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# Understanding mental health from the perception of Middle Eastern refugee women: A critical systematic review

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ABSTRACT

Women from a refugee background suffer higher psychological distress levels than men with a refugee background. Conceptualisation of mental health plays an important role in using mental health services for people from refugee groups. The purpose of this review is to synthesize literature describing how Middle Eastern refugee women perceive mental health and its influence on mental health service utilisation. The review is registered with Prospero, and we conducted an analysis that complies with PRISMA guidelines and identified 8 relevant documents, including 6 peer-reviewed papers, and two dissertations. The findings of four qualitative, three mixed-method, and one quantitative studies were synthesized through data extraction and thematic analysis. Based on the findings, cultural beliefs, values, and expressions play a critical role in understanding mental health. These included: (a) culturally influenced idioms of distress in conceptualising mental health (b) the role of stigma in mental health perception and service utilisation. (c) a preferred method such as professional services or lay techniques including prayer and social support for mental health treatment. The discussion section contextualizes and examines these key themes to consider how a better understanding of mental health can be used to support the development of programs and policies to increase the use of mental health services by individuals from a refugee background. This may, in the end, lead to reduced burdens of diseases related to mental health among those seeking asylum or seeking refugee status.

## 1. Introduction

Pre and post-migration stressors associated with forced displacement and migration can lead to complex mental health issues for women from refugee backgrounds (Donnelly et al., 2011; Sijbrandij et al., 2017; Hassan et al., 2016), with women more likely to experience psychological distress and mental illness than men with refugee backgrounds (Jarallah and Baxter, 2019; Vromans et al., 2021; Hollander et al., 2011b; Sijbrandij et al., 2017). While all refugees may experience challenges such as separation from their families, security risks, and exposure to violence, women are at particular risk of violence and exploitation (Unw, 2016, Boswall and Akash, 2015; Abo-Hilal and Hoogstad, 2013). While such stressors are well documented and previous reviews have explored the prevalence of mental disorders for refugees (Fazel et al., 2005; Tinghög et al., 2017; Alpak et al., 2015; Erim et al., 2018), less well understood is the way that refugee women conceptualise and understand mental health issues. An understanding of this is crucial for examining both the contributors to mental illness as well as some of the drivers around service utilisation for mental health issues.

Over the last fifteen years, the Middle Eastern region has seen a dramatic increase in forced migration (Brand, 2017), which has been characterised by prolonged displacement and multiple temporary or 'informal' settlements for refugees before permanent resettlement (Brand, 2017). There is some evidence that refugees from Middle Eastern backgrounds have worse mental health than those originating from other regions (Jarallah and Baxter, 2019). Understandings of mental health are rooted in broader cultural and gender norms (Klimentina et al., 2021). These cultural and gender underpinnings and these particular migration pathways are likely to mean Middle Eastern women have a particular understanding of mental health that is important to consider when examining how best to support this group.

However, reviews (Blackmore et al., 2020; Bogic et al., 2015; Morina

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et al., 2018) of mental health for refugees have not specifically considered perceptions of mental health or have done this more broadly across refugee groups as part of wider systematic reviews (Byrow et al., 2020). Thus, this systematic review aimed to understand how Middle Eastern refugee women perceive and comprehend mental health and mental health-related issues in order to examine in detail gender and cultural considerations relevant to this region.

### 1.1. Background

The World Health Organization (WHO) defines mental health as "a state of well-being in which an individual realizes their abilities, copes with the normal stresses of life, is productive, and has a positive impact on others" (Who, 2004). According to the United Nations High Commissioners for Refugees, a refugee is someone who flees persecution or armed conflict and an asylum seeker is someone whose claim for refugee status is still being assessed (Unhcr, 2015). In this paper, for parsimony in general we use the term 'refugee' to refer to both refugees and asylum seekers given the often overlapping experiences of these two groups. However, we acknowledge the specific impacts of unresolved immigration status and where relevant also note this in the document.

Over 80 million people are currently forcibly displaced due to human rights violations, violence, and persecution including 4.1 million asylum seekers and 20.7 million refugees; (Unchr, 2020). Approximately half of all refugees, internally displaced persons, and stateless persons are women and girls (Unchr, 2020). However, often data on refugee and asylum-seeking women are conflated making it difficult to draw a valid conclusion about their numbers (Davaki, 2021). Middle Eastern countries continue to suffer displacement and humanitarian crises in 2020 (Unchr, 2020), and the majority (67%) of refugees come from just five nations, most of which are experiencing conflict or war, including Syria and Afghanistan. Afghanistan is considered a Middle Eastern country in this review, given it is part of the Greater Middle East (Worldatlas, 2022). Previous reviews have also used this classification (Desa et al., 2022).

Refugees experience a range of pre-and post-migration stressors, and the asylum-seeking process is additional stress. War, civil unrest, and torture in countries of origin are among the experiences refugees commonly undergo, where violence also gives rise to the loss of family and relatives, as well as extended periods of hardship and deprivation (Hassan et al., 2016; Fazel et al., 2005; Steel et al., 2009; Kirmayer et al., 2011). Refugee women are at particular risk of gender-based violence and exploitation (Unw, 2016, Boswall and Akash, 2015; Abo-Hilal and Hoogstad, 2013). A variety of psychological disorders have been linked to exposure to these adverse events, including post-traumatic stress disorder (PTSD) and depression (Alemi et al., 2014; Alpak et al., 2015; Fazel et al., 2005). Post-migration, there is also a range of stressors depending on resettlement country contexts that include challenges securing housing and employment, learning a new language, ongoing family separation, and discrimination (Hynie, 2018) For women, the impact of displacement and resettlement can include them having to assume additional responsibilities in their new country, for example changing gender roles including becoming the main income earner, which could add psychological stress. (Jabbar and Zaza, 2016). There is a link between pre-and post-migration stress conditions and the refugee journey and the increase in mental health issues among refugees such as PTSD, anxiety, and depression (Hollander et al., 2011b; Thompson et al., 2018; Gerritsen et al., 2006). Mental distress, post-traumatic stress disorder, depression, and anxiety are more prevalent among women from refugee background than in men from similar settings, reflecting broader gender disparities in mental health (Sullivan et al., 2020; Davaki, 2021). While countries of resettlement may have different social, economic, cultural, and political factors that influence the availability and use of mental health services by refugees (Porter and Haslam, 2005; Priebe et al., 2016), a range of barriers to mental health service utilisation have been identified including difficulties understanding the health system, cost, transport, trauma and a lack of culturally appropriate mental health services (Desa et al., 2020; Priebe et al., 2016, Desa et al., 2022). For women, additional responsibilities such as childcare and cultural norms about women's unchaperoned access to health services can add additional barriers. (Burford-Rice, 2020, Desa et al., 2022).

With regards to studies looking specifically at refugees and asylum seekers from the Middle East, a study in Australia of 2399 people from refugee or asylum-seeking backgrounds reported that people born in Middle Eastern regions like Iran and Iraq, as well as in Central Asia including Afghanistan, have higher psychological distress levels than people from other countries like Eritrea, Myanmar, Ethiopia, and Congo (Jarallah and Baxter, 2019). The prevalence of mental distresses reported by women was higher than that of men in the same study (Jarallah and Baxter, 2019). In a study of Middle Eastern refugees and migrants, in the US Arab refugees showed higher depression and anxiety symptom levels than Arab Americans born in the U.S.(Pampati et al., 2018), and this population had an increased risk of developing adverse mental health outcomes (Moradi and Hasan, 2004; Shannon et al., 2015; Wright et al., 2015). A study of Afghans living in San Diego (USA) found that most refugee Afghan women suffered from depression regularly (Alemi et al., 2015), corroborating the findings of research from the Netherlands(Gerritsen et al., 2006), Australia (Sulaiman-Hill and Thompson, 2012) that close to 50% of Afghan refugees had a lifetime diagnosis of depression. In another study on Middle Eastern refugees, mainly Iraqi refugees resettled in Sweden, PTSD symptoms were mostly related to pre-settlement trauma, whereas common mental disorders were related to post-settlement social and economic status, discrimination, alienation, and the threat of violence (Lindencrona et al., 2007). Other than the study of Jarallah and Baxter above, data was not disaggregated by gender.

