

## Evaluation of the Psychological Adjustment of Bihari Adults about Their Education Facilities in Mirpur Camps of Dhaka City in Bangladesh

Mushreen Islam<sup>1</sup>, Md. Wahidul Haque<sup>2</sup>, ABM Maqsdul Haque<sup>3</sup>, Md. Abdullah Yusuf<sup>4</sup>

<sup>1</sup>Assistant Professor (CC), Department of Community Medicine & Public Health, Monno Medical College and Hospital, Manikganj, Bangladesh; <sup>2</sup>Country Coordinator-Humanitarian Access, We Act For Kids Foundation, Dhaka, Bangladesh; <sup>3</sup>Head of the Department, Department of Community Medicine & Public Health, Monno Medical College and Hospital, Manikganj, Bangladesh; <sup>4</sup>Professor, Department of Microbiology, National Institute of Neurosciences and Hospital, Dhaka, Bangladesh

### Abstract

**Background:** The Bihari community in Bangladesh, displaced during the 1971 Liberation War, continues to live in socio-economically marginalized conditions, particularly in the Mirpur camps in Dhaka. Despite decades of settlement, many remain stateless and face restricted access to basic services, especially education. Education plays a crucial role in shaping psychological adjustment and social well-being. **Objective:** This study aimed to assess the psychological adjustment of Bihari adults in relation to their educational facilities available in Mirpur camps, identify barriers, and examine the impact on mental health. **Methodology:** This cross-sectional study was conducted among 140 Bihari adults aged 18 to 60 years living in 20 camps in Mirpur, Dhaka. Data were collected using a semi-structured questionnaire, including socio-demographic, perceptions of educational quality and accessibility, and the General Health Questionnaire (GHQ-28). **Results:** The study found that 65% of respondents demonstrated poor psychological adjustment. Younger adults (18-27 years) and those with higher educational attainment showed significantly better psychological resilience ( $p < 0.05$ ). Family income and duration to stay in the camps also influenced outcomes. Analysis revealed that poor quality of educational resourced, unqualified teachers, inadequate infrastructure, and limited accessibility was strongly associated with higher levels of depression, anxiety, insomnia, and social dysfunction. **Conclusion:** This research highlights those inadequate educational opportunities significantly undermine psychological adjustment of Bihari adults in Mirpur camps. Improving educational infrastructure, teacher training, financial aid, and access to education is essential for both mental health and social integration of the Bihari community.

**Keywords:** Bihari community; psychological adjustment; education facilities; refugee camps; mental health

**Received:** 02 April 2025; **Accepted:** 20 May 2025; **Published:** 1 December 2025

**DOI:** <https://doi.org/10.3329/jmomc.v11i2.90262>

**Correspondence:** Dr. Mushreen Islam, Assistant Professor (CC), Department of Community Medicine & Public Health, Monno Medical College and Hospital, Manikganj, Bangladesh, Email: [islaammushreen@gmail.com](mailto:islaammushreen@gmail.com); ORCID : 0009-000-7744-8933, Contact no- 01670050551

**How to cite this article:** Islam M, Haque MW, Haque ABMM, Yusuf MA Evaluation of the Psychological Adjustment of Bihari Adults about Their Education Facilities in Mirpur Camps of Dhaka City in Bangladesh. J Monno Med Coll. 2025 December;11(2):107-112

**Copyright:** This article is published under the Creative Commons CC BY-NC License  (<https://creativecommons.org/licenses/by-nc/4.0/>). This license permits use, distribution and reproduction in any medium, provided the original work is properly cited, and is not for commercial purposes.

### Introduction

The Mirpur camps in Bangladesh host a significant population of Bihari refugees displaced during 1971 Liberation War. Decades later, they continue to face challenges related to identity, citizenship, and socio-economic status. Overcrowded living conditions,

limited access to education, healthcare, and employment significantly affect their physical and mental health<sup>1,2</sup>. Psychological adjustment the ability to cope with life stressors is crucial for their well-being. This study examines how educational access influences the psychological adjustment, social integration, and quality of

life of Bihari adults<sup>3,4</sup>.

