structural and Social Stressors	Discrimination and Xenophobia	Workplace bias, name-based exclusion, fear in public spaces
	Legal and Economic Insecurity	Residency concerns, unemployment, poverty, limited access to care
	Language and Access Barriers	Difficulty finding services, lack of translated materials, fear of miscommunication
	Lack of Culturally Competent Services	Feeling misunderstood, irrelevant therapy models, lack of cultural awareness in providers
	Social Isolation	Difficulty forming friendships, limited social support, missing extended family

Theme 1: Cultural Beliefs and Stigma

Mental Illness as Weakness: Participants frequently described mental health issues as a personal failure or weakness, often internalized from early life. The prevailing notion was that "strong people don’t get depressed," leading many to suppress emotional distress. One participant shared, *“If you cry or feel anxious, people think you’re just weak. My uncle told me to toughen up instead of seeing a doctor.”*

Religious Interpretations: Several respondents framed mental illness through a religious lens, viewing it either as a divine test or the result of insufficient faith. For many, prayer was the first—and sometimes only—form of help. One individual stated, *“My mother told me I was being tested by God and should pray more instead of complaining.”* This belief often delayed or replaced clinical treatment.

Distrust in Western Mental Health Models: Many participants expressed skepticism toward Western psychological frameworks, perceiving them as incompatible with their cultural experiences. Some believed that Western therapists could not understand their background. *“How can someone who doesn't know my culture understand my pain?”* one participant asked, highlighting the perceived cultural gap.

Silence Culture: A significant number of participants described a culture of silence around emotional suffering, especially within family contexts. Open discussion of mental health was often seen as shameful. *“We don’t talk about these things. You just keep going and hope it passes,”* one interviewee explained.

Role of Traditional Healers: Despite being in an urban setting like Tehran, traditional healing practices remained influential. Participants spoke of seeking help from spiritual leaders, herbalists, or community elders before considering professional care. One stated, *“I went to a mullah who gave me something to drink and told me I was under the evil eye.”*

Gendered Perceptions of Mental Health: Mental health was often feminized, with emotional expression deemed more acceptable for women. Conversely, men were expected to suppress emotional vulnerability. *"If a man cries, they say he's not a man. But my sister can cry and talk to my mom,"* noted one male participant.

Fear of Social Repercussions: Participants feared that disclosing mental health issues could affect their family's standing within the community. Concerns included gossip, exclusion, or challenges with marriage prospects. One woman shared, *"My aunt said if people find out I saw a therapist, no one will want to marry me."*

Theme 2: Familial Dynamics and Expectations

Intergenerational Conflict: A recurring issue was the clash between immigrant parents and their children, particularly around values and identity. Younger generations, often more acculturated, felt misunderstood. *"My dad thinks I should be grateful and stop complaining. He doesn't get what it's like to be stuck between two cultures,"* explained a second-generation participant.

Parental Sacrifice Narrative: Participants expressed internal pressure due to the narrative of parental sacrifice. This often led to feelings of guilt and emotional repression. One person reflected, *"They left everything behind for us. How can I tell them I'm depressed? I should just be thankful."*

Family Honor and Reputation: Families often prioritized preserving honor and public image over addressing psychological issues. Discussions of mental health were discouraged to avoid bringing shame. *"My mother said, 'What will the neighbors think if they hear you're seeing a shrink?'"* recalled a young woman.

Communication Barriers: Many participants described strained communication within the family, where emotional expression was limited or misunderstood. Taboo topics and emotional language were often absent. *"We never say 'I love you' or 'I'm sad.' We just assume things or stay quiet,"* said one participant.

Gender Roles Within the Family: Traditional gender roles affected how mental health was addressed. Women often carried emotional burdens and caregiving responsibilities, while men were distant from emotional matters. *"I had to take care of my mom when she was depressed, but my brothers just stayed out of it,"* noted a female participant.

Support vs. Control: Some participants viewed familial support as overbearing, describing experiences of being micromanaged or infantilized. While families meant well, this often led to feelings of suffocation. *"They think they're helping, but it feels like they're controlling my life. I can't even go to therapy without them asking why,"* one individual shared.

Theme 3: Structural and Social Stressors

Discrimination and Xenophobia: Participants reported facing xenophobia and discrimination in public spaces, workplaces, and institutions. This contributed to chronic stress and a sense of not belonging. *"They hear my accent and suddenly I'm not qualified anymore,"* recounted a university graduate.