It has long been understood that culture has an impact on both the understanding of mental health and the experience of mental health and illness (Kleinman et al., 1978). In Kleinman's view, the biomedical model fails to take these cross-cultural perspectives into account. He contends that the biomedical model lacks an understanding of mental illness and the way people explain it to themselves and the model is heavily influenced by western cultural assumptions (Kleinman, 1980). In this way, while common 'western' understandings of mental health as defined by the Diagnostic and Statistical Manual for Mental Disorders (DSM) consider mental illness to fall within discrete categories of illness (e.g., depression or anxiety), such conditions may not have terms in other languages, or they may be expressed as spiritual conditions or through somatisation (Mezzich et al., 2009). A growing number of psychosocial frameworks (Im et al., 2020; Miller and Rasmussen, 2010; Watters, 2001) emphasize asking refugees to express their views about their distress, identifying their resiliency sources (e.g. spirituality, family support) (Paudyal et al., 2021) and building social support for cultural integration (Rayes et al., 2021). As described by (Kleinman et al., 1978; Kleinman, 1980) it is crucial to understand these cultural social processes, which influence each person's interactions, thoughts, and feelings which in turn affect access to health care.

Differences in cultural perceptions of mental illness may act as a barrier to mental health care adoption (Davidson et al., 2008). Refugee groups are consistently reported as having less mental health utilisation than the general population, regardless of their high prevalence of mental health disorders (Steel et al., 2009; Satinsky et al., 2019; Lamkaddem et al., 2014). This includes women refugees (Hollander et al., 2011a) such as Afghan refugee women (Alemi et al., 2014, 2016) in the United States and Syrian refugee women in Lebanon (Masterson et al., 2014), Canada (Guruge et al., 2018) and Germany (Renner et al., 2020) who reported unmet mental health needs and low use of mental health services.

There have been several studies conducted to date assessing belief systems, knowledge, attitudes, and perceptions related to mental health among Middle Eastern refugee populations. However, it is difficult to draw conclusions from those studies without a comprehensive synthesis of the literature because of differences due to conflated samples (men and

women), context, methodology, and study quality. There have been systematic reviews on mental health and mental health service utilisation more generally in refugees and one that also included perceptions of mental health (Byrow et al., 2020). However, the findings were not linked to the region of origin and did not consider the important cultural differences that may exist within regions, and grey literature and non-English studies were excluded (Byrow et al., 2020; Satinsky et al., 2019).

The need for improving our understanding of how Middle Eastern refugee women view and perceive mental health and mental health-related issues is urgent. This could help facilitate the uptake of mental health services and reduce the burden of mental disorders among the most vulnerable of this population. To address the current gaps in the evidence, the present study reviews the quantitative and qualitative studies, including the grey literature to examine; (i) perceptions and understandings of mental health; and (ii) the role of mental health perceptions in mental health service utilisation for refugee women from the Middle East.

## 2. Method

### 2.1. Search strategy and data source

This Systematic review was registered in PROSPERO's database under registration code (CRD42020222163). This systematic review used the PICO method (Eriksen and Frandsen, 2018) in developing the search strategy, as follows: The P (population of interest) was Middle Eastern refugee (and asylum-seeking) women over the age of 18. Data had to be disaggregated in studies that included both men and women, such that conclusions with respect to women specifically could be formed. There was no specific intervention (I) required for this review, with all empirical studies that reported primary data relevant to the research questions included. Similarly, no comparison (C) or control groups were required for inclusion, however, studies had to address the similarities and differences in perceptions and understandings of mental health and/or how that understanding could affect the use of mental health services among refugees and asylum-seeking groups. Finally, outcome (O) was measured by examining perceptions of mental health for refugee and asylum-seeking women from the Middle East.

The review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). Searches of electronic databases (MEDLINE, (Ovid) PsycINFO, ProQuest, and Scopus) were conducted using predetermined search strategies. The grey literature searches were performed using Google (search setting;.gov or.edu and pdf filetypes), open Grey, WHOLS, and SALHS. The search strategy used synonyms and terms associated with 1) women OR gender, AND 2) mental health/well-being, AND 3) refugee/asylum seeker this includes truncations when needed (see Table 1/Appendix A) for a full list of all search terms used). No restrictions were imposed on dates or languages when screening and including studies in both qualitative and quantitative fields. The references of relevant review articles and dissertations found in the search were hand-searched for further related articles.

**Table 1**
Search terms.

| Refugees | Mental Health | Women |
|---|---|---|
| Refugee*<br>Humanitarian*<br>"asylum seeker"* | Mental health/<br>"well-being"<br>mental disorders/<br>(depression or depressive or distress*<br>panic or phobic or phobia)<br>Emotional disorder<br>((mental* or psychiatr* or psychological*)<br>Health*<br>disorder* or disease*<br>Mental health services<br>Distress | (female* or wom?n or gender*).<br>human females/ |

### 2.2. Inclusion criteria

This search includes all studies published before the final search (Aug 15, 2021) in peer-reviewed or grey literature (e.g., dissertations or reports) spanning any time period and in any language that examined Middle Eastern refugee and asylum-seeking women's understanding of mental health. Studies were excluded from this review if data concerning Middle Eastern refugee and asylum-seeking women was not reported separately from other participant groups (that is, studies that included Middle Eastern refugee and asylum-seeking women in a larger sample but did not disaggregate data).

### 2.3. Study selection and screening

PRISMA guidelines were followed during screening and study selection (see Fig. 1). The initial search produced 12,242 results, 2,248 of which were duplicates that were removed, resulting in 9,994 papers. Google's grey literature tool did not add any more results. In all, 7 documents fitting the eligibility criteria were found among the 9,994 results generated by the search and grey literature search, and one dissertation was added by hand searching. The full texts of all were obtained. There were several reasons for excluding articles at full-text screening (n = 222) including a focus only on the prevalence of mental illness, a focus only on barriers to accessing mental health services, and resettlement stressors rather than focusing on conceptualizations and understandings of mental health (Fig. 1). As noted above, studies that did not include populations from the Middle East or did not disaggregate data by gender were also excluded. The screening and data extraction software tool 'Covidence' was used to screen the title and abstract. Blind votes were cast by three authors (RT, AZ, CD) on the final relevant papers. There were two papers with differing votes, and a fourth reviewer (PW) provided a final vote which assisted in resolving the decision to retain one of the two papers in the review.

### 2.4. Data extraction

Data was extracted from studies using a pre-designed extraction table to explore data related to gender, participant sample, cultural background/country of origin, and other characteristics as outlined in the first section of the results. No meta-analysis was conducted due to the small number of quantitative studies and the lack of comparable measures. Braun and Clarke's (2006) approach to thematic analysis was used to extract themes from the findings of the study with respect to gender, culture, mental health, and service access. Specifically, findings in the included papers were coded and then grouped into higher-order themes, presented in the following section.

### 2.5. Quality assessment

As part of the quality analysis, the Joanna Briggs Institute's (JBI) critical appraisal tools (Jbi, 2017) and for grey literature (AACODS) checklist (Tyndall, 2010) were applied. Since all the included papers in this review were cross-sectional studies, a critical appraisal checklist for cross-sectional analytical studies by the Joanna Briggs Institute (JBI) was used to evaluate the quality of the included studies. The checklist criteria and method were discussed among three authors (RT, AZ, and CD), and the lead author conducted appraisals as per the eight questions in the checklist. Among the criteria in the checklist were the subject/setting description, reliable measures, and analysis tools, outcomes analysis, and confounding factors identification. In general, the quality of the papers indicated moderate to high quality based on the checklist criteria.

