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Arab refugees in the world of mental health: A literature review

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Abstract

Purpose: In an effort to specifically address the needs of Arab refugees with regards to psychotherapy, this literature review covers the published research data within eleven scholarly articles and studies from the years 2005 to 2019 on the topics of common psychological ailments and symptoms among Iraqi and Syrian refugees, their perspectives and literacy on mental health & mental health treatments, and concludes with a brief discussion on implications for practice and unanswered questions for future research.

Conclusions: In the face of collective trauma, persecutions, adversity, exile and acculturation stress, many Arab refugees are astoundingly resilient. Although these refugees have significant, unaddressed mental health issues and other concerns regarding stigma and the avoidance of psychological treatment, there is evidence to suggest that their attitudes may change upon interaction with mental health professionals. To effectively treat refugees, practitioners must hold a concrete comprehension of the heritage, cultural, psychohistorical, and sociopolitical environments of which these refugees are a product; they must also confront their own biases and misperceptions.

Recommendations: Trans-diagnostic treatments that include an emphasis on increasing personal resilience, a comprehensive biopsychosocial understanding of the individual, and employ culturally-informed, evidence-based treatments like narrative exposure therapy for trauma, relaxation techniques, and direct, solution-focused approaches work best. More collaborations between mental health practitioners and prominent community leaders may help in addressing refugee mental health concerns and gaps in coverage. In future research, the attitudes and willingness of Arab refugees to seek psychological help must be examined.

Keywords: Iraqi Refugees; Syrian Refugees; Collective Trauma; Refugees and PTSD; Treatment of Refugees; Stigma; Refugee Mental Health; Attitudes Towards Psychotherapy

1. Introduction

Arab refugees have an intersectional identity. First, they are Arabs, with the Arab World, its culture, history, language, and heritage at the forefront of their identities. Second, they are refugees, people who have escaped violence and/or persecution in their home countries. In addition to these two categories, the merger of other elements of identity form different positionalities, including constructs like ethnicity, gender, age, and completed education level. To properly study Arab refugees, one must look at the intersectionality of individual constructs and positionalities as one, singular identity. However, the limited research available largely fails to address this intersectionality, often discussing either a general population of Arabs or a general population of refugees. Thus, there exists an immense gap in the literature which creates a massive limitation for our purposes. Nevertheless, in an effort to specifically address the needs of Arab refugees with regards to psychotherapy, this literature review covers the inadequate amount of published research data within eleven scholarly articles and studies from the years 2005 to 2019 on the topics of common psychological ailments and symptoms among Iraqi and Syrian refugees, their perspectives and literacy on mental health & mental health

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treatments, and concludes with a brief discussion on implications for practice and unanswered questions for future research studies.

2. Thematic Overview

Following numerous conflicts in the Middle East over the past few years (Kira & Tummala-Narra, 2015), including the invasion of Iraq and its subsequent sectarian violence, the civil wars in Syria and Yemen, along with severe economic and humanitarian crises throughout the region, a massive influx of refugees from these mainly Arab nations initially led to the worst refugee crisis since the end of the Second World War. Welcoming nations like Lebanon, Jordan, Turkey, Sweden, and Germany bore the burden of caring for these refugees and providing them with housing assistance and healthcare, including mental health care like psychotherapy and psychiatric services. Aside from the common language and cultural barriers associated with any attempt to provide such care in non-Arab, host countries (Kirmayer et al., 2011), these refugees also endured and survived some of the most horrendous violence of our time (Kira & Tummala-Narra, 2015), and many suffer from catastrophic psychological ailments such as psychosis, PTSD, depression and anxiety due to the years of trauma and fear (Kira & Tummala-Narra, 2015; Jamil et al., 2007).

The matter of social integration into new societies is also at the forefront of this issue. Even in comparison to other racial minority groups, research on Arabs is generally lacking (Melhem & Chemali, 2013). Studies that adequately address intersectionality within this population are still rarer. One example of such a study is a broad meta-analysis which found that refugees and internally displaced persons in particular had moderately worse mental health outcomes than non-refugees, and that the conditions of displacement also played a role to some extent (Porter & Haslam, 2005). Even more interesting in this meta-analysis were the results of intersectionality between age and migration status, gender and migration status, geographic origin and migration status, and socioeconomic status and migration status. The researchers found that older refugees, refugees with higher education, refugees from rural areas, refugees with better pre-displacement socioeconomic status, and female refugees all had worse outcomes than not only non-refugees, but also other younger, urban, less educated, poorer, and male refugees (Porter & Haslam, 2005). Therefore, the intersectionality of various aspects of identity plays a significant role in individual and group outcomes.

