

# What mental illness means in different cultures: perceptions of mental health among refugees from various countries of origin

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## Abstract

**Introduction:** Mental illness remains a significant issue for refugees worldwide. However, there remains a stigma surrounding mental health, mental illness, and mental health treatment throughout the world. Cultural stigma is just one of many barriers to mental health care for refugees that needs to be addressed.

**Purpose:** The purpose of this review was to distinguish the perceptions of mental health among refugees according to country of origin, because knowing these cultural differences can break some of the barriers and lead to better treatment approaches to mental health care for refugees.

**Methodology:** An extensive literature review of relevant articles published between 2000 and 2021 was performed using the databases APA PsycInfo, Global Health, MEDLINE via Ovid, CINAHL Plus with Full Text, and Google Scholar. The following groupings of search terms were used: (i) refugees, asylum seekers, displaced, and migrants; (ii) perceptions of mental illness, perceptions of mental health, and stigma of mental illness.

**Results:** There were numerous similarities and differences in the perceptions of mental health among refugees from different cultures. There were similarities in terms of mental health stigma, with certain cultures thinking of mental health/illness as taboo, as shameful, or associating it with evil spirits. A few of the cultures studied had similar ideas about the causes of mental illness, believing it was due to traumatic events or possession by evil spirits. The refugee groups had some common treatment options, including informal conversation, religious-based ideas, and community-level solutions. Some of the differences between refugees from different cultures involved certain symptoms associated with mental health, including physical symptoms, and differing degrees of religiosity.

**Conclusions:** This review of the perceptions of mental health held by refugees from countries around the world highlights the importance of cultural differences. Mental health care in this population should focus on cultural competency and community-level solutions and include mobile health clinics and telehealth.

## Keywords

refugee mental health, perceptions of mental health, stigma, mental illness, mental health treatment

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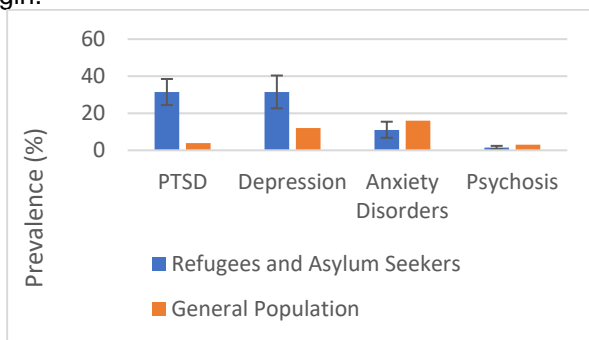
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## Introduction

Mental illness remains a huge problem in the refugee population despite recent efforts to combat this unfortunate reality. Blackmore et al. (2020) conducted a meta-analysis and systematic review of the prevalence of mental illness in refugees and asylum seekers. Their review was conducted across 15 countries, and the prevalence of posttraumatic stress disorder, depression, anxiety disorders, and psychosis was determined. The authors found significantly more posttraumatic stress disorder and depression in refugees and asylum seekers than in the general population (Figure 1). By contrast, they found that the prevalence of both anxiety disorders and psychosis in refugees and asylum seekers was comparable to the prevalence in the general population (Figure 1). For most of the cases of posttraumatic stress disorder and depression, the rates of mental illness among refugees and asylum seekers were not only high but persisted for many years after initial resettlement. There was no difference in prevalence between refugees displaced fewer than 4 years and those displaced more than 4 years (Blackmore et al., 2020). Another systematic review from 2020 found considerably higher rates of mental health disorders and biological markers of persistent stress among refugees than among migrants and the general population of the host country (Byrow et al., 2020). As can be gleaned from the study of 15 different countries in the meta-analysis by Blackmore et al. (2020), mental illness is clearly prevalent in refugees arriving from many different countries and is not specific to one country of origin.



**Figure 1.** Prevalence of mental illness in refugees and asylum seekers compared to that in the general population (Blackmore et al., 2020).

Globally, the stigma surrounding mental illness remains an important issue due to its high prevalence and strong impact (Adu et al., 2021). Often, the stigma from mental illness is defined as context specific (Major & O'Brien, 2005). According to a 2021 review article by Adu et al., "Mental illness-related stigma is rooted in culture...it can be societal, familial, perpetuated by health professionals, or situated within the individual themselves" (Adu et al., 2021, p. 1).