Legal and Economic Insecurity: Unstable legal status and financial hardship were common stressors affecting mental health. The stress of unstable jobs, inflation, or visa issues was constant. *"I can't plan for next year because I don't know if we'll still be allowed to stay,"* said a father of two.

Language and Access Barriers: Difficulty accessing services due to language gaps was a major barrier. Many described struggling to find translated resources or interpreters. *"I had to take my cousin to translate for me at the clinic. I couldn't explain my feelings myself,"* one participant explained.

Lack of Culturally Competent Services: Participants felt that available mental health services did not reflect their cultural background, leading to feelings of being misunderstood. *"The therapist kept telling me to just think positive, but that doesn't work in our culture,"* said one woman.

Social Isolation: Several individuals described loneliness and limited social support, especially in the absence of extended family networks. *"Back home, there was always someone around. Here, it's just me and my phone most days,"* lamented a recent arrival.

Discussion and Conclusion

This qualitative study explored how cultural and familial factors influence mental health among immigrant communities residing in Tehran. Three central themes emerged from the interviews: (1) Cultural Beliefs and Stigma, (2) Familial Dynamics and Expectations, and (3) Structural and Social Stressors. These themes illuminate how mental health among immigrants is deeply embedded in social, cultural, and institutional contexts, often shaped by intersecting pressures that affect help-seeking, identity, and emotional well-being.

The first theme, Cultural Beliefs and Stigma, highlighted how mental illness is frequently perceived as a sign of personal weakness or moral failure, leading to widespread stigma and emotional suppression. This finding aligns with prior research indicating that culturally rooted perceptions of mental illness often prevent individuals from acknowledging or addressing psychological distress (8, 9). For many participants, religious interpretations framed mental suffering as a divine test or a consequence of spiritual deficiency, discouraging formal treatment. Similar spiritual explanations have been reported among immigrant families in other settings, where prayer and traditional healing practices are often prioritized over clinical intervention (1, 10).

The interviews also revealed a pervasive silence culture, in which discussions of mental health were considered taboo within the family and broader community. This echoes findings from studies of Latinx and Asian immigrant populations, where "saving face" and family honor take precedence over emotional disclosure, particularly in collectivist cultures (12, 13). Gendered beliefs further complicate these dynamics, with women permitted a limited range of emotional expression, while men are expected to suppress vulnerability. These gender expectations reflect broader societal norms reported in immigrant populations, where mental health stigma is compounded by traditional gender roles (5, 18).

The second theme, Familial Dynamics and Expectations, demonstrated how family serves both as a source of resilience and a site of psychological tension. Many participants discussed intergenerational conflicts arising from differing acculturation levels. Parents often held tightly to traditional norms, while children adapted more rapidly to local values and practices. This generational rift has been extensively documented in immigrant mental health research, which shows that children may experience stress from role reversals and cultural brokerage responsibilities, while parents experience loss of authority and cultural continuity (14, 16). In our study, these dynamics often manifested as conflict, guilt, or emotional disengagement between family members.

Another key finding was the internalized pressure linked to the parental sacrifice narrative—a theme in which children felt obligated to succeed or stay emotionally strong as repayment for their parents' migration efforts. This sense of indebtedness often prevented young people from disclosing mental health struggles, mirroring findings from studies where cultural expectations of gratitude and filial duty suppress emotional expression (6, 8). This familial pressure was further compounded by the notion of protecting family reputation or "saving face," especially when families feared gossip or social exclusion. Such findings resonate with studies on immigrant communities in both urban and rural contexts where family honor acts as a gatekeeper against mental health help-seeking (2, 11).

Additionally, participants in this study spoke of communication barriers within the family, particularly around emotions. Many described a lack of emotional vocabulary or safe space to discuss mental health, often resulting in misunderstanding or avoidance. Prior research confirms that emotional literacy and expression are often underdeveloped in families where survival, economic stress, or trauma dominate daily life (9, 21). In such contexts, traditional roles often prevail: mothers assume caregiving responsibilities and emotional labor, while fathers are distanced from family emotional dynamics, reinforcing unequal gender expectations within the household (7, 12).