Regarding migrants more broadly, language and cultural barriers, along with family structures, also contributed to more mental health problems (Kirmayer et al., 2011). These results may also pertain to refugee attitudes regarding psychotherapy or their willingness to seek it. Language barriers, socio-economic, and socio-cultural circumstances may play a pivotal role in whether or not refugees have access to treatment or attempt to gain access at all. Karnouk et al. (2019) also identified bias towards psychotherapy, and particularly stigma, as a main barrier in seeking mental health treatment in the Arab World. Furthermore, one must imperatively note that Arabs are generally a collectivistic people who depend on their families or surrounding communities for advice, care, support, and comfort. In such tightly-knit communities, one must protect his or her social status and family honor, and absolutely avoid any ostracization, particularly the immense amount of stigma associated with mental illness in the Arab culture. Therefore, "mental health patients in Arab countries tend to express their psychological problems in terms of physical symptoms, thereby avoiding the stigma attached to mental illness…[and] tend to underutilize mental health services and to hold negative attitudes toward formal mental health [care] " (Al-Krenawi, 2005).

The Arab world generally lacks awareness regarding mental health issues or even professionals who assist with such issues (Al-Krenawi, 2005). As a demonstrative example of this problem, the Kingdom of Jordan is a relatively stable, advanced, middle-income part of the Arab World as of 2019. Yet, there are only three mental hospitals for adults and only one psychiatric hospital for children in the entire country, and only 64 outpatient facilities; overall, there are only two psychiatrists, 0.27 psychologists, and 0.04 nurses for every 100,000 inhabitants in Jordan (Karnouk et al., 2019). For the most part, Arabs tend to turn to religious leaders for guidance and support regarding psychological problems and rely on their religious beliefs in order to cope with these struggles (Al-Krenawi, 2005). Beyond this, psychotherapies are relatively unknown in Arab countries such as Syria, and either lack availability or are only basic in services offered (Wells et al., 2016). Emotional distress in the Arab World also tends to be perceived as a normal part of life rather than a mental condition, and, according to one Lebanese study, only a fraction (10.9%) of Arabs seek care for psychological symptoms (Wells et al., 2016). With this fact in mind, one must first comprehend the magnitude of the mental health issues facing Arab refugees before even trying to assess their perspectives and attitudes regarding psychotherapeutic treatment along intersectional variables.

2.1. Mental Health Issues Among Migrants and Refugees

Among migrants and refugees, there are multiple risk factors for and a high prevalence of mental health issues (Kazour et al., 2017; Kira & Tummala-Narra, 2015; Kirmayer et al., 2011; Jamil et al., 2007), influenced by the three stages of

migration: premigration, migration, and post-migration resettlement into a new location (Kirmayer et al., 2011). Each of these stages is associated with its own dangers and stressors, the experiences of which (particularly experiences of *adversity*) taking their toll on the migrants. For example, Kirmayer et al. (2011) predictably found that extreme exposure to violence often leads to higher rates of trauma-related disorders such as PTSD.

Other pinpointed challenges in addressing the mental health issues of migrants and refugees were communication difficulties due to language and cultural barriers, the culturally influenced expression of illness and associated behaviors, differences in family structures and adaptation, acculturation, integration, and intergenerational conflicts (Kirmayer et al., 2011). Therefore, clinicians ought to take all of these factors, including the experiences of the individual in each of the three stages of migration, into consideration upon assessment of a migrant or refugee client. Kirmayer et al. (2011) also found that many of the cultural and communication issues can be improved with help from professional translators, family consultations, and community organizations. Lastly, culturally-appropriate follow-ups to recognize issues in adaptation are also recommended to prevent further mental health issues.