With stigma playing a large role, there are numerous barriers to mental health care for refugees (Koesters et al., 2018). These barriers are at the patient level, the provider level, and a systems level. Barriers to mental health care at the patient level include cultural beliefs about mental health, linguistic barriers, lack of health care knowledge, distrust of authority or services, and financial strain. At the provider level, barriers involve faulty communication skills and a lack of cultural competency. At the systems level, there may be a need for more interpreters and improved reimbursement systems. Differences between host countries such as initial restrictions to health care access can also serve as barriers (Koesters et al., 2018). Many diverse approaches to overcoming these barriers have been implemented and studied in different countries with different refugee populations (Patel et al., 2014). Additionally, various types of interventions have been and continue to be tried and evaluated in a number of host countries (Giacco & Priebe, 2018). There are certain general principles that are being emphasized in the efforts to improve refugees' mental health care, including overcoming these barriers to care and promoting social integration (Giacco & Priebe, 2018).

The systematic review by Byrow et al. (2020) determined that the most important barriers that refugees have in seeking mental health care fit into three categories: cultural, structural, and refugee-specific factors. Cultural barriers include mental health stigma, (lack of) knowledge of major models of mental health, and social concerns. The review found that research participants in the 24 studies, who were all refugees, talked about mental illness in a negative way. Unfavorable cultural perceptions played an important role in these barriers: "One of the primary barriers to help-seeking behavior that has been consistently observed across populations, relates to perceptions of mental health and mental health treatment" (Byrow et al., 2020, p. 2). In consideration of this topic, "perceptions" may be defined as attitudes, beliefs, or knowledge about mental health. The review by Byrow et al. (2020) found that these mental health perceptions impact refugees' perceived need for mental health care and their engagement in mental health care. Therefore, mental health perceptions can provide additional knowledge concerning behavioral differences in the utilization of services in different populations (Andrade et al., 2014; Byrow et al., 2020). Overcoming refugees' barriers to mental health care is even more challenging because of the immense heterogeneity across different populations of refugees, host countries, and contexts (Koesters et al., 2018). Mental health perceptions differ between different cultures, with diverse explanations and beliefs behind them (Byrow et al., 2020).

## Purpose

This article distinguishes the perceptions of mental health of refugees according to their country of origin, because knowing these cultural differences has the potential to improve refugee mental health care. If the culture-specific perceptions of refugees from various countries of origin can be better understood, taken into consideration, and utilized for treatment purposes, then the barriers to care will be reduced. Furthermore, this information could provide insight into better approaches to refugee mental health treatment that are more specialized, individualized, and therefore more effective for certain populations.

## Methodology

### Study design

This study was a comprehensive review. The following electronic databases were searched for original research and review articles that assessed perceptions of mental health among refugees from different countries of origin: American Psychiatric Association (APA) PsycInfo database, Global Health database, MEDLINE via Ovid, and CINAHL Plus with Full Text. This search included two groupings of terms (keywords): (i) refugees, asylum seekers, displaced, and migrants; (ii) perceptions of mental illness, perceptions of mental health, and stigma of mental illness.

### Inclusion and exclusion criteria

Only relevant peer-reviewed articles published from the year 2000 to September 2021 were reviewed. Only articles that included the name of a specific group of refugees (from one specific country of origin) in the title were selected. Finally, only those articles that focused on refugees' perceptions, ideas, thoughts, or feelings about mental health were selected. Articles not published in English were excluded. Duplicate articles were excluded.

This search produced 4,405 results. Of these, only articles that included the name of any specific group of refugees (from one specific country of origin) in the title were selected. Of these, only those that focused on refugees' perceptions, ideas, thoughts, or feelings about mental health were selected. Sixty articles met the inclusion criteria. In addition, to find more information on specific topics, the references from some of the articles found were explored and utilized, and an additional search was completed on Google Scholar with the search term "refugee perceptions of mental illness." Of the 60 articles, only those that focused on one of four themes (causes of mental illness, symptoms and behavior associated with mental illness, mental health treatment, and mental health stigma) were ultimately included (Table 1). The search resulted in the review of

eight articles. All eight are primary research articles. Six of these were from the reference search and two were found on Google Scholar.

### Data collection and analysis

Perceptions within the following four themes were identified in the reviewed studies: causes of mental illness, symptoms and behavior associated with mental illness, mental health treatment, and mental health stigma (Table 1).

## Results

The perceptions of mental illness and mental health care among refugees from various countries of origin were categorized into the four themes described above. Overall, there were both similarities and distinctions among the five main refugee populations studied, which are outlined below.