Most qualitative studies demonstrated a moderate to high level of

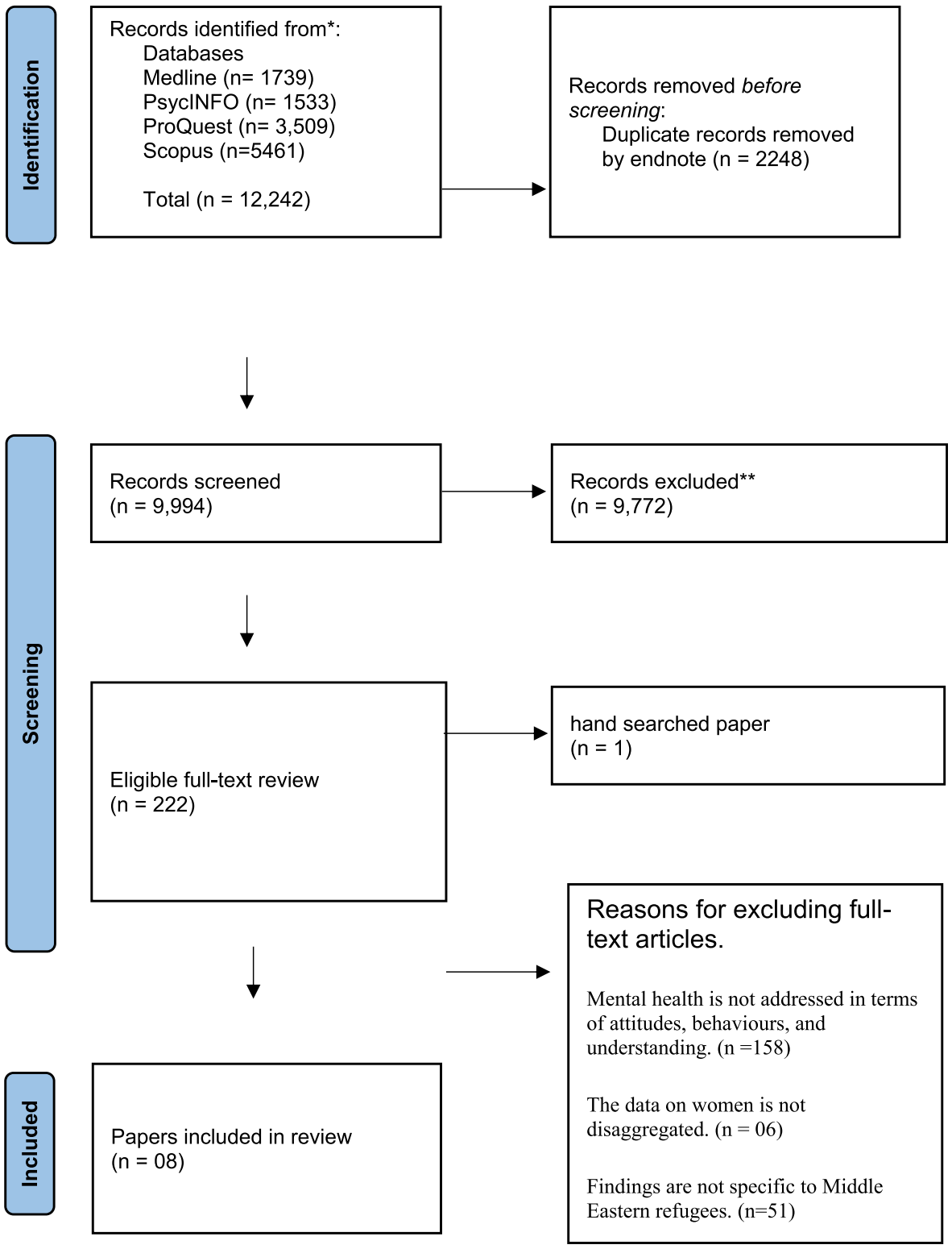


**Fig. 1.** PRISMA flow chart.

methodological standards. Qualitative studies generally used guided questions for semi-structured interviews, produced verbatim transcriptions, undertook coding procedures, and provided quotes from participants, to derive their findings. Most qualitative studies used semi-structured interviews for data collection; however, differences in sample size, cultural groups, and research methods (focus groups and one-on-one interviews) made it difficult to compare the results of the studies. All studies (qualitative, quantitative, and mixed) primarily used purposive sampling, snowball sampling, non-random convenience, and convenience sampling as methods of sampling. Most of the studies used a combination of these sampling methods and (Al Laham et al., 2020) used a mental health services register for convenient sampling. Furthermore, in one of the studies, the collected data did not appear to be explored in-depth or in a systematic way, despite the focus and aim relating to the

'perception' of mental health (Al Laham et al., 2020; Martin, 2009; Seven et al., 2021). A total of three out of four qualitative studies mentioned details of data finalisation (Alemi et al., 2016; Burford-Rice, 2020; Kerbage et al., 2020; Seven et al., 2021), but there were almost no reports regarding member checking (Alemi et al., 2016). acknowledged that member checking could not be done due to the participants being a 'hard-to-reach' group.

The papers focused more on barriers to mental health service utilisation rather than factors and attitudes that contribute to understanding mental health. Though all papers mentioned ethical considerations, the level of detail varied widely. For example, some only described getting consent and securing ethics clearance. However (Alemi et al., 2016; Burford-Rice, 2020), detailed the ethical considerations, including trust, privacy, and confidentiality. Given the focus on refugees, this lack of ethics discussion could be concerning when it comes to potential privacy or perceived coercion. Most studies noted funding sources and authors' conflicts of interest, however, only (Ahmed et al., 2017; Kerbage et al., 2020; Seven et al., 2021) reported no conflict of interest from the funding sources' perspective. The majority of the funding came from the same countries and institutions where the studies were conducted. In contrast (Martin, 2009; Al Laham et al., 2020), did not disclose the sources of funding or the authors' conflicts of interest. In general, these points about the quality of studies indicate the variety of obstacles associated with refugees' research. Compliance with extensive ethics protocols, small or unavailable sampling units, difficult to reach groups (Alemi et al., 2016), and cultural appropriation concerns are among the challenges in conducting research with this group.

## 3. Results

### 3.1. Overall characteristics of papers

This review included both quantitative and qualitative studies. A full description of the statistical study design, sample characteristics, and sample size, as well as quantitative and qualitative studies, can be found in Table 2. Table 3 sets forth those papers that addressed particular themes addressed by identification numbers (IDs) identified in Table 2. The review identified 8 documents between 2013 and 2020, including 6 peer-reviewed papers and two dissertations. Four papers were qualitative and one was quantitative. The other three were mixed-method publications (Table 2). As a result of the mixed sample (men/women) in all included papers, only women's data was used for the analysis. These papers included 546 participants, of whom 221 were women (40.4%). All of the documents were based in the countries of resettlement, including four originating from the United States, two from Lebanon, one from Australia, and one from Canada. Three papers from the same study said that asylum seekers were eligible to be included in the study but did not specify whether any of their subsequent participants were asylum seekers (Alemi et al., 2015, 2016, 2017b). The other papers did not refer to asylum-seeking status but one document referred to three participants previously being asylum seekers, but they had resolved immigration status now (Alemi, 2013). As such given no findings were disaggregated by asylum seeker/refugee or precarious immigration status was not identified as a theme, we refer to the rest of the findings as applying to 'refugees', though we acknowledge it is possible at least some of the studies included asylum seekers.

(One out of the 8 papers (Ahmed et al., 2017) dealt solely with the experiences of refugee women. Seven others included both men and women collated samples. In most papers, refugees were the informant group, although (Al Laham et al., 2020; Seven et al., 2021; Klimentina et al., 2021; Martin, 2009) also included the non-refugee group. Three papers (Kerbage et al., 2020; Al Laham et al., 2020; Klimentina et al., 2021; Burford-Rice, 2020; Simkhada et al., 2021) included both refugee and service-provider perspectives. In addition, three papers (Alemi et al., 2015, 2016, 2017b) stated refugee or asylum seeker as inclusion criteria, but the sample characteristics did not specify the number of asylum seekers. Another study (Alemi, 2013)reported on three participants who initially settled in the United States as asylum seekers. However, the analysis and results described only refugees (Table 1).

All papers included adult participants (over the age of 18), and the number of participants in the papers ranged from 12 to over 130, with the largest sample being in the quantitative study (Table 2).

In four papers, depression was examined in terms of beliefs and understandings of depression, along with associated factors. Three papers focused on perceptions and experiences of mental health services, and one on settlement factors and help-seeking behaviours for mental health support (Table 2/Table 3). The papers' purposes, aside from two, varied considerably. In two similar studies (Kerbage et al., 2020; Al Laham et al., 2020), the research aims were to examine the perception and experiences of refugees about mental health and mental health services. Among four papers on depression (Ahmed et al., 2017) reported on maternal depression understanding in refugee women, whereas (Alemi et al., 2015, 2016, 2017b) focused on the beliefs, associated factors, and explanatory model related to depression in refugees.

Additionally (Burford-Rice, 2020), examined resettlement stressors and help-seeking behaviours, and (Alemi, 2013) an extensive study with three publications explored gender-specific beliefs about depression and explanatory models of depression among refugees. Four of the papers that used qualitative methods employed purposive sampling in conjunction with in-depth interviews, and one of them used the focus group method. A quantitative paper used a survey and questionnaire, but the other three used a mix of interviews and surveys.

