

Mental Health Service Use Among Middle Eastern Migrant Women: Social Work's Role in Promoting Mental Health Literacy

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Abstract: *Migrants who relocate to the United States from the Middle East are more likely to face a host of structural and individual barriers that can significantly contribute to their mental health issues and affect their psychological well-being. Addressing mental health problems and incentivizing help-seeking behavior is important among women who are more likely to face daily stressors in childcare, household responsibilities, and marital relationships. In this paper, we discuss factors that impact help-seeking for mental health problems among Middle Eastern migrant women including English language proficiency, structural challenges, and cultural factors such as shame and stigma. We argue that when considering its potential effectiveness, targeting mental health literacy may serve as the best direction for future research and social work intervention in order to enhance help-seeking behavior among this population. Recommendations for social workers include using community-based partnerships to provide educational resources regarding mental health services through healthcare centers, social service agencies, and local Muslim and Arab organizations.*

Keywords: *Immigrants and refugees; Middle Eastern women; mental health literacy; mental health; social work healthcare use; help-seeking behavior*

Historically, migration channels from the Middle East to the United States were established in the latter decade of the 1800s following political unrest in Syria, Lebanon, and Israeli regions (Cumoletti & Batalova, 2018; Slewa-Younan et al., 2014). In 1880, approximately 50,000 Arab immigrants resettled in the U.S., most of whom were predominantly Christian, in an initial wave of migration that concluded in the early 1900s (Harjanto & Batalova, 2022). Subsequent political upheavals across Iraq and Syria in the 1950s ushered in another surge of Middle Eastern immigrants shortly thereafter (Connor, 2016). The term “migrants” combines two groups of foreign-born individuals: immigrants, generally defined as persons residing in a country other than their own, and refugees, defined as persons forced to flee their country of origin for their own security and survival (Paarlberg, 2023). Revisions to the 1965 Immigration Act have contributed to a steady stream of immigrant and refugee arrivals from the Middle East, many of whom aim to better their occupational and scholastic prospects or seek refuge from war and persecution by migrating to the U.S. (Cumoletti & Batalova, 2018).

Middle Eastern migrants are often subsumed under the larger category of Arab Americans who are generally defined as having “ancestral, cultural, ethnic, linguistic, familial, or heritage ties to one or more of the 22 Arab League countries” (Abuelezam et al., 2018, p. 2). However, not all Middle Easterners are Arab. The Middle East refers to a geopolitical region encompassing the southern and eastern borders of the Mediterranean

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Sea and the Arabian Peninsula. Countries in the Middle East including Bahrain, Cyprus, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, the Syrian Arab Republic, the United Arab Emirates, and Yemen (Gul et al., 2015). This paper concentrates on Middle Eastern migrants as its population of focus as they may be particularly vulnerable to mental health conditions as a result of sustained exposure to war and political turmoil.

An estimated 1.2 million Middle Eastern immigrants and refugees presently reside in the United States, the vast majority of whom originate from Muslim-majority countries (U.S. Census Bureau, 2019). Current rates of admission differ by country as Iraqis (250,000) were reported to account for the majority of refugees admitted to the U.S. in 2019, followed by 120,000 migrants from Lebanon, 93,000 Syrians, and 59,000 migrants from Yemen (Harjanto & Batalova, 2022). In the years of the Trump administration, records indicate low acceptance rates that include 481 Syrian, (Baugh, 2022) 537 Iraqi, (Monin et al., 2016) and 18 Yemeni migrants (Radford & Connor, 2017). The growing number of migrant populations in the U.S., including a large number of more recent migrants from the Middle East, underscores the importance of providing reliable and adequate support after resettlement to promote positive health outcomes within this population.

Newly resettled migrants are subject to a host of structural and interpersonal barriers that can make it difficult to adjust to the policies of their new host country. Compared to the general population, Middle Eastern migrants are more likely to experience difficulties with language barriers and encounter cultural disparities that contribute to negative employment trajectories and health problems (Wei et al., 2015). Additionally, accessing and navigating local legal, educational, and healthcare systems can be made difficult as a result of insurance and transportation barriers (Elsouhag et al., 2014). In light of these challenges, Middle Eastern migrants, and women especially, are at significantly higher risk of developing mental health conditions, particularly in consideration of daily stressors such as household, childcare, and employment responsibilities.