### Somali refugees

The Somali and Somali Bantu are the largest groups of foreign-born Africans in the United States and make up 45% of the African refugee population (Carroll et al., 2007; Johnson et al., 2009). A substantial proportion of Somali refugees, between 14% and 31.5% of the population, suffer from mental illness (Boynton et al., 2010). A pilot study by Bettmann et al. (2015) extensively examined the perceptions of mental health and mental health treatment in Somali and Somali Bantu refugees in the United States. The study found that this population mostly described mental illness in terms of observable behaviors. Of the 20 participants interviewed, seven of them believed that just hearing an individual's verbal expressions can determine whether someone is mentally ill. Overall, this population utilized the terms "worried," "crazy," and "stressed" as almost synonymous with various types of mental illness. There were several physical symptoms that the Somali refugees associated with mental illness (see Table 1). In terms of the stigma of mental illness, the authors explained that the refugees' perceptions of stigma were variable from one individual to the next (Bettmann et al., 2015). Palmer's (2006) study in London revealed a greater emphasis on stigma in certain Somali refugee communities: "For the overwhelming majority of Somalis, mental illness carries a certain taboo and has associations with madness" (Palmer, 2006, p. 51).

The study by Bettmann et al. (2015) examined the refugees' ideas of the causes of mental illness in detail. The Somali refugees attributed the causes of mental illness to many factors. Some of their descriptions seemed very situational and revolved almost exclusively around important events in an individual's life.

Theme	Somali Refugees (Bettmann et al., 2015) (Palmer, 2006)	Burmese Refugees (Kim et al., 2021) (Fellmeth et al., 2015)	Syrian Refugees (Al Laham et al., 2020) (Kerbage et al., 2020)	Bhutanese Refugees (MacDowell et al., 2020) (Maleku et al., 2021)
<b>Causes of Mental Illness</b>	<ul style="list-style-type: none"> <li>Worry, stress, wanting something unattainable, traumatic events, significant loss</li> <li>50%: God causes illness</li> <li>15%: Possession by evil spirits</li> </ul>	<p>Kim et al. (2021):</p> <ul style="list-style-type: none"> <li>Number one cause is past traumatic experiences</li> <li>Post-resettlement challenges: expectations unmet, difficult adjustment, loss of social support</li> <li>Possession by evil spirits</li> <li>Sinning in past life</li> </ul> <p>Fellmeth et al. (2015):</p> <ul style="list-style-type: none"> <li>Current economic, family, and domestic challenges</li> <li>Excessive worry</li> </ul>	<ul style="list-style-type: none"> <li>External stress including adverse living conditions</li> <li>Believed distress was a normal shared reaction to adversity</li> <li>Environmental/structural stressors: lack of fulfillment of basic needs</li> <li>Psychosocial stressors: loss of social or occupational role (including loss of social networks)</li> <li>Socio-cultural norms</li> <li>Possession by evil spirits</li> </ul>	Emphasis on mind-body-spirit connection
<b>Symptoms and Behavior Associated with Mental Illness</b>	Associated many physical symptoms with mental illness: “sensations of heat coming out of the head, dizziness, poor vision, feeling that one’s head is upside down, the inability to see letters, the inability to repeat what others say, feeling nauseous, and lack of appetite” (Bettmann et al., 2015, p. 744).	<p>Fellmeth et al. (2015):</p> <ul style="list-style-type: none"> <li>Loss of control over emotions</li> <li>Inappropriate or abnormal social behavior</li> <li>Excessive worry</li> <li>Physical symptoms</li> </ul>	Mental and physical symptoms (metaphors of external tension causing buildup of pressure and of being strangled)	Majority described people with mental health problems as unpredictable
<b>Mental Health Treatment</b>	<ul style="list-style-type: none"> <li>Medical: “the majority” of participants believed in medical treatments</li> <li>Nonmedical: caring acts by the family or community (including informal talking)</li> <li>Religious: “the majority” of participants read the Quran, talking to the Imam</li> </ul>	<p>Kim et al. (2021):</p> <ul style="list-style-type: none"> <li>Alternative treatments such as praying and meditation</li> <li>Advocated for community-level solutions: education, training</li> </ul> <p>Fellmeth et al. (2015):</p> <ul style="list-style-type: none"> <li>Most commonly mentioned and first line: social and emotional support (talking with family and friends)</li> <li>Seen as more extreme: medication, hospitalization</li> </ul> <p>Neither study indicated counseling as primary treatment option</p>	<ul style="list-style-type: none"> <li>Initial treatment: seeing religious healers</li> <li>Advocated for community-level interventions with increased social engagement</li> <li>Only real solution is resettlement in new country</li> </ul>	<ul style="list-style-type: none"> <li>Majority believed there was no cure for mental illness</li> <li>Coping mechanism: support-seeking behavior (talking with family, friends, community members)</li> <li>Coping mechanism: physical, mental, and spiritual practices including yoga and walking</li> <li>Traditional religious rituals and customs</li> </ul>
<b>Mental Health Stigma</b>	<ul style="list-style-type: none"> <li>U.S. article: context and treatment dependent, variable</li> <li>London article: mental illness = taboo = associated with madness</li> </ul>	<p>Kim et al. (2021):</p> <ul style="list-style-type: none"> <li>Built into Burmese cultures</li> <li>Mental illness is possession by evil spirits or due to sins</li> <li>Mental illness is taboo, brings shame to the individual and family</li> <li>Mentally ill are mentally unfit to be around others</li> <li>Talking about mental health openly jeopardizes role in community</li> </ul>	<ul style="list-style-type: none"> <li>Mental illness is associated with shame and fear</li> <li>Mental illness is an internal dysfunction or “craziness” within</li> <li>Mental illness is possession by evil spirits</li> </ul>	<ul style="list-style-type: none"> <li>57.7%: the term “mental illness” causes them to feel embarrassed</li> <li>52.2%: it brings shame to attend counseling, is seen as a sign of weakness</li> <li>&gt;71%: those who seek counseling are viewed in an unfavorable manner</li> <li>Mental health is taboo</li> <li>Mentally ill are seen as incapable</li> </ul>