Studying psychological adjustment in marginalized communities, especially those historically displaced, provides insights for policy interventions. Biharis in Mirpur camps face statelessness, socioeconomic marginalization, and limited access to basic services, including education<sup>5,6</sup>. Education is vital for mental health, social inclusion, and resilience, yet legal, economic, and infrastructural barriers restrict the Biharis' access<sup>7</sup>. Prior research indicates that education enhances psychological resilience and social integration in marginalized populations, as seen in studies on Rohingya refugees and Bihari communities<sup>8,9,10</sup>. However, the link between education and psychological adjustment among Bihari adults remains underexplored, warranting comprehensive research.

Exploring the connection between educational access and psychological adjustment is essential for designing interventions that enhance both education and mental health. This study fills a critical gap by focusing on adult Biharis in Mirpur camps and aims to inform policies and programs to improve their educational and psychological outcomes. The main objective of this study was to assess the psychological adjustment of the Bihari adults about current educational facilities available for Biharis in Mirpur camps.

## Methodology

**Study Settings and Population:** This study was a descriptive type of cross-sectional study to assess the psychological adjustment of Bihari adults in relation to educational facilities in the Mirpur camps of Dhaka, Bangladesh. The study population included Bihari adults aged 18 to 60 years residing in 20 camps in Mirpur. While the calculated sample size was 384, due to time and resource constraints, 140 adults were interviewed using purposive sampling.

**Study Procedure:** Participants were selected based on inclusion criteria, such as residence in Bihari camps, age 18-60, willingness to participate, and cooperation. Those outside the age range, non-Bihari, or unwilling were excluded. Data was collected using a semi-structured, pre-test questionnaire, administered personally by the researcher, and the General Health Questionnaire (GHQ-28). The questionnaire captured information on psychological adjustment, access to education, and social demographic characteristics.

**Statistical Analysis:** All collected data were recorded systematically and analyzed using SPSS version 24 with Chi-square and ANOVA tests to identify patterns and

relationships between educational access and psychological outcomes.

**Ethical Consideration:** The study adhered to ethical considerations, ensuring informed consent, confidentiality, and cultural sensitivity throughout the research process, with necessary approvals obtained from relevant authorities.

## Results

A total of 140 Bihari adults participated in this study. The majority (30%) were aged 18-27 years, followed by 24.3% aged 48-60 years, with a mean age of  $36.31 \pm 12.08$  years. Male respondents constituted 55.7%, female 40.7% and 3.6% identified as third gender. Educational attainment was low: 20% had no education, 20.7% had incomplete primary education, and only 12.9% had a graduate degree or higher. Occupation-wise, most respondents were involved in weaving (27.9%), followed by unemployment 16.4%, Teaching 12.9%, and housewives 10.7%. Nearly half of the participants 46.4% had a monthly family income below 15,000 BDT. Most of the Bihari adults (73.6%) lived in the camps for >25 years (Table 1).

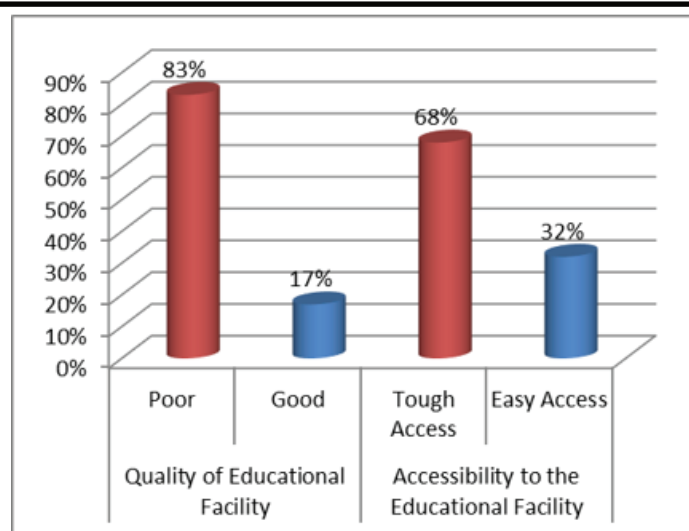
Respondents generally perceived the educational facilities as poor. About 83% of respondents agreed about overall poor educational facilities, insufficient materials, unavailability of technology, inadequate capacity of Teacher and teaching methods, and classrooms were often overcrowded, poorly maintained, and uncomfortable. Counseling, tutoring and special needs support were largely unavailable, highlighting significant gaps in educational quality. Most respondents (68%) disagreed that educational facilities were easily accessible, including distance and transportation were tough, cost-related barriers, limited financial aid. Equal access and opportunities for quality education were restricted, enrollment and participation in educational programs were also challenging for many (Figure I).