### 3.2. Pre and post-settlement experiences

The majority of Afghan refugee women cited experiencing war, home invasions, unjustified interrogation, a prison for family members, fear of being killed by the ruling authorities, and separation of families (Alemi, 2013; Alemi et al., 2014, 2016, 2017b). During the refugee journey, Afghan refugees also described stressors that were encountered, including having to climb mountains in order to reach their neighbouring country Pakistan, hunger, insufficient food and water, and finding temporary camps to stay in during the journey across the mountains (Alemi, 2013; Alemi et al., 2016). The included Afghan refugee papers reported on experiences in the United States (Alemi, 2013; Alemi et al., 2014, 2015, 2016, 2017b) and Australia (Burford-Rice, 2020). Resettlement stressors for refugee women included language difficulties that hindered effective social interactions with others in the host country, no control over children, and navigating the system, most notably the transport system that women found difficult to navigate. These difficulties particularly during the first year of resettlement caused many Afghan refugee women to identify their gender group with the highest risk of depression (Alemi, 2013; Alemi et al., 2016, 2017b; Burford-Rice, 2020). Additionally, financial difficulties were cited by a variety of respondents (Alemi et al., 2016).

Syrian refugee papers explored experiences in Lebanon and Canada. In the two papers from Lebanon, Syrian refugees were living in different parts of the country, not necessarily in refugee camps. Stressors for Syrian refugees identified in the papers are mainly related to experiences in Lebanon rather than pre-migration stressors in Syria as described in these papers (Kerbage et al., 2020; Al Laham et al., 2020). This included psychosocial factors and environmental stressors such as unemployment, job exploitation, a lack of money, a lack of basic needs, discrimination and bullying of their children, harassment and physical assaults by the locals, poor access to education and health care, overcrowding, poor housing, and movement restrictions primarily related to arrest at army checkpoints (Al Laham et al., 2020; Kerbage et al., 2020). There was also widespread dissatisfaction expressed by participants, including their perception that aid agencies are discriminating against them and altering their welfare payments abruptly for months. All Syrian refugees in Lebanon considered that resettlement in a third country would solve all of their problems (Al Laham et al., 2020; Kerbage et al., 2020).

**Table 2**
Characteristics of the papers.

| Study ID | Author | Year | Country | Study Design | Purpose/Aims | Sampling method/size | Analyses/outcomes | Findings |
|---|---|---|---|---|---|---|---|---|
| 1 | Alemi et al. | 2016 | USA | Qualitative: semi-structured interviews. | To explore Afghan refugees' views about depression along with cultural aspects and etiology related to depression. | Purposive, convenience & snowballing. 7 women and 11 men. | Qualitative Description Technique and Thematic Analysis. 'Standard qualitative content analysis method was used. Mental Health | Cultural beliefs play a significant role in etiology, conceptualisation of mental health, and help-seeking behaviours. |
| 2 | Kerbage et al. | 2020 | Lebanon | Qualitative: semi-structured interviews. | To explore Syrian refugees' perceptions of mental health services and service providers' experiences working with refugees. | Purposive Sampling in-total 25 Syrian refugees-18 women) and 60 service providers. | Inductive coding with Thematic Analyses. Mental Health | Psychological labelling makes it shameful, but Syrian refugees believe that emotional suffering is a natural part of life. Significant gaps in perceptions and needs were also identified that could impact trust between providers and refugees. |
| 3 | Dana Al Lahm | 2019 | Lebanon | Qualitative: focus group discussions (FGD) and in-depth interviews. | An investigation of perceptions of mental health among Syrian refugees and their impact on healthcare-seeking behaviours was conducted in Wadi Khaled, a rural area of Lebanon bordering Syria. | Purposeful and convenience sampling including 18 Syrian refugees (13 women) and 28 local Lebanese (21 women). | Thematic Analysis. The relationship between mental illness, cultural beliefs, and religion. | Syrian refugees and Lebanon populations associated mental illness with shame, stigma, and fear. A religious healer was seen as less stigmatizing and more culturally acceptable than mental health providers for those with mental illness. |
| 4 | Burford Rose | 2020 | Australia | Qualitative: | Examining the stressors of resettlement and the need for mental health services among women from refugee backgrounds. | Snowball sampling and convenience sampling were combined. A total of 30 participants were recruited, including 11 refugee women from Afghanistan. A group of service providers was also included in the study. | The data was analysed using thematic analysis with inductive coding (Clarke and Braun, 2013 and 2006). -Help-seeking behaviour. -Mental health -Stressors associated with resettlement. -Mental health conceptualisation. | Various cultural conceptions of mental health contribute to stigma, including labels such as 'crazy' attached to mental health issues and judgments from the community. Informal help-seeking methods involved social support, including family and community support. As well as language and communication issues, gender-related stressors (controlled by husbands) are associated with resettlement. |
| 5 | Alemi et al. | 2015 | USA | Quantitative | To examine the factors that predict and are associated with psychological distress symptoms in Afghans from refugee background. | Non-random sampling mainly convenience and snowballing technique. 130 Adult Afghan refugee including 56 female and 74 male. | -Afghan Symptoms Checklist (ASCL) and questionnaire -SPSS, version 21.0 software was used for the analysis; Pearson correlations, t-tests, and analysis of variance. - Psychological distress is correlated with and predicted by variables levels. | Women were more likely to experience symptoms of depression, anxiety, and concentration problems as a result of psychological distress. |
| 6 | Ahmed et al. | 2017 | Canada | Mix-Method | Understating mental health perspectives to examine Syrian refugee women's experiences with pregnancy and motherhood after resettlement in Canada. | Purposeful sampling including 12 Syrian refugee women. Structured questionnaire and Focus group discussion. | -SPSS Statistics 20.0. Chi-square tests and t-tests t -Thematic Analysis. -Mental health -To understand refugee women experiences related to mental health in perinatal and post-natal period. - Screening depressive symptoms among Syrian refugee women. | The mental health of Syrian refugee women can be affected by a variety of factors. There may be a number of factors that increase the vulnerability of refugee women to maternal depression, including social isolation, language barriers, economic factors and experiences that may be unique to them. Almost two thirds of the participants had positive screening results for depression. |
| 7 | Alemi et al. | 2017 | USA | Mix-Method | Understanding the beliefs about depression in | Snowballing technique including 93 adult | -SPSS, version, 21.0 -Cultural consensus | The gender-specific models of depression share |

(*continued on next page*)

**Table 2** (*continued*)

| Study ID | Author | Year | Country | Study Design | Purpose/Aims | Sampling method/size | Analyses/outcomes | Findings |
|---|---|---|---|---|---|---|---|---|
| | | | | | Afghans from refugee backgrounds using a mix-method approach. | Afghan refugee (43 women & 50 men). -Structured questionnaire -in-depth interviews. | analysis. -ANTHROPAC software. | similarities with each other, even though men and women differ on factors that might account for their differences in beliefs. The demographic factors such as gender do not affect beliefs about depression, but experiences, such as higher distress levels, may result in women feeling more depressed. |
| 8 | Alemi et al. | 2013 | USA | Mix-Method | A multi-method approach was used to investigate the beliefs about depression among Afghan refugee families. | In total 132 participants including 18 Afghan refugee women for a qualitative data and 43 women for both quantitative and qualitative data and 130 for a quantitative data were recruited. Non-random and a mixture of snowballing and convenience sampling. | **Quantitative analysis:** SPSS, version 21.0 software and ANTHROPAC software were used for the analysis of (Afghan Symptoms Checklist (ASCL) and questionnaires). **Qualitative Analysis:** For semi-structured in-depth interviews Qualitative description technique and Thematic Analysis. 'Standard qualitative content analysis method were used. | Quantitative: According to the results of all depression domains, the proportion of shared beliefs among women (.52) was significantly higher ($p < .05$) than that among men (.46). The average level of agreement between women and men regarding depression causality was significantly higher (women = .54, men = .42). Qualitative: The understanding of Afghan refugee culture regarding depressive disorders can improve the provision of depression treatment and care by better understanding how depressive symptoms are presented in clinical settings and the influences on help-seeking behaviour. |

**Table 3**
Papers relevant to themes (quantitative and qualitative) resulting from analysis.

| Paper/ID numbers | Qualitative them | Total n | Paper ID numbers | Quantitative Theme | Total n |
|---|---|---|---|---|---|
| 1,2,3,6,7,8 | Theme 1: Conceptualisation of mental health from a cultural perspective: Idioms of distress, symptoms, and risk factors, | 06 | 5, 6 | Higher psychological distress in refugee women. Physical symptoms | 02 |
| 2,3,4,6 | Theme 2: Stigma and its role in the understanding of mental health-related problems Shame, fear and Embarrassments. | 06 | | | |
| 1,2,3,4,6,7,8 | Theme 3: An understanding of mental health in relation to mental health service utilisation Preferred method Professional help and traditional help such a 'Tabib" and prayer. | 07 | | | |

On the other hand, in the Canadian paper (Ahmed et al., 2017) the focus was on Syrian refugee experiences and perceptions about depression mainly maternal depression. This study did not explore or discuss any pre-migration stressors. In terms of post-resettlement stressors, only depression-related experiences were explored, in which women shared their happy times in Syria and how they got strong social support which they are lacking in Canada (Ahmed et al., 2017).