Table 1. Comparison of refugee mental health perceptions according to country of origin



Half of the refugees studied believed that God was the cause of mental illnesses. As one woman explained, “Everything is because of God. You get better because of God and you get sick because of God” (Bettmann et al., 2015, p. 746). In terms of managing mental illness, “the majority” of the Somali refugee participants did believe in medical treatments, including medicine, going to the hospital, and seeing a doctor (Bettmann et al., 2015, p. 747). However, they felt that talking to doctors was a form of assessment but not a form of treatment. If talking were to be utilized to manage mental illness, it was informal and with a family member or friend (Bettmann et al., 2015). Palmer’s (2006) study indicated that Somali refugees in London viewed many available psychiatric treatments with mistrust. The Somali refugees in the U.S. study discussed many nonmedical treatments for mental illness. Reading the Quran, as reported by “the majority of participants,” was a treatment method for all illnesses, and mental illness was no exception (Bettmann et al., 2015, p. 749). The Somali refugees explained that Imams, who are Islamic religious leaders, served important roles in the treatment of mental illness by visiting patients and reading the Quran for the family. Moreover, almost half of the participants stated that individuals with mental illness were kept at home while they were ill (Bettmann et al., 2015).

**Burmese refugees**

Burmese refugees are among the largest of the refugee groups in the United States; between 2002 and 2019, around 178,000 refugees resettled in the United States from Burma, otherwise known as Myanmar (Admissions and arrivals, 2019). A study by Kim et al. (2021) on the perceptions and barriers to mental health services in refugees from Burma discussed three themes: sources of mental illnesses, barriers to service use, and working toward community solutions. These Burmese refugees believed that the number one source of mental illness was past traumatic experiences and that memories of these experiences persisted for decades. The other major source reported was post-resettlement challenges. In terms of barriers to mental health service use, there was a glaring lack of understanding of mental health: “Mental health is a new concept to most refugees from Burma” (Kim et al., 2021, p. 967). Most of these individuals had never lived where mental health services were available. This lack of knowledge led to an inability to recognize mental health problems and to access treatment. Language difficulty was frequently cited as a barrier, especially because of the lack of an appropriate translation of the term “mental health” (and other mental health terminology) in these refugees’ languages. Another major barrier to care was cultural stigma: mental health stigma is ingrained in Burmese cultures. A common faith-based belief

is that mental illness occurs in someone who has sinned in a past life. When discussing mental health management, these refugees emphasized the need for community-level solutions, including widescale education and training programs for all individuals in the community (Kim et al., 2021).