**SPsychological adjustment (GHQ-28):** Based on 4 different parameters psychological adjustment had been calculated in the scale of the General Health Questionnaire (GHQ-28). Somatic symptoms, Anxiety or insomnia, social dysfunction and depression status, these four parameters were calculated by asking a set of questionnaires which the respondents experienced over the last 4 weeks. After those overall scores had been counted and categorized. Most of the respondents (64.0%) reported poor physical well-being which reflected their high somatic symptoms. Almost 65.0% of respondents experienced anxiety or insomnia.

High levels of strain, nervousness, and irritability were reported, with difficulties maintaining focus and staying busy. Respondents showed reduced social functioning. About 62.0% were less capable in socially functional. Significant depressive symptoms were observed. Around 68.0% felt unhappy and hopeless and perceived themselves as worthless (Table 2).

**Table 1: Distribution of the respondents according to the Socio-demographic Characteristics (n=140)**

| Particulars                                         | Frequency   | Percent |
|-----------------------------------------------------|-------------|---------|
| <b>Age Groups</b>                                   |             |         |
| • 18 to 27 years                                    | 42          | 30      |
| • 28 to 37 years                                    | 32          | 22.9    |
| • 38 to 47 years                                    | 32          | 22.9    |
| • 48 to 60 years                                    | 34          | 24.3    |
| <b>Mean±SD</b>                                      | 36.31±12.08 |         |
| <b>Gender</b>                                       |             |         |
| • Male                                              | 78          | 55.7    |
| • Female                                            | 57          | 40.7    |
| • Third Gender                                      | 5           | 3.6     |
| <b>Educational Qualification</b>                    |             |         |
| • No education                                      | 28          | 20      |
| • Primary incomplete                                | 29          | 20.7    |
| • Primary                                           | 28          | 20      |
| • Secondary incomplete                              | 24          | 17.1    |
| • SSC                                               | 7           | 5       |
| • HSC                                               | 6           | 4.3     |
| • Graduate and above                                | 18          | 12.9    |
| <b>Occupation</b>                                   |             |         |
| • Unemployed                                        | 23          | 16.4    |
| • Housewife                                         | 15          | 10.7    |
| • Students                                          | 13          | 9.3     |
| • Teacher                                           | 18          | 12.9    |
| • Private job                                       | 7           | 5       |
| • Small business                                    | 10          | 7.1     |
| • Garment worker                                    | 6           | 4.3     |
| • Weaving                                           | 39          | 27.9    |
| • Seamstress                                        | 5           | 3.6     |
| • Rickshaw puller                                   | 4           | 2.9     |
| <b>Monthly Family Income</b>                        |             |         |
| • Low-income status (≤15,000 BDT)                   | 65          | 46.4    |
| • Middle income status (16,000-30,000 BDT)          | 50          | 35.7    |
| • Upper Middle-income status (31,000 to 50,000 BDT) | 25          | 17.9    |
| <b>Duration of stay in the camp</b>                 |             |         |
| • <25 years                                         | 37          | 26.4    |
| • ≥25 years                                         | 103         | 73.6    |



**Figure 1: Quality education and accessibility to the educational facility (n=140)**

**Table 2: Distribution of the Respondents according to their Psychological Adjustment (n=140)**

| Psychological Adjustment  | Frequency | Percent |
|---------------------------|-----------|---------|
| <b>Somatic Symptoms</b>   |           |         |
| Low                       | 51        | 36.0    |
| High                      | 89        | 64.0    |
| <b>Anxiety/Insomnia</b>   |           |         |
| Anxiety                   | 91        | 65.0    |
| Non-Anxiety               | 49        | 35.0    |
| <b>Social Dysfunction</b> |           |         |
| Socially Functional       | 87        | 62.0    |
| Socially Non-Functional   | 53        | 38.0    |
| <b>Depression Status</b>  |           |         |
| Severe Depression         | 95        | 68.0    |
| No Depression             | 45        | 32.0    |

Significant associations were found between psychological adjustment and age ( $F=44.942$ ,  $p<0.05$ ), educational qualification ( $X^2=51.770$ ,  $p<0.05$ ), monthly family income ( $X^2=27.090$ ,  $p<0.05$ ), and duration of stay in the camp ( $X^2=52.609$ ,  $p<0.05$ ). Younger adults (18-27 years), literate individuals, those with higher income ( $>30,000$  BDT), and recent camp residents ( $<25$  years) exhibited better psychological adjustment. Sex and occupation were not significantly associated with psychological adjustment (Table 3).