2.2. Mental Health Issues Specific to Iraqi and Syrian Refugees

Specifically among Iraqi refugees, not only have many of them been forcibly displaced from their homeland due to foreign occupation and political upheavals, but most are also victims of prolonged, serial warfare, sanctions, deprivation, and/or torture over the last few decades. Since the early 1990s, European and American psychotherapists have noticed Iraqi refugees seeking treatment for conditions associated with their inescapable, traumatic pasts (Jamil et al., 2007). These refugees have suffered a cumulative trauma alongside their fellow Iraqis, including but not limited to imprisonments, multiple relocations, unsanitary refugee camps, poor nutrition, and the torture and/or death of loved ones (Jamil et al., 2007). In an extended study on the mental health conditions of Iraqi refugees, Jamil et al. (2007) recruited 116 adult Iraqi refugees (46 males, 70 females) at a community mental health center and assessed them in an interview format in their native Arabic. The measures covered anxiety, depression, and PTSD. The researchers found that a majority (54.3%) of the male clients and 11.4% of the female clients had a non-comorbid diagnosis of PTSD; 34.3% of the women and 4.3% of the men in the study had a non-comorbid diagnosis of depression. Meanwhile, 13% of the men and 17.1% of the women in the study received either a different diagnosis (i.e., bipolar disorder; schizophrenia) or a comorbid diagnosis (i.e., depression and PTSD, etc.…) Moreover, more than 80% of the participants in the study by Jamil et al. (2007) had reported recent, intense symptoms of depression and anxiety; 90% of the female participants and 92% of the male participants had lived through wartime trauma, and the men (85%) were significantly more likely to report former imprisonment and torture than the women (33%). The authors also statistically determined that there were significantly different diagnostic patterns for the male refugees versus the female refugees (Jamil et al., 2007), implying a major role in the intersectionality of gender, ethnicity, and refugee status among Iraqi refugees.

In their migration to other countries in search of asylum, refugees encounter new psychological traumas and stressors along the way or in their new environments. Post-migration issues and matters of acculturation likewise add to their list of mental health problems and psychiatric symptoms, which then further complicate their abilities and attempts to integrate into their new surroundings in an unending cycle of traumatization. LeMaster et al. (2018) conducted a one-year, longitudinal path analysis of 298 Iraqi refugees and cross-sectionally assessed pre- and post-migration mental health factors, at baseline upon arrival in the United States and then one year later, finding that pre-migration trauma was directly and positively associated with symptoms of PTSD and depression at baseline, but not with symptoms of PTSD or depression at the one-year follow-up; the effects of pre-migration trauma on acculturation, English language skills, and depressive symptoms at 1-year follow-up were also statistically non-significant, but the effect of that trauma on symptoms of PTSD was both positive and statistically significant (LeMaster et al., 2018). Resilience upon initial assessment at baseline was associated with less depressive symptoms after a year, but had no statistically significant associations with PTSD symptoms, English language skills, or acculturation at the one-year follow-up. On the other hand, PTSD symptoms at baseline were significantly and positively associated with both depressive symptoms at baseline and PTSD symptoms a year later; depressive symptoms at baseline were likewise significantly and positively associated with depressive symptoms a year later and negatively associated with acculturation, but had no statistically significant associations with symptoms of PTSD after a year. Lastly, exposure to daily stressors was significantly and negatively associated with acculturation and English language skills after a year, while social support was significantly and positively associated with acculturation and negatively associated with symptoms of depression and PTSD at the one-year follow-up (LeMaster et al., 2018). This final result demonstrates the vital importance of social support systems for the Iraqi refugees, who tremendously benefit from the presence of friends and family in all regards. According to the authors, "collectivist versus individually-oriented decision-making may contribute to these effects. Among Middle Eastern communities, mental health problems may be viewed as social issues that need to be solved collectively" (LeMaster et al., 2018), yet another instance in which the intersectionality of culture and refugee status impacts mental health outcomes.