In addition, another study exclusively looked at pregnant refugee and migrant women from Myanmar who were currently living on the Thai-Myanmar border (Fellmeth et al., 2015). This population was studied because of the high prevalence of mental illness during a woman’s childbearing years (Stewart et al., 2003). Specifically, the rates of mental illness are up to three times higher during the perinatal period than at other times in a woman’s life (Gavin et al., 2005). When questioned about the causes of mental illness, these women emphasized current challenges in addition to excessive worry (Fellmeth et al., 2015). In contrast to the study by Kim et al. (2021) previously discussed, only one of the 92 pregnant participants believed that trauma can contribute to mental illness. This article provided possible explanations for these contrasting results, including the methods used to elicit information and this specific population’s protective factors. A minority of participants believed that spirits caused mental illness. When suicide was discussed, these female refugees described suicide almost exclusively in terms of shame. As an example of shame leading to suicide, the study quoted one of the participants, “One girl I knew killed herself because she lost some expensive jewelry and felt ashamed when her family was angry with her” (Fellmeth et al., 2015, p. 6). Additionally, these refugees believed suicide was not necessarily caused by mental illness and described suicide as a separate condition. In terms of managing mental illness, the most commonly mentioned first line of treatment was social and emotional support from talking with family and friends. These refugees from Myanmar thought both medication and hospitalization could be utilized as management strategies, but these were frequently seen as extreme measures (Fellmeth et al., 2015).

**Syrian refugees**

Since the beginning of the Syrian civil war, over one million Syrians have fled to Lebanon (Syria regional refugee response, 2019). A study in Lebanon looked at the mental health perceptions and experiences of Syrian refugees in mental health treatment and of Lebanese mental health professionals (Kerbage et al., 2020). Similarly to the refugees from Burma, Syrian refugees associated mental illness with stigma, shame, and fear (Al Laham et al., 2020). The Syrian refugee participants, who were in mental health treatment, believed the greatest causes of their emotional distress were environmental and psychosocial stressors (Kerbage et al., 2020). Sociocultural norms, which were inevitable in

many cases, also appeared to be intimately connected to mental health for some individuals (Al Laham et al., 2020). Additionally, they felt that their emotional distress was a normal shared reaction to adversity that everyone in their community was feeling (Kerbage et al., 2020). In terms of their specific symptoms of emotional distress, these Syrian refugees in treatment believed that all displaced Syrians were experiencing these same symptoms. Interestingly, it was common for the Syrian refugees to describe their mental distress as a buildup of pressure. They saw mental illness as an internal dysfunction or “craziness” within an individual and therefore did not attribute how they were feeling to mental illness. At the same time, their practitioners and policymakers (professionals) viewed the distress of these individuals as symptoms of mental illness (Kerbage et al., 2020).

Another study on Syrian refugees in Wadi Khaled, a specific community within Lebanon, revealed that mental illness was associated with religious beliefs and the supernatural, including the idea of possession by evil spirits (Al Laham et al., 2020). Syrian refugees advocated for community-level solutions (Kerbage et al., 2020). Whereas the professionals were recommending short-term interventions for these refugees, the refugees believed that the only real solution to their social and mental health problems was resettlement in a new country (Kerbage et al., 2020).

**Bhutanese refugees**

Bhutanese refugees are another major population of refugees who have resettled in the United States (MacDowell et al., 2020). A study by MacDowell et al. (2020) on these refugees revealed that this group generally exhibited negative perceptions of mental illness and mental health treatment.

**Cambodian refugees**

Lastly, Wong et al. (2006) studied barriers to mental health services in Cambodian refugees from the largest Cambodian refugee community in the United States. A majority of the barriers reported were structural, including the high cost of mental health services, linguistic difficulties, and transportation issues. Interestingly, Cambodian refugees reported cultural barriers much less frequently. Less than 6% of Cambodian refugees endorsed any mental health concerns related to stigma, disapproval from family, lack of confidence in Western medicine, or a higher level of confidence in indigenous treatments (Wong et al., 2006). Aside from this information, the data on Cambodian refugees were limited.

Summary of similarities between different refugee groups

- Causes of mental illness:
  - o Traumatic events (Somali, Burmese)
  - o Possession by evil spirits (Somali, Burmese, Syrian)

- Physical symptoms associated with mental illness (Somali, Burmese, Syrian)
- Mental health treatment:
  - o Informal talking with family and/or friends (Somali, Burmese, Bhutanese)
  - o Religious (Somali, Syrian, Bhutanese)
  - o Community-level solutions (Burmese, Syrian)
- Mental health stigma:
  - o Mental health/illness is taboo (Somali, Burmese, Bhutanese)
  - o Possession by evil spirits (Burmese, Syrian)
  - o Associated with shame (Burmese, Syrian, Bhutanese)
  - o Mentally ill are mentally unfit/internally dysfunctional/incapable (Burmese, Syrian, Bhutanese)

**Discussion**

The results indicate that there are many differences and many similarities in the perceptions of mental health among refugees from different countries of origin. The cultures of refugees greatly influence how they think and feel about mental health. The commonly reported causes of mental illness included traumatic events and possession by evil spirits, and physical rather than psychological symptoms were often emphasized. The frequently stated mental health treatment options included religious methods and informal conversations. Overall, the mental health stigma was very prevalent, with multiple refugee groups regarding mental illness as taboo or shameful.