Quality and accessibility of educational facilities were significantly associated with psychological adjustment ( $X^2=53.793$  and  $123.158$ ,  $p<0.05$ ). Respondents with good quality and easy access to educational facilities showed better psychological adjustment. Somatic symptoms, anxiety/insomnia, social dysfunction, and severe depression were all significantly associated with poor psychological adjustment ( $p<0.05$ ). Respondents with low

functioning had good psychological adjustment, whereas severe depression strongly predicted poor adjustment (Table 4).

**Table 3: Association between socio-demographic variables and psychological adjustment**

| Socio-Demographic Variables         |                | Good Psychological Adjustment | Poor Psychological Adjustment | Total      | P Value |
|-------------------------------------|----------------|-------------------------------|-------------------------------|------------|---------|
| Age group                           | 18 to 27 Years | 31 (73.8%)                    | 11 (26.2%)                    | 42 (100%)  | 0.000   |
|                                     | 28 to 37 Years | 0 (0%)                        | 32 (100%)                     | 32 (100%)  |         |
|                                     | 38 to 47 Years | 18 (56.2%)                    | 14 (43.8%)                    | 32 (100%)  |         |
|                                     | 48 to 60 Years | 0 (0%)                        | 34 (100%)                     | 34 (100%)  |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.244   |
| Gender                              | Male           | 29 (37.2%)                    | 49 (62.8%)                    | 78 (100%)  |         |
|                                     | Female         | 20 (35.1%)                    | 37 (64.9%)                    | 57 (100%)  |         |
|                                     | Third Gender   | 0 (0%)                        | 5 (100%)                      | 5 (100%)   |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.000   |
| Educational qualification           | Illiterate     | 0 (0%)                        | 57 (100%)                     | 57 (100%)  |         |
|                                     | Literate       | 49 (59%)                      | 34 (41%)                      | 83 (100%)  |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |
| Occupation                          | Unemployed     | 13 (25.5%)                    | 38 (74.5%)                    | 51 (100%)  | 0.074   |
|                                     | Employed       | 36 (40.4%)                    | 53 (59.6%)                    | 89 (100%)  |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.000   |
| Monthly family income               | <30000 BDT     | 29 (25.2%)                    | 86 (74.8%)                    | 115 (100%) |         |
|                                     | >30000 BDT     | 20 (80%)                      | 5 (20%)                       | 25 (100%)  |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |
| Duration of stay in the Bihari camp | <25 years      | 31 (83.8%)                    | 6 (16.2%)                     | 37 (100%)  | 0.000   |
|                                     | >25 years      | 18 (17.5%)                    | 85 (82.5%)                    | 103 (100%) |         |
| Total                               |                | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |

\*Pearson's chi-square test, significant at  $p < 0.05$ ; \*\*One way ANOVA test, significant at  $p < 0.05$