The civil war in Syria has also been a major, recent contributor to the international refugee crisis, particularly in Lebanon, Turkey, and Europe. In a study on the prevalence of PTSD in a population of Syrian refugees living in Lebanon, Kazour et al. (2017) note in line with other presented research that refugees in general are at a higher risk for psychological ailments because of forced migration, pre-migration trauma, and issues of resettlement into new cultures under harsh socio-economic circumstances. For example, the prevalence of depression in Syrian refugees is 43.9%; the research team in Lebanon also sought to determine the prevalence of PTSD among the Syrian refugees there. To do so, the team surveyed 452 Syrian refugees [55.8% female] between 18 and 65 years old [mean age was 35.05 years] in 6 camps of the Central Bekaa region. The authors statistically determined that the Syrian refugees had a 35.4% lifetime prevalence of PTSD and a point prevalence of 27.2%, with *town of origin* in Syria as a statistically significant predictor of lifetime PTSD (i.e. refugees from Aleppo had a significantly higher rate of PTSD than the refugees from Homs) (Kazour et al., 2017). This final finding leads to the conclusion that not only nation, ethnicity, culture, or education level, but also hometown or specific region of origin within a country may play a fundamental, intersectional role in the outcomes of refugee mental health and must be taken into deep consideration by mental health professionals as well.

2.3. Arab Refugee Literacy and Perspectives on Mental Health

As discussed above, the Arab culture strongly stigmatizes psychological illness, mental health treatment, seeking psychotherapy, and even the professions of psychologists and other mental health workers in the field of treatment. Thus, the main question at hand is what attitudes refugees may hold towards psychotherapy and if they are willing to seek these services when faced with mental health issues. Unfortunately, the research on this topic is highly limited at the present time besides a couple studies documenting the mental health *literacy* or *perspectives* of Iraqi and Syrian refugees regarding psychotherapeutic treatment, with prior research suggesting that a low level of mental health literacy (defined as the "knowledge and understanding of the nature and treatment of mental health problems") is a major, contributing factor in insufficient treatment-seeking among people with psychological issues (Slewa-Younan et al., 2014). This study also mentioned that a lack of *willingness* to access mental health care on the part of refugees poses a substantial challenge, noting that refugees are significantly less likely than the general population to go to the hospital despite a higher rate of trauma-related conditions (Slewa-Younan et al., 2014).

In order to assess the mental health literacy of Iraqi refugees in western Sydney, Australia regarding knowledge about PTSD and their beliefs on the helpfulness of treatments, Slewa-Younan et al. (2014) used a culturally-adapted Mental Health Literacy Survey and presented the 225 Iraqi refugee participants in the study with a fictitious vignette of a same-gender character meeting culturally-valid, diagnostic criteria for PTSD in their native Arabic. The participants were then asked to choose one label from a list of randomly-placed options (i.e. 'fear'; 'no real problem'; 'just a phase'; 'depression'; 'weak character'; 'nervous breakdown'; 'posttraumatic stress disorder'; 'serious medical condition (e.g. brain tumor)'; 'stress'; 'not integrating well in Australia/homesickness'; and 'physical condition' (e.g. migraine or back pain)) as to what they believed was the character's main problem. After selecting one of the options, the Iraqi participants were then asked to look at a list of possible interventions in response to the problem and determine whether the activities or people listed would be helpful, harmful, or neither, also deciding which intervention and person they thought would be most helpful to the fictitious character in the vignette. The results of this study were both stunning and somewhat concerning: 41.8% of the Iraqi participants chose 'fear' as the main problem, 19.6% chose 'depression,' 11.6% selected 'nervous breakdown' while only 14.2% of the respondents selected the proper diagnosis of PTSD. In general comparison, 34.3% of Australians surveyed chose the proper diagnosis of PTSD. Moreover, the Iraqi refugees most frequently (80%) selected 'reading the Koran or the Bible' as the most helpful treatment in response to the character's condition, while 'finding new hobbies' came in as a close second (76%). Still worse, a majority of the Iraqis (57.8%) believed that that 'trying to deal with the problem alone' would be helpful. In general comparison, the Australians surveyed selected 'physical activity' (93.5%), 'get out more' (88%), and 'learn relaxation' (87.9%) as the top interventions of choice, while only 6% of the Australians believed that trying to deal with the problem alone would be helpful. Oddly, 84.9% of the Iraqi participants also selected 'psychiatrists' as the people most likely to be helpful in this situation, seemingly inconsistent with their other response given that the science of medicine and the theology of religion often tend to contradict each other (Slewa-Younan et al., 2014). The results of this research study indicate that there exists a deep discrepancy between the mental health literacy and beliefs of Iraqi (Arab) refugees and those of the general Australian (i.e., Western) host population, reflecting an intersectional difference in interpretation of psychological symptoms/mental health issues rooted in culture, ethnicity, or place of origin, and leading to the conclusion that mental health practitioners ought to consider collaboration with Iraqi religious and community leaders for the best possible transcultural mental health services for the refugee population.