This review is novel in its inclusion and comparison of refugees from numerous countries of origin. To date, most of the research has focused on a specific population of refugees from one cultural background. The study of refugees’ perceptions of mental health has the potential to aid the refugee mental health crisis. The article by Kim et al. (2021) on Burmese refugees emphasizes the importance of addressing the mental health problems of refugees: “Unrecognized and untreated mental health issues may interfere with or even prevent refugees from successful integration into the host society” (Kim et al., 2021, p. 966). To give refugees a fair chance of integrating into their new society, mental health problems must be tackled. Furthermore, awareness of cultural perceptions of mental health can offer valuable information to service providers and policymakers (Andrade et al., 2014). When studying Syrian refugees and professionals, Kerbage et al. (2020) reported that, “Among professionals, 56 of the 60 repeatedly highlighted Syrian culture as the main challenge to working with Syrian refugees. They considered it an obstacle to the efficient provision of mental health care” (Kerbage et al., 2020, p. 5). However,

the culture of one population of refugees can differ immensely from that of another refugee population; therefore, studying one culture in isolation is not sufficient. In their research on Burmese refugees, the authors determined, “a one-size-fits-all approach will not work with refugee communities because of their inherent ethnocultural and linguistic heterogeneity,” further reiterating the need for culturally specific mental health care (Kim et al., 2021, p. 970).

Bettmann, et al. were solely focused on Somali refugees when they stated, “In order to effectively approach and treat mental health issues in a population, it is imperative to first understand some of the population’s basic beliefs surrounding mental health” (Bettmann et al., 2015, p. 741). Nevertheless, some of their findings about the mental health perceptions of this population were similar to the perceptions found in other refugee populations from different cultures. Therefore, some of their recommendations could prove useful in these other refugee groups. The studies on the Somali refugees, Syrian refugees, and the pregnant Burmese refugees all found that physical symptoms were frequently reported when discussing mental health issues (Bettmann et al., 2015; Fellmeth et al., 2015; Kerbage et al., 2020). Western-trained physicians often carry a dualistic body-versus-mind perspective (Kirmayer et al., 2011). It would be helpful for all medical doctors treating these populations of refugees to learn more about the ways in which common mental illnesses may manifest in physical symptoms in order to more efficiently and effectively determine the etiology of these symptoms (Bettmann et al., 2015). Similarly, in the specified cultures, symptoms of mental illness were described more in physical terms, such as the widespread Somali description of a buildup of pressure, which may initially seem to be a physical symptom (Bettmann et al., 2015). Therefore, it would be beneficial for doctors working with refugees to learn about some of these common physical descriptions and to consider that seemingly physical descriptions may reflect their cultural interpretation of their mental health symptoms.

In these three groups of refugees, substantial benefit can come when mental health professionals work closely with medical doctors to treat mental illness in a more holistic manner. The potential of this type of strategy is exemplified in a community health center in Boston where both medical doctors and mental health professionals work, which has led to increased referrals to mental health care (Bettmann et al., 2015). One potential solution could be to implement mobile health clinics that treat both physical and mental health issues. These clinics could even provide social needs such as housing and transportation as an additional component. Im et al. (2021) applied a multitier mental health and psychosocial support services (MHPSS) model to provide

mental health care to refugees in a holistic manner. Their approach was built on existing MHPSS models, which are used in some refugee communities, and emphasizes trauma- and culture-informed care. Refugees have multilayered mental health needs that can benefit from the coordinated systems of care and the holistic framework proposed by Im et al. (2021). The use of more integrative models for mental health care in refugee communities could provide many advantages for refugee mental health.

Because the cultural stigma surrounding mental health is widespread, the suggestions by Kim et al. (2021) for Burmese refugees would likely be helpful for other refugee populations as well. Mental health stigma is so entrenched in Burmese culture that even speaking about mental health openly jeopardizes one’s role in this community; thus, Burmese refugees need indirect approaches to mental health. Primary care doctors for these refugees need to provide encouragement and referrals. This is because primary care physicians are “the most effective way of getting [Burmese] people to use mental health services... ‘they won’t go on their own voluntarily’” but “would follow through with their physician’s recommendations” because they are viewed as trusted professionals and authority figures (Kim et al., 2021, p. 969). Because of the power of primary care physicians in the eyes of many refugees, there should be routine refugee mental health screening in primary care settings. In addition, the importance of cultural competency must be emphasized to primary care doctors and mental health professionals working with any refugee populations in order to effectively interact with patients and their families (Kim et al., 2021). Practices that treat even a small number of refugees should require training in culturally sensitive care (Byrow et al., 2020). Mental health practitioners would benefit from learning and utilizing the DSM-5’s cultural formulation interview guide as a tool to provide culturally sensitive and individualized treatment while also enhancing the therapeutic alliance (Byrow et al., 2020).