Prevalence rates of mental health symptoms among Middle Eastern migrants vary across the literature ranging from 13% (Kulwicki & Ballout, 2015) to 50% (Amer & Hovey, 2012). However, most studies indicate significant levels of depression and PTSD among Arab Americans including Iraqi migrants with a refugee background (Kira et al., 2007; May et al., 2013; Taylor et al., 2014). These findings demonstrate the importance of examining ways to improve help-seeking for mental health treatment within this population. Current research suggests that the prompt detection and treatment of mental health symptoms are critical to the maintenance of psychological and emotional well-being over time (Roberts et al., 2018; World Health Organization, 2021). While in recent years, important strides have been made to address prominent mental health problems among migrant populations (Hasan et al., 2021), barriers that impact the ability of resettled migrant communities to access treatment remain.

Gender

While all migrants face challenges to their psychological well-being, it is important to acknowledge the gendered factors that uniquely influence the experiences of women from the Middle East and their role in help-seeking behavior. In particular, Middle Eastern migrant women experience higher levels of mental health problems in comparison to men. For example, a study in Dearborn, Michigan suggests a 50% prevalence rate of PTSD among Iraqi women (Abuelezam et al., 2018) with a third of women meeting the threshold for anxiety and 14% reporting severe symptoms in a similar study in the U.S. (Hassouneh & Kulwicky, 2007). This area of focus is particularly important as studies suggest that despite reporting higher levels of mental health symptoms than men, Muslim women in particular are less likely to use mental healthcare services (Ciftci et al., 2013).

First, in marital contexts, Middle Eastern women report high levels of intimate partner violence (IPV), sexism, and sexual violence (Knifton, 2012; Vu et al., 2016). In particular, Middle Eastern women are likely to be victims of IPV due to a host of factors that include a male-dominated culture, dependence on their male partners for financial security, and a lack of non-marital support (Abuelezam et al., 2018). IPV has detrimental effects on the psychological well-being of the victims as rates of depression are significantly linked to domestic violence among Arab American women (Douki et al., 2007). Subsequently, despite being more likely to be in need of mental healthcare, Middle Eastern women who experience IPV may be less likely to seek help due to a fear of consequences that may arise in the marriage.

Additionally, in comparison to men, Middle Eastern women are more likely to be valued as caretakers and viewed as the primary head of household chores (Jamil et al., 2007). Among this population, women are likely to be preoccupied with childcare, domestic, and employment duties leaving less opportunity to engage in health-promoting behaviors (Fakhr El-Islam, 2008; Wieland et al., 2012). Given their role in the household, an admission of mental illness may carry a social stigma that creates a perception of a woman as incompetent or unable to engage in her role as a caretaker (Chaleby, 1988). Therefore, women may be less incentivized to seek mental health treatment in order to maintain a positive reputation as a mother and to protect the reputation of her family as a whole.

Mental Health Literacy

Mental health literacy, a construct that refers to beliefs about mental disorders which aid their recognition (Jorm et al., 1997), management, and prevention, plays an essential role in help-seeking for mental health conditions among Middle Eastern migrant women. The use of mental health services is best precipitated by a knowledge and understanding of how to effectively maintain an optimal level of emotional well-being (Choudhry et al., 2019). Under a general umbrella, mental health literacy can be partitioned into three main categories: beliefs regarding the etiology of mental illness, stigma and attitudes towards those with mental illness, and the ability to access services when necessary (May et al., 2013). Due to its modifiability, improving mental health literacy among Middle Eastern

migrant women is an important area of study with several implications for the field of social work and improved mental health outcomes among this population.

The purpose of this review was to discuss factors that impact help-seeking for mental health problems among Middle Eastern migrant women. The discussion focuses on prominent factors that affect help-seeking behavior including English language proficiency, structural challenges such as a lack of knowledge and transportation barriers, as well as cultural factors such as family, community, and religion.

Challenges in Mental Health Service Use

Limited English Proficiency

Limited English proficiency (LEP) is a prominent barrier to help-seeking for mental health conditions among minority populations (Villatoro et al., 2018). Recent estimates indicate that Middle Eastern migrants largely report either Arabic or a similar dialect as their primary language with only 10% of immigrants identifying as solely English speakers (U.S. Census Bureau, 2019). Subsequently, LEP significantly affects the ability of Middle Eastern migrants to set up and maintain medical appointments as well as to communicate and convey medical problems to providers. LEP among Middle Eastern migrant women can create barriers to understanding health information and accessing mental health services (Simpson & Carter, 2008). Approximately 40% of Middle Eastern migrants report LEP, a slightly lower estimate than what is found among immigrants in general. Furthermore, LEP tends to be higher among Iraqi (50%) and Syrian (47%) immigrants in comparison to immigrants from other Middle Eastern countries such as Lebanon (28%) (Harjanto & Batalova, 2022). This finding may be explained by the higher level of concentration in economic, educational, and industrial institutions with Western foundations such as the American University of Beirut (AUB) and Lebanese American University (LAU) in countries such as Lebanon in comparison to Iraq and Syria (Abi Doumit et al., 2019). Thus, women with higher English proficiency who migrate from countries such as Lebanon may experience fewer challenges with communication while navigating systems of mental healthcare in the U.S.