With regards to Syrian refugees in the host nation Jordan, Karnouk et al. (2019) recruited 100 therapy clients (39 males, 61 females) that represented both the Syrian refugee community (65%) and the Jordanian host community (35%). The Patient Satisfaction Questionnaire, consisting of measurements on patient satisfaction, bias towards the therapist,

effects of therapy, and stigma, was distributed to the participants in their native Arabic. The authors found that respondents from both groups had a high level of satisfaction with the treatment (77.8% rated it as 'very good' and 16.3% rated it as 'good'), a low level of bias against the therapist, an overall positive evaluation of the treatment process (88.8% expresses positive therapeutic effects while only 3.1% found it to have no effect), and only a moderate level of self-stigmatization (Karnouk et al., 2019). The authors warn that these apparently positive results regarding Arab perspectives on psychotherapy ought to be interpreted cautiously, but their study does suggest a more positive attitude towards mental health treatment among Arabs (including the Syrian refugees in the sample) than one would initially predict. Indeed, the *contact* with mental health professionals and services may be the factor that positively alters attitudes towards psychotherapy and the profession, alongside improving psychological wellness. Therefore, attitudes of Arab refugees towards psychotherapy without this prior engagement in treatment are yet to be determined. In the future, a concrete understanding of these attitudes, or what role psychotherapy may play in their lives, will be fundamental to providing refugees with the best possible mental health options and treatments.

2.4. Implications for Mental Health Practice

The world's refugees have often faced collective traumas, group annihilation anxiety, exile, political and religious persecution, and/or torture in their countries of origin, and are then confronted by discrimination, acculturation stress, and economic difficulties in their new host nations (Kira & Tummala-Narra, 2015). Nevertheless, many refugees are resilient, even with regards to community mental health stigma. Over 40% of Arab refugees resist the stigma and stereotyping associated with their psychological conditions (Kira & Tummala-Narra, 2015).

To effectively treat refugees, psychotherapists and other mental health professionals must hold a concrete comprehension of the heritage, cultural, psychohistorical, and sociopolitical environments from which these refugees emerge, and of which are an intersectional product. Most importantly, clinical practitioners must also be aware of and confront their own biases, attitudes, or misperceptions regarding their refugee clients in order to plan trans-diagnostic treatments for the comorbid disorders that the refugees suffer from (Kira & Tummala-Narra, 2015). Such methods include an emphasis on increasing personal resilience, a comprehensive biopsychosocial understanding of the individual, and employ culturally-informed, evidence-based treatments like narrative exposure therapy for trauma, relaxation techniques, and direct, solution-focused approaches (Kira & Tummala-Narra, 2015).

Refugees' attitudes towards psychotherapy and their potential, cultural stigmas toward mental health conditions and treatment must also be considered. Psychoeducation will most likely play a vital role in initial assessment and treatment sessions. Furthermore, the support of family members and ethnic or religious leaders in their respective communities ought to be attained. In the future, more collaborations between mental health practitioners and prominent religious leaders may help in addressing refugee mental health concerns and gaps in coverage.

3. Conclusion

Important questions that remain to be answered in future research include what general attitudes Arab refugees have regarding psychotherapy, how these attitudes compare between various subgroups in the Arab refugee population and to the general Western population, and whether Arab refugees would be willing to seek treatment for specific psychological symptoms and issues if this treatment was available to them. How does the intersectionality of age, gender, nationality, and education level impact the refugees' attitudes and willingness to seek psychotherapy, and what effect does the cultural stigmatization of mental health and illness have on these attitudes? A more comprehensive understanding of Arab refugees' attitudes and willingness will assist psychotherapists and other mental health workers in creating enhanced psychoeducation or treatment protocols for Arab refugee clients.

Compliance with ethical standards

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This research did not involve any human participants or private data, and therefore did not require any ethical review or approval. The author reports no conflict of interest in the publication of this research.

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