### 3.2.1. Findings

From the analysis of qualitative data and the synthesis of quantitative data from the eight papers in this review, three main themes were identified, including two subthemes encapsulated within the main themes. The following sections provide an overview of the key findings based on the themes and sub-themes arising from the studies. Themes 1 and 2 focus particularly on understandings of mental health, and theme 3 focuses on the impacts of these conceptualisations on mental health service utilisation.

### 3.2.2. Theme 1: conceptualisation of mental health from a cultural perspective

Under the broad theme of "cultural conceptualisation" of mental health, key foci included idioms of distress, symptoms, and some risk factors related to mental health.

Seven out of eight papers, consisting of four qualitative papers, two mixed methods, and one quantitative, described refugee women's understanding of mental health in the context of presenting physical symptoms and cultural idioms of distress rather than using other ways of describing mental health. The reported findings did not map clearly onto 'western' understandings of mental illness/symptomatology of disorders. In these studies, women described feeling "pressure", "being strangled",

or feeling no hope for the future as examples of emotional distress. Observable physical symptoms and somatisation were also described as being associated with depression, such as indigestion and a bad taste in the mouth. A study of Afghan refugees (Alemi, 2013) with three papers (Alemi, 2013; Alemi et al., 2015, 2016, 2017b) identified that in association with depression, participants used the terms asabi/irritability, ghamgheen/sadness, and ghosagiry/self-isolation. Additionally, the phrase "daze", excessive rumination, was used to describe their beliefs, such as 'thinking too much', or feeling sad (ghamgheen). In their quantitative study of 135 refugees, Alemi et al. found twice as many women reported higher psychological distress than men (Alemi et al., 2015).

In their rich description of mental health (Kerbage et al., 2020) Kerbage et al., found in a qualitative study that all Syrian refugee participants in their study in Lebanon made reference to feelings of suffocation "(خنقة/being strangled"), chest pain, and physical signs as means of describing emotional distress. In the same study, all participants reported a range of other cultural idioms of distress. For instance, كرامة ما في/losing dignity, (مستقبل ما في/being unable to envision a future, and إحباط/feeling frustrated. According to (Kerbage et al., 2020) Syrian refugee women described disrupted mental health as a normal and inherent part of external stressors and the refugee journey. In refugee women's description; it's not a mental illness or a problem with mental health, it's just that "we're tired".

On the other hand, findings of another qualitative study on Syrian refugees (Al Laham et al., 2020) in Lebanon reported that all of the participants used the Arabic word "Daght/pressure" frequently in conversations to describe mental health problems or expressions such as "I'm tired" or stressed or exhausted." Additionally, Syrian refugee women identified fear of a future, a lack of religious duties, and pre and post-migration stressors as contributing risk factors to mental health disruption (Al Laham et al., 2020). It was reported in the same study that all of the participants strongly believed that 'magic, black magic, and Jin' caused all types of mental disorders (Al Laham et al., 2020). However, in the discussion sections of both studies, their gender differences were not discussed in depth. In both studies, the perspective of mental health service providers was also examined. Syrian culture has been referred to as "traditional" and different from modern psychiatry, where words such as "depression" are often described as "I'm nervous" or "I'm exhausted". According to a Canadian study with a mixed-method (Ahmed et al., 2017) on Syrian refugee women who had maternal depression, the women described being "bored" and "tired" as mild symptoms of depression, which were different from severe cases of depression. A number of women in the same study (Ahmed et al., 2017) described feeling sad, having a low mood, being irritable, short-tempered, or tired as not symptoms of depression, but due to being separated from family or external factors during their refugee journey.

A mixed-method study of Afghan refugees in the USA with three papers (Alemi, 2013; Alemi et al., 2015, 2016, 2017b) examined refugees' gender-based and cultural beliefs about depression, predictors, and correlates, and explanatory models of depression. Among the three papers, one was quantitative (Alemi et al., 2015) one was qualitative (Alemi et al., 2016), and one was a mixed-method paper (Alemi et al., 2017a). In these papers, Afghan women were likely to report excessive somatisation including reporting paleness and having a bitter taste in their mouths. There were symptoms of indigestion, a sense of darkness in front of the eyes, dizziness, sweating excessively on the palms, laboured breathing, and cold hands and feet. Afghan women reported twice as many somatic symptoms related to depression than men in the study(Alemi et al., 2015). Further, the mixed-method paper found that that gender was not associated with beliefs about depression, but experiences, like higher distress levels, contribute to feeling depressed more often in women (Alemi et al., 2017b). Culturally conceived distress, such as sadness ('ghamgheen'/apprehension), loss of appetite, and concentration problems were reported to be associated with depression by the participants. Alemi (2016, p. 639) one Afghan woman mentioned; "when I first arrived here (USA), I always felt ghamgheen/sadness, stress and my children were young and I stayed home all day, which exacerbated my stress and affected me even more because I could not speak the language" (Alemi et al., 2016). According to Afghan women, most of their stress and worries come from their children being scattered throughout central Asia and their families being divided (Alemi, 2013; Alemi et al., 2016, 2017b). In these papers Afghan refugee women were more likely to endorse cultural idioms of distress and somatic symptoms; however, it was suggested that this could be related to higher distress levels in refugees (Alemi, 2013; Alemi et al., 2016, 2017b). Further, in these papers (Alemi, 2013; Alemi et al., 2016, 2017a) core beliefs shared by both genders included fostering the success of children, maintaining an Afghan identity, and keeping family harmony away from a breakdown. In the mixed-method explanatory model of depression paper; Afghan refugee women presented a different theme regarding intergenerational concerns, such as a modest dress code for children, and raising many children as a risk factor for depression (Alemi et al., 2017b).

According to the Australian paper, Burford (2020,p.139) Afghan women shared the following narratives related to the conceptualisation of mental health: "if my mother go there people said my mother is nuts or crazy and the meaning of crazy and mad in my culture is very bad. […] the psychologists has very bad name in my culture". "Afghani people talk "if you go to the psychologist" the Afghani people say "you are mad, you are crazy" and maybe they can't make friend with you, the psychologists has very bad name in my culture " (Burford-Rice, 2020). Aspects of Afghan culture suggest that mental health issues may be viewed as contagious, and those suffering from physical symptoms should be advised to remain isolated (Burford-Rice, 2020). Burford (2020,p.140) as one woman described … "they think like if this person has a mental health tomorrow I will I get in the same situation, […] like I get mental health tomorrow, so they think like that. Sort of like flu you know" (Burford-Rice, 2020).

### 3.2.3. Theme 2

In this theme area, stigma and its role in the understanding of mental health-related problems were discussed.

A total of seven of the eight papers, four qualitative and three mixed-method, found that women from refugee backgrounds viewed mental health and mental illness issues negatively and associated with stigma. The majority of women in these papers reported embarrassment, fear, judgment by the community, and shame associated with mental health issue disclosure and mental health service utilisation. However, some women also noted mental health issues as a collective phenomenon that everyone experiences as refugee (Kerbage et al., 2020) According to some Syrian refugee women in one study, despite the stigma, they readily endorsed the services available to them (Ahmed et al., 2017). However, in another, all Syrian refugee participants described mental illness sufferers as crazy even when they had utilised mental health services independently (Al Laham et al., 2020).