The third theme, Structural and Social Stressors, underscored the role of systemic and environmental conditions in shaping mental health. Participants commonly cited experiences of xenophobia, legal precarity, financial instability, and limited access to culturally competent care as central sources of emotional strain. These structural barriers are well documented in the literature, particularly in immigrant communities facing hostile political climates, economic exclusion, and restricted social mobility (1, 19). Similar to other global studies, the fear of deportation or lack of legal status emerged as a consistent source of chronic anxiety (10, 11).

Language barriers were frequently cited as impeding access to mental health services. Many participants expressed difficulty in articulating complex emotional issues in Persian or navigating the healthcare system. These findings mirror other research indicating that even when services exist, linguistic isolation and cultural incongruity deter utilization among immigrant populations (3, 22). In addition, participants reported dissatisfaction with available mental health services, describing providers as ill-equipped to understand or integrate cultural values into therapy. These sentiments align with calls in the literature for culturally competent care models that address not only language but also cultural narratives of distress, coping, and healing (15, 23).

Many participants also described social isolation, especially due to the absence of extended family networks and lack of meaningful social connections. In traditional societies, extended kin often serve as emotional and logistical support, but migration frequently severs these bonds. This absence can lead to loneliness and reduced emotional buffering in times of crisis—a finding supported by studies that point to the importance of social cohesion and family proximity in maintaining mental health among immigrant families (4, 9). For single parents, elderly immigrants, and recent arrivals, these effects were especially pronounced.

Despite these challenges, the findings also highlight elements of resilience and coping. Several participants described using spiritual beliefs, community networks, and cultural rituals to navigate distress. These culturally grounded forms of resilience have been widely documented across immigrant communities,

where religion, mutual aid, and collective identity serve as buffers against adversity (17, 20). However, the effectiveness of these resources depends on context and availability; in settings like Tehran, where immigrants face legal and economic restrictions, such protective mechanisms may be weakened or inaccessible.

Collectively, this study affirms the complex interplay between cultural meaning systems, family expectations, and structural inequality in shaping the mental health of immigrant communities. It supports existing research suggesting that immigrant mental health cannot be fully understood through individual or biomedical models alone, but must be approached through relational, cultural, and systemic lenses (1, 24). As prior scholars have argued, centering the lived experiences of immigrants reveals the inadequacies of current service models and the urgent need for culturally responsive, family-centered, and community-driven mental health interventions (3, 23).

This study has several limitations. First, the sample was limited to 24 participants residing in Tehran, which restricts generalizability to immigrant communities in other geographic or cultural settings. The diversity of national origins within the sample—while valuable—also introduced considerable variability in cultural beliefs, which may not be fully captured in the thematic framework. Second, as a qualitative study based on self-reported data, the findings may be subject to recall bias, social desirability bias, or underreporting of sensitive issues. Although efforts were made to establish trust during interviews, participants may have withheld information due to fear, stigma, or mistrust. Lastly, the study focused only on semi-structured interviews and did not triangulate data with observational or clinical measures, which may have enriched the findings and provided additional depth.

Future research should build on these findings by conducting comparative studies across different host contexts, including rural areas and countries with differing immigration policies. Longitudinal designs would also be useful to track how cultural and familial dynamics evolve over time and how they affect mental health trajectories across generations. Additional research is needed to explore the intersectionality of gender, legal status, and religion in more detail, particularly among underrepresented groups such as undocumented individuals, LGBTQ+ immigrants, and refugee populations. Future studies might also benefit from mixed-methods approaches, combining qualitative insight with quantitative measures to assess the prevalence and impact of specific stressors. Finally, participatory action research involving community stakeholders could foster the co-creation of culturally relevant interventions and policies.

Mental health practitioners and service providers working with immigrant communities should prioritize cultural competence in all aspects of care, including assessment, diagnosis, and treatment. It is essential to engage with cultural beliefs respectfully, while also challenging stigmatizing narratives through education and dialogue. Family-based approaches should be integrated into mental health interventions, recognizing both the protective and stress-inducing roles families may play. Community outreach and psychoeducation can help destigmatize mental health and increase awareness of available resources. Furthermore, policies should be developed to ensure linguistic accessibility, legal protection, and social integration opportunities for immigrants, as these structural factors are deeply intertwined with psychological well-being.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Written consent was obtained from all participants in the study.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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