**Table 4: Association between quality of educational facility, accessibility and psychological adjustment**

| Other variables                           |                         | Good Psychological Adjustment | Poor Psychological Adjustment | Total      | P Value |
|-------------------------------------------|-------------------------|-------------------------------|-------------------------------|------------|---------|
| Quality of Educational facility           | Poor                    | 25 (21.6%)                    | 91 (78.4%)                    | 116 (100%) | 0.000   |
|                                           | Good                    | 24 (100%)                     | 0 (0%)                        | 24 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.000   |
| Accessibility to the educational facility | Tough Access            | 4 (4.2%)                      | 91 (95.8%)                    | 95 (100%)  |         |
|                                           | Easy Access             | 45 (100%)                     | 0 (0%)                        | 45 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |
| Somatic symptoms                          | Low                     | 49 (96.1%)                    | 2 (3.9%)                      | 51 (100%)  | 0.000   |
|                                           | High                    | 0 (0%)                        | 89 (100%)                     | 89 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.000   |
| Anxiety/insomnia                          | Anxiety                 | 0 (0%)                        | 91 (100%)                     | 91 (100%)  |         |
|                                           | Non-anxiety             | 49 (100%)                     | 0 (0%)                        | 49 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |
| Social Dysfunction                        | Socially non-functional | 0 (0%)                        | 87 (100%)                     | 87 (100%)  | 0.000   |
|                                           | Socially functional     | 49 (92%)                      | 4 (8%)                        | 53 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) | 0.000   |
| Depression status                         | Severe depression       | 4 (4.2%)                      | 91 (95.8%)                    | 95 (100%)  |         |
|                                           | No depression           | 45 (100%)                     | 0 (0%)                        | 45 (100%)  |         |
| Total                                     |                         | 49 (35%)                      | 91 (65%)                      | 140 (100%) |         |

\*Pearson's chi-square test, significant at  $p < 0.05$

## Discussion

The study highlights critical insights into the socio-demographic profile, psychological adjustment, and educational facilities in the Bihari camps of Mirpur. Findings reveal a complex relationship between the accessibility and quality of education and the psychological well-being of Bihari adults. Overall, 35% of respondents demonstrated good psychological adjustment, while 65% showed poor adjustment, influenced by factors such as age, education, income, and length of stay in the camps. Younger adults (18-27 years) displayed better adjustment due to recent or ongoing engagement in education, whereas older adults, especially those residing in the camps for over 25 years, exhibited poorer adjustment, often linked to long-term socio-economic struggles, depression, and detachment from the education system.

Educational attainment emerged as a critical determinant. Respondents with secondary or higher education displayed better psychological adjustment, consistent with the empowering role of education reported in other marginalized contexts<sup>11</sup>. Conversely, those with little or no education were more vulnerable to psychological distress, reinforcing the cyclical link between deprivation and poor mental health. Family income further influenced outcomes, with higher income households above 30,000 BDT reported better adjusted, while low-income respondents expressed dissatisfaction with education due to economic hardships, echoing findings from refugee populations in Africa and South Asia<sup>12</sup>.

The quality education facilities were found to be poor, with 69.3% of respondents disagreeing those adequate resources available and nearly half reporting unqualified teachers and ineffective methods. Such deficiencies intensify psychological stress, aligning with evidence from refugee and slum communities worldwide, where poor infrastructure and overcrowded classroom worsen mental health<sup>13</sup>. Accessibility was another challenge, with 57.1% disagreeing that facilities were easily accessible and citing financial constraints, lack of aid, and transport barriers concerns similarly documented among Roma camps in Europe and refugee settlements in the Middle East<sup>14</sup>.

Psychological health directly intersected with educational adjustment, adults with lower levels of anxiety, insomnia, and social dysfunction displayed greater resilience, while those suffering from depression and social isolation reported poor adjustment. Similar trends have been observed among displaced populations such as Syrian refugees in Lebanon, where trauma limited participation in education<sup>15,13</sup>.

To improve the psychological well-being and social

integration of Bihari adults in the Mirpur camps, a multifaceted approach is essential. Upgrading educational infrastructure through better teacher training, adequate resources, and manageable class size can significantly enhance learning outcomes and psychological adjustment. Accessibility must be strengthened with financial aid and transportation support to reduce barriers faced by low-income families. At the same time, community-based mental health programs should be introduced to provide counseling and psychological support, particularly for older adults and those experiencing severe depression. Addressing broader socio-economic issues such as poverty and unemployment is equally critical, as these factors are closely linked to education and mental health. Finally, gender-sensitive initiatives are needed to ensure Bihari women, who face additional barriers, gain equal access to education and targeted support for their psychological and social needs.

In sum, the findings underscore that educational deprivation in the Bihari camps is both a cause and consequence of psychological distress. Consistent with global studies on marginalized communities, addressing these challenges requires integrated interventions that improve educational infrastructure while also offering targeted mental health support<sup>14</sup>.