Syrian refugees in three studies (Ahmed et al., 2017; Al Laham et al., 2020; Kerbage et al., 2020) reported stigmatization, fear, and shame surrounding mental health issues and utilizing mental health services. Community members mocked and judged people receiving mental health care. According to some, it was "taboo" and meant the person seeking mental health care was crazy, as discussed in the earlier section (theme 1) about conceptualising mental health. This view of mental health issues as "being crazy" adds to the stigma and prevents people from seeking mental health care. As a result of embarrassment, stigma, and fear attached to mental health services, Syrian participants in these papers preferred direct communication with each other over seeking professional help.

The participants did not view mental illness as a medical issue, but rather as an internal malfunction within the individual, or as "craziness". (إضطراب,جنون). This study inferred that due to this labelling of "crazy," all Syrian refugees in this study insisted on having a collective experience of "being tired" rather than linking it to mental health issues due to the stigma (Kerbage et al., 2020). People with mental illness were repeatedly

described as "complicated," "crazy," "stupid," and "weird" by participants, including those who had accessed mental health services themselves. There was an association between mental illness and shame, stigma, and fear for both groups (Syrian refugees and Lebanon's population). Syrian refugee women, however, expressed mixed feelings in this study. While some endorsed religious practices of seeking help, others still sought professional mental health services despite mental health stigma (Al Laham et al., 2020). Some Syrian refugee women in the Canadian study (Ahmed et al., 2017) stated that they would not hesitate to seek help regardless of mental health stigma, but the small sample size limits the generalisability.

According to a study (Burford-Rice, 2020) of Afghan refugee women in Australia, mental health stigma is connected to family honour. Within the community, the reputation of the family was closely tied to the reputation of the women. Women seeking mental health services would be putting their family's reputation at risk due to the stigma attached to mental health issues. As one woman shared, "they will not talk about the girl, they will talk about the girl's family". In Burford (2020,p.138) another woman mentioned "they will think that if they go to any service for help, other people will think wrong about her and her reputation will be very bad in my community. For example, if people see that this woman is going to the other service they will think why she going? Is she mad? […] people backbiting about her. That's the reason to stop women from going to any service". Mental health problems were also widely labelled as "mad" and "crazy" in Afghan culture (Burford-Rice, 2020).

As reported by Syrian women (Ahmed et al., 2017), a husband sometimes forbids his woman to speak about mental health problems or seek help out of fear of being stigmatised. Ahmed (2017,p.7) one Syrian woman shared; "for every woman, her husband's way of thinking is different …. Some men, they don't like that their wives to speak, even to her neighbours. It's a form of privacy"(Ahmed et al., 2017). Another Afghan woman shared "[if a]woman has serious mental issues they end up not to share it in public because it is good that it is confidential because it would be a fun stuff for them like spread out […] the family don't appreciate to share it out so they just keep it within the house" Burford (2020,p.137).

#### 3.2.4. *Theme 3*

An understanding of mental health in relation to mental health service utilisation.

All included papers discussed the topic of mental health service utilisation behaviours in some way in relation to understanding of mental health. Four qualitative, three mixed-methods, and one quantitative paper shared findings related to beliefs or preferred ways to utilize mental health services. With the exception of two Afghan refugee papers (Alemi et al., 2017b; Alemi, 2013) where the participants endorsed western mental health services, there was a general distrust of the western method for treating mental health issues among the participants. Included papers found prayers, community connections, and the treatment of religious scholars to be preferable.

In Syrian refugee studies(Ahmed et al., 2017; Al Laham et al., 2020; Kerbage et al., 2020), the participants showed positive affirmation for prayers and reading of the Quran, and that maintaining a strong faith eases mental health problems. However (Al Laham et al., 2020), study reported mixed responses from Syrian refugee women in Lebanon. According to a Syrian woman, "they said she was touched or something and they took her to Sheikh, and up until now, the majority do the same thing" Al Laham (2020, p.880).

Some women described going to religious Imams as positive, while others described how Imams discouraged them from going to western treatment and convinced them that their mental health issues were due to "Jin" possession (Al Laham et al., 2020). The findings of this study also revealed that both the Syrian refugee group and the Lebanese population claimed to believe in black magic and Jin possession, which is why many adhered to the practice of visiting religious healers. Similarly (Ahmed et al., 2017; Simkhada et al., 2021; Martin, 2009), reported that participants considered western medicine or therapies less favourable and untrustworthy, instead preferring prayer and traditional healers. Participants in the Syrian refugee studies were also inclined to view lack of faith as the main culprit of mental health troubles, so reaching out to religious scholars was supported by many (Al Laham et al., 2020; Alemi et al., 2016). "When a person feels he is missing something in his religious duties, he feels sick." said one Syrian woman "AL Laham (2020, p. 879). In addition, some have mentioned that true Sheikhs don't confirm or deny possession of "jin. "Rather, they read Quran on you as it is their duty (Al Laham et al., 2020).

Several papers explored Afghan refugee experiences. A number of participants in these (mixed-method, qualitative, and quantitative) papers believed that prayer and keeping strong religious faith alleviate mental health symptoms (Alemi, 2013; Alemi et al., 2015, 2016, 2017b). In one of these papers (Alemi et al., 2017a) it was found that Afghan participants were in favour of western medication and would not mind receiving professional help. There were thematic differences between genders, Afghan refugee women preferred traditional healers "Tabib" and Afghan men preferred listening to music to reduce depressive symptoms (Alemi et al., 2017b). Although all participants in these papers supported alternative methods, they expressed a willingness to accept a western approach to mental health care and services. However, the discussion section did not address gender differences in service utilisation behaviour in light of cultural expectations that women refrain from music and entertainment (Alemi et al., 2017b). In addition, Afghan women were more inclined to suggest strengthening social support groups to alleviate mental stress (Alemi, 2013; Alemi et al., 2016). One Afghan woman recommended that "the Afghan community should establish a group or organization for Afghan people, where they would meet socially, and converse in their languages such as Pashto or Dari." Virtually all Afghan participant narratives mentioned that being together with the family helped alleviate mental stress (Alemi et al., 2016). Afghan women have also reported turning to religion when they are stressed or overwhelmed. One Afghan woman shared; "whenever I have a problem, my mother has always advised me to pray. Praying will help you connect with God. Having a strong faith will be very beneficial. When you turn to God, she says, he will always answer your questions" Burford (2020, p. 148). The same study (Burford-Rice, 2020) also found that the younger generation of Afghan refugee women was more inclined to use professional mental health services and that this is due to better education and greater awareness of mental health issues.

In this review, participants in the Afghan and Syrian refugee studies shared a wide variety of preferences for mental health service utilisation. On the one hand, some participants discussed the lack of resources and lack of awareness regarding mental health, particularly in Lebanon (Kerbage et al., 2020), and on the other hand, they were reluctant to acknowledge mental illness or mental stressors or to use the word "depression" in the discourse (Ahmed et al., 2017). Several of them stated that they were just tired and supported non-traditional methods such as prayer and having faith in religion to relieve mental stress (Al Laham et al., 2020; Kerbage et al., 2020).

However, it is noteworthy that Syrian refugees suspected their mitigating circumstances to be the cause of their mental illness, so many did believe that they would not require western medications if their circumstances were reversed. On the other hand, many Afghan refugees were willing to accept western medication, however, they also recognized the importance of religious practices in healing mental stress (Alemi, 2013; Alemi et al., 2016, 2017b).

Mix-method papers (Table 1) IDs may appear in both the qualitative and quantitative columns in Table 2.

## 4. Discussion

To the best of our best knowledge, this study represents the first systematic review of existing research examining perceptions of mental health and mental health-related problems among Middle Eastern

refugee women. Our findings suggest that conceptualisations of mental health for this group are heavily influenced by cultural values and expectations as well as spiritual and religious beliefs which was reflected in the use of idioms of distress and the stigma associated with mental illness, which in turn framed beliefs about and use of mental health services. Our discussion below discusses the key themes derived from the analysis of the included studies as well as the limitations of the review and recommendations for policy and practice.