Studies of the perceptions of mental illness in the Somali, Syrian, and Bhutanese refugees revealed that these groups share a strong focus on religion (Al Laham et al., 2020; Bettmann et al., 2015; Maleku et al., 2021). The study on Syrian refugees in the rural area of Wadi Khaled in Lebanon described that, in this community, religious healers are culturally acceptable and less stigmatizing to go to for mental health problems than mental health professionals (Al Laham et al., 2020). This article even described working with religious healers as the “key to identifying [mental health] symptoms and creating referral pathways to [mental health] professionals” (Al Laham et al., 2020, p. 875). Similarly, the article by Bettmann et al. (2015) discussed how refugees’ spiritual explanations and treatments of



mental illness cannot be disregarded. Instead, mental health practitioners should directly address these spiritual aspects and attempt to use these strongly held beliefs to help them understand a patient's symptoms and trajectory (Bettmann et al., 2015). It is imperative that mental health professionals working with all three of these refugee groups collaborate not only with religious healers and other religious leaders but also with any additional community leaders. Mental health and public health professionals could spend time teaching religious leaders about mental health problems and the benefits of medical treatment, counseling, and group therapy. These professionals could then encourage the leaders to share this education with their followers, such as by talking about mental health issues in sermons, classes, seminars, newsletters, or social media. In addition, the professionals could ask these leaders to encourage their followers to seek help for mental health problems and not suffer in silence. It would be very beneficial for religious leaders to inform their followers that suffering from mental health problems does not mean that the sufferer has sinned, that he or she does not have enough spiritual faith, or that this is God's punishment. On the contrary, mental illness is a disease, similar to high blood pressure or any other physical condition, and should be treated this way. Understanding this and hearing it from one's religious or community leader could decrease the guilt and shame that so many feel when they are having mental health problems.

Because the religious, traditional, and familial practices are deeply valued in the Somali, Syrian, and Bhutanese cultures, these practices need to be considered and likely incorporated into any mental health treatment plan. Working with family was commonly seen as an initial step in mental health treatment in the refugee populations reviewed; thus, the involvement of family and community members in assessment and treatment may provide more effective care. The incorporation of family members would be especially beneficial for certain refugees from Myanmar, because the pregnant refugees' most commonly used treatment was emotional and social support from family and close friends (Fellmeth et al., 2015). The involvement of family would also benefit Bhutanese refugees, who discussed seeking social support in order to cope (Maleku et al., 2021).

Although there were several distinctions between the mental health perceptions of refugees from different cultures, there were also many similarities. Therefore, it is crucial to include some general recommendations for refugee mental health care. Providing community-level solutions is essential. This would include education and training for community leaders in addition to education for all individuals within refugee communities (Kim et al., 2021). In all

refugee groups, there is a need for increased mental health literacy pertaining to overall mental health, mental illness, and treatment for individuals struggling with mental health problems. The study on pregnant refugees from Myanmar emphasized the importance of psychoeducation, particularly because only one participant believed that trauma could cause mental illness (Fellmeth et al., 2015). In reality, the trauma that so many refugees experience contributes to the development of mental health problems (Johnson & Thompson, 2008). Because "translation difficulties, in combination with a lack of understanding about mental health, aggravate cultural stigma," increased mental health literacy could help to reduce stigma (Kim et al., 2021, p. 970).

In addition to psychoeducation's potential to decrease stigma, refugee communities could also incorporate public stigma interventions that focus on changing culture-specific negative perceptions of mental illness (Byrow et al., 2020). Even just altering the language used when discussing mental health could have an impact. For example, Kerbage et al. (2020) noted that Syrian refugees thought of the MHPSS as a source of support and felt it was helpful and provided them with a safe environment to talk about their problems. However, they did not consider MHPSS to be a specialized clinic, the idea of which may have turned many refugees away (Kerbage et al., 2020). Psychoeducation and improved mental health literacy would not only impact the initiation of care but also help with treatment adherence and maintenance when individuals have a better understanding of the science of mental illness.