Limitations of the study include a small sample size, reliance on self-reported data, and the cross-sectional design, which restricts casual inference. Additional limitations involve potential cultural biases, unmeasured external socio-economic factors, subjectivity in psychological assessment, and the limited scope of educational facilities considered. Despite these constraints, study provides valuable insights into the interplay between educational access and psychological adjustment among Bihari adults in Mirpur camps.

## Conclusion

The study demonstrates a significant and complex relationship between psychological adjustment and the quality and accessibility of educational facilities among Bihari adults in the Mirpur camps. With 65% of respondents experiencing poor psychological adjustment, the findings highlight the profound impact of socio-demographic factors particularly age, education, and family income on mental well-being. Younger adults, those with higher educational attainment, while older adults, the less educated and low-income groups showed higher levels of anxiety, depression and social isolation. The poor state of educational infrastructure, combined with financial

hardship, lack of qualified teachers, and inadequate resources, further exacerbates psychological distress. These findings mirror trends observed in other marginalized and refugee populations, where limited educational opportunities and socio-economic deprivation reinforce cycles of exclusion and poor mental health. Addressing these challenges requires a holistic and integrated approach. Strengthening the quality and accessibility of education must go hand in hand with targeted mental health interventions to improve overall well-being. Without such combined efforts, the Bihari community's marginalization is likely to persist, echoing the struggles faced by disadvantaged populations worldwide.

**Acknowledgement:** None

**Contributions to authors:** Islam M, Haque MW, Haque ABMM were involved in conceptualization, data collection and literature collection. Data analysis and manuscript writing were done by Islam M, Haque MW, Yusuf MA and data are analyzed by Islam M. Manuscript revision was done by all seven authors.

**Funding:** This research project was not funded by any group or institution.

**Conflict of Interest:** We do not have any conflict of interest (financial or others).

## References

- 1.Rahman MA. Statelessness and the struggle for citizenship: The case of the Urdu-speaking Biharis in Bangladesh. *Refugee Surv Q.* 2010; 29(3): 54-79.
- 2.Alam S. Stateless at birth: A critical analysis of the nationality status of the Bihari community in Bangladesh. *J Immigr Asylum Natl Law.* 2014; 28(2): 133-47.
- 3.Bhui K, et al. Refugees, psychological distress and mental health services in the UK. *Br J Psychiatry.* 2019; 213(2): 501-5.
- 4.Nahar L. Living in Camps: Impact on health of Bihari population in Bangladesh. *Public Health Rev.* 2016; 38(1): 104-23.
- 5.Nath B. Statelessness and the right to education: A study of Bihari refugees in Bangladesh. *Int J Refugee Law.* 2017; 29(1): 104-23.
- 6.Yasmin T. The stateless Biharis of Bangladesh: Struggles for recognition and citizenship. *Asian J Hum Rights.* 2019; 6(1):59-82.
- 7.Rashid S, Kabir M. Education in refugee camps: The case of Bihari camp in Dhaka. *Refugee Stud Q.* 2020; 19(2): 78-94.
- 8.Hertzman C, Power C. Health and human development: Understandings from life-course research. *Dev Rev.* 2003; 23(1): 26-74.
- 9.Khan MT. Statelessness and citizenship rights: The case of the Bihari community in Bangladesh. *Refugee Surv Q.* 2016; 35(2): 92-113.
- 10.Akhter S, Sultan R. Marginalization and education: The case of Bihari community in Bangladesh. *J Educ Dev.* 2019; 39(2): 123-38.
- 11.Ross CE, Mirowsky J. Why education is the key to socioeconomic differences in health. *Soc Sci Med.* 2010; 72(3): 450-6.
- 12.Dryden-Peterson S. Refugee education in countries of first asylum: Breaking open the black box of pre-settlement experiences. *Theory Res Educ.* 2016; 27(4): 401-9.
- 13.Betancourt TS, Meyers-Ochki SE, Charrow AP, Hansen N. Annual research review: Mental health and resilience in refugee children and adolescents living in low- and middle- income countries. *J Child Psychol Psychiatry.* 2020; 61(5): 582-96.
- 14.Mendenhall M, Russell SG, Buckner E. Urban refugee education: Strengthening policies and practices for access, quality, and inclusion. New York: Columbia University; 2017.
- 15.Freudenberg N, Ruglis J. Reframing school dropout as a public health issue. *Prev Chronic Dis.* 2007; 4(4): A107.