In this review, all included papers described refugee women suffering from high levels of psychological distress and exhibiting symptoms of mental health problems. Refugee women had culturally related idioms of distress to describe mental health issues or mental health-related symptoms in most of the qualitative studies. All of the women in the studies were from Afghanistan or Syria and there were some cultural differences between the two groups. Syrian refugee women showed distress mainly through tiredness, boredom, and exhaustion, while Afghan refugee women expressed distress primarily through sad/ghamgheen, ghosagiri/social isolation, and irritability. Syrian refugee women described feelings of "being tired" and "exhausted" as part of their journey as refugees, and such expressions can sometimes indicate mild depression. However, these expressions do not necessarily indicate a severe form of depression. One of the strongest findings of this study is the use of culturally specific expressions by Middle Eastern refugee women to express their understanding of mental health. Differences in the understanding of mental health can have a direct impact on how individuals perceive mental health and their use of mental health services. For example, one study found (Weatherhead and Daiches, 2010), that Muslim communities in the United Kingdom sought help for mental stressors primarily from religious authorities, prayers, social support, and family support. These differences between the Islamic and Western interpretations of mental distress affected the way in which Muslim communities sought assistance (Weatherhead and Daiches, 2010).

In general, idioms of distress findings are in-line with refugees from other regions; (Im et al., 2017; Rasmussen et al., 2011; Rechtman, 2000; Carroll, 2004). For example, in a study from Germany with Syrian men refugees, they discussed idioms of distress such as Halal/Haram but did not specifically focus on mental health issues (Lindert et al., 2021). Various studies on African refugees (Backe et al., 2021; Hinton et al., 2010, 2015) have demonstrated the importance of a culturally derived understanding of mental health and the idioms of distress. However, these studies do not focus exclusively on the perspectives of women refugees.

In the earlier part of this article, the WHO definition of health was outlined, which basically states that a person experiences positive impacts on others, realizes their own abilities, and copes with the normal stressors of life (Who, 2004). In light of this review's findings of understandings of mental health, it is noteworthy that many refugee women perceived mental stress and mental illness as inherent aspects of their lives, and they did not necessarily require assistance. These findings suggest that the women in this study perceived mental health stability differently and considered it to be a natural phenomenon they will live with regardless of whether the disorder is stable or not.

Most qualitative studies in this review identified stigma as a major factor in shaping mental health conceptualisation and this had implications for the utilisation of mental health services. The participants in these studies viewed mental health negatively, and respondents were worried about stigma, stereotypes, and judgments about mental health affecting their reputations in society. In addition, they said receiving mental health support can negatively affect the social standing of family members and cause embarrassment. This was consistent with previous studies' findings on other refugee groups (Byrow et al., 2020; Clement et al., 2015; Satinsky et al., 2019). It is important to note that 'stigma' can refer to both the beliefs surrounding stigma and the implications of those beliefs as well (Deacon, 2006).

The Mental Illness Stigma Framework (MISF) is an overarching phenomenon that argues that stigma involves multilayers as a social process (Fox et al., 2018). The framework components include perspectives of stigmatiser and stigmatised outcomes of each perspective and intersectionality. The stigmatiser category includes stereotypes, discrimination, and prejudice, while the stigmatised category includes anticipated, experienced, and internalised stigma. Outcomes of the former category include social rejection, while outcomes of the latter address delayed response to available support, etc. Furthermore, the 'intersectionality' part deals with overlapping aspects identified such as gender, race, and socioeconomic status. Additionally, perceived stigma is linked to both perspectives (of the stigmatiser and the stigmatised). The findings of this review identifying stigma in relation to mental health indicated that there are multiple layers to the stigma process. Refugee women feared embarrassment and shame for their families (anticipated stigma). They also emphasized the harm done to the reputation of the family by the community (stereotype, discrimination, and prejudice). Additionally, the idea that women carry the burden of honour in their families indicates the intersectionality characteristic. It is imperative to enable refugee women to speak out regarding the basis for their problems. Improving culturally acceptable models of care can be assisted by exploring the lived experiences of depression and listening to their perspectives on the significance of their situations. Most of the existing models and frameworks concerning mental illness stigma are lacking in adequately conceptualising both the concepts of being stigmatised and stigmatizing others; however, the advantage of this approach is firmly grounded in the perspective of both mental illness sufferers and non-sufferers. (Fox et al., 2018).

From the perspective of mental health conceptualisation in using services, findings in this review suggest a lack of trust in professional mental health treatment and a preference for alternative approaches such as traditional healing or religious practices. Previous research has shown that refugees face a range of barriers, including structural and financial (Byrow et al., 2020) issues, and also a fear of authority, and a lack of trust in government systems (Nickerson et al., 2020; Colucci et al., 2015). Nevertheless, a limited amount of research has been conducted on the nature of the 'lack of trust' phenomenon. In a similar way, participants expressed concerns that western modes of treatment do not take the whole picture into account (including their understanding of mental health), thereby lacking credibility. Though some Afghan participants in the study appeared to be open to conventional western treatment and mediation (Alemi et al., 2017b), the majority of Syrian and Afghan respondents were more inclined to support social support, family bonding, and community support as the preferred method for accessing mental health services (Al Laham et al., 2020; Alemi, 2013; Alemi et al., 2015, 2016; Kerbage et al., 2020).

These findings may indicate a deeper clash with the western model of treatment, which may require further exploration in future research. It is also possible that this is rooted in a sense of collective identity (Hofstede, 1983) and the need for social connections as one big family, as some Syrian refugee participants commented that we are each other's doctors and support. (Al Laham et al., 2020). In Hofstede's cultural dimension theory (Hofstede, 1983) assessment, self-awareness, community, family, and hope are interconnected within the collectivism construct. Community and family resilience, however, are more likely to impact emotional wellbeing in collectivist cultures. Middle Eastern cultures rank highly on the collectivism scale, falling into Hofstede's Arab cultural category (Hofstede, 1983). Researchers (Mohamed and Thomas, 2017; Yaylaci, 2018) have previously observed that communities of refugees can suffer from mental health issues when there is no sense of collective ownership or responsibility. Yet, mechanisms of collectivism coping can assist refugees in their recovery and successful integration (Cetrez and Demarinis, 2017).

A number of studies in this review, however, presented a complex picture regarding the combination of different approaches to the utilisation of mental health services. For example, participants acknowledged the necessity of professional mental health services and nevertheless endorsed their own faith-based methods (prayer, imams,

and reading the Quran). As to the differences, Afghan refugee women endorsed professional services as well as lay methods, such as traditional Tabib and prayer. By contrast, Syrian refugee women preferred non-professional approaches. The importance of an individual's beliefs and how this can influence their preferred modes of treatment is evident here, most notably when it comes to mental health services, due to the stereotypes and stigmas that are attached to them. Research has shown that faith and religion can play a significant role in the resettlement of refugees (Blount and Acquaye, 2018; Majumdar, 2019). Middle Eastern refugees, especially those who practice their faith (Hasan et al., 2018), are noted to benefit from religion, faith to enhance their psychological well-being, and their beliefs to strengthen their emotional resilience (Hein and Niazi, 2016). In addition, the belief system can influence the way people understand mental illness and its treatment (Slewa-Younan et al., 2017). Therefore, it is crucial to gain an interdisciplinary understanding of refugee mental health issues that acknowledges the spiritual, and religious beliefs embedded in their cultural values. Providers of services to refugees can benefit from a comprehensive and culturally appropriate understanding of mental health by recognising cross-cultural differences that can promote culturally sensitive services.

There is an absence of research on Middle Eastern refugee women in this area. Despite the fact that recent data indicates that the Middle Eastern region, particularly Syria and Afghanistan, is the largest source of refugees and women are more likely to suffer from mental disorders. Reflecting on Kleinman's (1980) framework, even in the most homogenous of populations social realities differ considerably among individuals. Different people adhere to differing degrees of social norms, including their awareness, understanding, and acceptance of them. In turn, this consequently affects how people react and perceive sickness, as well as their decision-making process. Different socioeconomic classes, educational levels, family dynamics, ethnicity, and religion, can affect social realities. This is particularly relevant for women coming from refugee backgrounds, as refugees often come from culturally diverse environments before settling in host countries. Experiences such as these may have a considerable effect on health-related decisions and social realities within the host country. Additionally, it has highlighted the need for more long-term research, particularly research that identifies how and when psychosocial approaches might be most effective for people who are resettling into a host country and trying to integrate with optimum mental health.

### 4.1. Strengths and limitations

It is an original contribution of this review to synthesize Middle Eastern refugee women's perspectives on their understandings of mental health, experiences of cultural idioms of distress in interpreting mental health, as well as a consideration of stigma and how these understandings can impact mental health service utilisation. Bringing together this evidence allowed consideration of the themes common across the groups of refugees in different resettlement contexts as well as highlighting nuanced differences, as well as to show how important it is to consider the understanding of mental health when seeking to improve mental health service utilisation, and identifying key research gaps.