Another potential approach to break the barrier of mental health stigma is to use telehealth and mental health apps. Refugees could use their phones or any other electronic device for psychiatry visits, counseling sessions, or self-help interventions. This approach might encourage refugees who fear the stigma of treatment to seek mental health care. This is because telehealth visits and mental health apps can be used in the privacy of one's own home, out of view of anyone who patients might worry would look down on them for getting mental health treatment. Telehealth and apps could also help refugees start mental health treatment and then act as a bridge to in-person visits with mental health professionals if needed. In addition to acting as a bridging aid, these approaches may be used to augment or complement other types of mental health treatment. Therefore, both telehealth and mental health apps could "lower the threshold for refugees to seek help" (Golchert et al., 2019, p. 2). These mental health interventions would also allow for greatly increased flexibility in terms of both treatment time and location. One example of mobile mental health is Step-by-Step (SbS), a culturally adaptive e-mental health intervention



developed by the World Health Organization for depression (Burchert et al., 2019). In a study on the usage of SbS among Syrian refugees, Burchert et al. (2019) found that “The majority of the respondents reacted positively to the presented app prototypes, stressing the potential health impact of the intervention (n = 28; 78%), its flexibility and customizability (n = 9; 53%) as well as the easy learnability of the app (n = 12; 33%)” (p. 1).

In addition, enhancing the sense of community felt by refugees could have a major effect on refugee mental health (Kim et al., 2021). This could be accomplished by facilitating social engagement to establish better ties to their community. For most refugees, community and social connections are lost when they come to a new country (Kim et al., 2021). In contrast to these general recommendations that apply to most of the refugee groups reviewed, it would be more appropriate to suggest approaches to improve the structural aspects of mental health care in Cambodian refugees, because this population did not report culturally based mental health barriers and had less concern about stigma (Wong et al., 2006).

### Limitations of the study

There are some limitations to this review. There was heterogeneity among the studies in terms of the methods, protocol, and measures used. These studies were also conducted in different host countries, which have variable income levels and barriers to care. Although the reviewed studies on Syrian refugees and refugees from Myanmar took place in Lebanon and the Thai-Myanmar border, respectively, the rest of the reviewed studies occurred in the United States or the United Kingdom (London) (Al Laham et al., 2020; Fellmeth et al., 2015; Kerbage et al., 2020). As Byrow et al. (2020) emphasized regarding their review, “Given that most studies included individuals living in a high-income resettlement country, these findings may not be generalizable to individuals in other countries,” especially considering that the majority of refugees are located in developing countries (Byrow et al., 2020, p. 18). Because the study designs were generally not longitudinal in nature, there is no way to know how perceptions may have changed over time. Byrow et al. (2020) felt that the duration of resettlement and associated variables could greatly impact a refugee’s knowledge about mental health and the best treatment strategies.

### Future directions

There are many possible future directions. It would be helpful to examine different refugee cultures in a more standardized manner. This could be accomplished with a study that looks at

more than one population of refugees, which would enable standardization of not only the major themes assessed but also the methods and measures utilized. A study that looks at multiple populations of refugees in a single host country would achieve even greater uniformity. It would also be interesting to use longitudinal research designs to determine if and how the mental health perceptions in the populations studied change over time. Longitudinal studies would also enable researchers to determine if there are key time points when certain mental health treatment interventions or programs are most effective (Byrow et al., 2020). In addition, it would be useful to determine whether there are associations between mental health perceptions and specific mental health treatments that are efficacious. Research that utilizes culture-specific mental health perceptions to create interventions for different refugee groups would enable us to see how specialized mental health services make a difference in the mental health outcomes of refugees.

### Conclusions

This review studied the perceptions of mental health, mental illness, and mental health treatment among refugees from various countries of origin, unlike previous studies that focused on one group of refugees. From this review, it is clear that refugees’ thoughts and feelings about mental health are impacted by their specific cultural group. Refugee groups varied in terms of their opinions about the causes of mental illness and the treatment options emphasized by them. However, mental health was similarly stigmatized as taboo and perceived as a shameful dysfunction, and treatment options frequently revolved around religion and informal family assistance. Furthermore, physical symptoms of mental illness were often highlighted, and mental illness was commonly thought to result from traumatic events and possession by evil spirits. Interventions to address the refugee mental health crisis should take cultural background, including cultural perceptions of mental illness, into account. Specifically, refugee mental health care could be improved with more integrative treatment methods, greater involvement of primary care practitioners, psychoeducation of community leaders, telehealth, and more culturally oriented approaches.

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## Conflict of interest

The authors declare that they have no conflicts of interest.

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