However, there are several limitations associated with the review process. The number of papers is relatively small. The focus of the topic and the specificity of the gender could be the reasons for the smaller number of studies that have been identified. In addition, the majority of the papers that were submitted were from high-income countries, and only two were from low-income countries despite there being no restrictions on the submission date or language. Only Syrian and Afghan refugee women were participants in the papers identified through the review. In addition, while theoretically, the papers included participants who were asylum seekers, none of the papers explicitly highlighted any differences between refugees and asylum seekers. Given the substantial impact of insecure immigration status on mental health, this is a significant gap. These factors may limit the generalisation of the review. However, this suggests possible areas for future research focusing on similar topics as there is a paucity of research focused on the perception of mental health and its implications among refugee populations.

### 4.2. Recommendations for policy and practice

Since there has not previously been a synthesis of research on mental health perceptions by women from refugee backgrounds in the Middle East, the findings of this study present important implications for policy, processes, and services concerning mental health for refugees. In light of strong cultural influences on perceptions of mental health and preferred mental health service modes, it seems clear that refugee groups should wherever possible receive mental health support from a provider with a similar background, though this may not always be feasible and there may also be concerns regarding confidentiality. As such it is crucial for mental health service providers to receive effective training on designing and delivering culturally sensitive services. Additionally, it is important that tools designed to measure mental illness – such as screening tools for depression and anxiety as well as guidelines such as the DSM-5 - are used with caution for both culturally diverse people as well as refugees, particularly since they may not be validated for use in these populations and may not capture their unique understandings of mental health (Lewis-Fernández et al., 2014). Understanding how people with refugee backgrounds conceptualise mental health can offer service providers valuable information for developing effective mental health services that also enhance trust with their clients, which can be the cornerstone to the development of lasting services.

## 5. Conclusion

This is the first systematic review that examines the perception of mental health among Middle Eastern refugee women. It is interesting to note that this review revealed the use of culturally influenced vocabulary related to mental health and how stigma is embedded in cultural values and expression in Middle Eastern refugee groups. In addition, the study also found that these conceptions of mental health have a significant impact on willingness to use mental health services. Additionally, it calls attention to the necessity of culturally appropriate services and training for service providers. As refugees, women face a range of pre- and post-migration stressors, including gender-based sufferings in the course of their journey, and mental health services adapted to the refugee context can be tailored to reduce the burden of disease associated with mental health among refugee women.

## CRediT authorship contribution statement

**Roheena Tahir:** Writing – original draft, Writing – review & editing, Conceptualization, Methodology. **Clemence Due:** Conceptualization, Methodology. **Paul Ward:** Conceptualization, Methodology. **Anna Ziersch:** Conceptualization, Methodology.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A

*Search Strategy*

### *A.1. MEDLINE*

| 1 # | 2 Searches |
|---|---|
| 3 1 | 4 Refugees/ |
| 5 2 | 6 (refugees or "asylum seek*" or humanitarian*).tw,kw. |
| 7 3 | 8 or/1-2 |
| 9 4 | 10 exp Women/ |
| 11 5 | 12 (female or wom?n or gender*).tw,kw. |
| 13 6 | 14 or/4-5 |
| 15 7 | 16 Mental Health/ |
| 17 8 | 18 exp Mental Health Services/ |
| 19 9 | 20 exp Mental Disorders/ |
| 21 10 | 22 ((mental* or psychiatr* or psychological*) adj2 (ill* or disorder* or disease* or distress* or disab* or problem* or health* or "well-being" or wellbeing or patient* or treatment)).tw,kf. |
| 23 11 | 24 ((chronic* or severe* or serious* or persistent) adj2 (mental* or psychiatr* or psychological*)).tw,kf. |
| 25 12 | 26 (emotional adj3 (disorder* or problem*)).tw,kf. |
| 27 13 | 28 (depression or depressive or panic or phobic or phobia or "self injur*" or "self harm" or "substance abuse").tw,kf. |
| 29 14 | 30 or/7-13 |
| 31 15 | 32 3 and 6 and 14 |

34 A.1.1. Medline Guide:
35/= Subject Heading or MeSH heading.
36 * = Truncation symbol, will find all variations of the words' ending – eg **therap*** will find **therapist, therapists, therapy, therapies**.
**37 .ti,ab.** = searching for these words only in the title or abstract of the paper.
**38 .kf.** = searching for these words in the author supplied keywords.
**39 adj3** = Adjacency – words need to be within 3 (can be a different number) words of each other.
**40 .pt.** = Publication type.
**41 or/x-y** = Boolean search of OR – used to combine all variations of words within one concept, will make the results bigger.
**42 and/x,y,z** = Boolean search of AND – will tie the concepts together and make the results smaller.

### A.2. PsycINFO

| 43 # | 44 Searches |
|---|---|
| 45 1 | 46 exp refugees/ |
| 47 2 | 48 (refugee* or "asylum seek*" or humanitarian*).ti,ab,id. |
| 49 3 | 50 or/1-2 |
| 51 4 | 52 exp human females/ |
| 53 5 | 54 (female* or wom?n or gender*).ti,ab,id. |
| 55 6 | 56 or/4-5 |
| 57 7 | 58 mental health/ |
| 59 8 | 60 mental health services/ |
| 61 9 | 62 exp mental disorders/ |
| 63 10 | 64 ((mental* or psychiatr* or psychological*) adj2 (ill* or disorder* or disease* or distress* or disab* or problem* or health* or "well-being" or wellbeing or patient* or treatment)).ti,ab,id. |
| 65 11 | 66 ((chronic* or severe* or serious* or persistent) adj2 (mental* or psychiatr* or psychological*)).ti,ab,id. |
| 67 12 | 68 (emotional adj3 (disorder* or problem*)).ti,ab,id. |
| 69 13 | 70 (depression or depressive or panic or phobic or phobia or "self injur*" or "self harm" or "substance abuse").ti,ab,id. |
| 71 14 | 72 or/7-13 |
| 73 15 | 74 3 and 6 and 14 |

76 A.2.2 PsycINFO Guide:
77/= Subject Heading or MeSH heading.
78 * = Truncation symbol, will find all variations of the words' ending – eg **therap*** will find **therapist, therapists, therapy, therapies**.
**79 .ti,ab.** = searching for these words only in the title or abstract of the paper.
**80 .id** = searching for these words in the author supplied keywords.
**81 .lo** = geographic location.
**82 adj3** = Adjacency – words need to be within 3 (can be a different number) words of each other.
**83 .pt.** = Publication type.
**84 or/x-y** = Boolean search of OR – used to combine all variations of words within one concept, will make the results bigger.
**85 and/x,y,z** = Boolean search of AND – will tie the concepts together and make the results smaller.

### *A.3. DATABASE: ProQuest*

noft(refugees* OR "asylum seek*" OR humanitarian*) AND noft(female* OR woman OR women OR gender*) AND noft((((mental* or psychiatr* or psychological*) NEAR/2 (ill* or disorder* or disease* or distress* or disab* or problem* or health* or "well-being" or wellbeing or patient* or treatment)) OR ((chronic* or severe* or serious* or persistent) NEAR/2 (mental* or psychiatr* or psychological*)) OR (emotional NEAR/3 (disorder* or problem*)) OR (depression or depressive or panic or phobic or phobia or "self injur*" or "self harm" or "substance abuse")))

### A.4. DATABASE:Scopus

((TITLE-ABS-KEY (refugee* OR "asylum seek*" OR humanitarian*) AND TITLE-ABS-KEY (female* OR woman OR women OR gender*))) AND ((TITLE-ABS-KEY (depression OR depressive OR panic OR phobic OR phobia OR "self injur*" OR "self harm" OR "substance abuse") OR TITLE-ABS-KEY (((mental* OR psychiatr* OR psychological*) W/2 (ill* OR disorder* OR disease* OR distress* OR disab* OR problem* OR health* OR "well-being" OR wellbeing OR patient* OR treatment))) OR TITLE-ABS-KEY (((chronic* OR severe* OR serious* OR persistent) W/2 (mental* OR psychiatr* OR psychological*))) OR TITLE-ABS-KEY ((emotional W/3 (disorder* OR problem))))) AND (LIMIT-TO (DOCTYPE, "ar") OR LIMIT-TO (DOCTYPE, "cp")).

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