The effects of LEP on help-seeking begin with the ability to simply set up an appointment with a healthcare provider. Initially, LEP can limit access and engagement with healthcare systems when migrants experience difficulties making necessary appointments. Calling and booking medical consultations with healthcare receptionists has presented difficulties for migrant women with LEP across all cultural groups (Cheng et al., 2015), particularly when accessing mental health services (Donnelly et al., 2011). These obstacles can be partly attributed to a lack of available interpreters. To begin with, challenges with finding adequate interpreters for securing provider appointments may deter migrants from actively engaging in healthcare services (Asgary & Segar, 2011). In the context of mental health, these challenges are exacerbated by the conceivable shame and sensitive nature related to the disclosure of mental health problems (Al-Omari et al., 2022; Im & Rosenberg, 2016; Knifton, 2012).

After initial appointment setup, migrant women may be unable to communicate the full details of their medical and social history when they visit a doctor's office. In a qualitative study examining Muslim women's experiences with healthcare providers, women with higher levels of English proficiency were better able to communicate medical problems and obtain necessary health information from providers (Simpson & Carter, 2008). In comparison, women with LEP are more likely to adopt a passive role in the patient-provider relationship and are less likely to inquire about their health information (Kang et al., 2016). Healthcare visits can result in Middle Eastern women experiencing difficulties conveying medical problems or asking questions that are necessary to fully evaluate their physical or mental health status. Thus, in order to maintain optimal health, the importance of being able to communicate and obtain basic medical information cannot be understated.

Structural Challenges

Lack of knowledge

As they adjust to the norms and policies of the U.S. healthcare system, Middle Eastern migrant women may experience difficulties locating providers, comprehending healthcare coverage, understanding differences between generalist and specialist practitioners, and knowing the functions of hospitals and primary care centers (Simpson & Carter, 2008). In a study examining Muslim women's experiences with the U.S. healthcare system, several women reported difficulties choosing providers and understanding the nuances of health insurance coverage (Khan et al., 2019). For example, women reported not knowing the difference between private and public insurance, what specific benefits are covered under their insurance plan, and the role of copays in medical appointments (Simpson & Carter, 2008). Furthermore, some migrant women report using emergency services in cases where an appointment with a provider is more appropriate (Samra et al., 2019). Thus, the ability to navigate structural challenges to healthcare begins with having a sufficient understanding of the services that are available.

Transportation barriers

Women who do not reside within close distance of formal mental health services may experience challenges accessing and attending necessary appointments due to lack of transportation (Kang et al., 2016). Consequently, findings of a study examining healthcare utilization suggest that Iraqi and other Arab migrants with transportation barriers are less likely to access healthcare services (Elsouhag et al., 2014). While these findings specifically pertain to medical care, one can imagine that when transportation difficulties play a role in attending medical appointments and routine check-ups, the incentive to manage transportation difficulties for the use of mental health services is much lower.

Cultural competence in healthcare systems

When examining the structural role of healthcare systems in perpetuating barriers that prevent migrant women from engaging with the formal services, cultural competency emerges as a significant factor. Arab-Muslims in the U.S. have reported feelings of distrust toward medical professionals as a result of experiences with broken healthcare systems in

their countries of origin (Khan et al., 2019; Padela & Zaidi, 2018). Likewise, immigrants across various populations report being wary of healthcare professionals, such as social workers and counselors, particularly in the field of mental health (Amri & Bemak, 2013; Kakoti, 2012). Specifically, Middle Eastern migrants describe fears that providers may brainwash their children or introduce them to behaviors that are religiously taboo (Alhomaizi et al., 2018). Thus, it is important to view mental health service use through a holistic lens that accounts for the structural barriers that uniquely affect service use among this population.

Cultural Factors: Shame and Stigma

Several studies suggest that among collectivistic communities, the mental health of an individual family member is a reflection on the entire family (Aarethun et al., 2021; Amri & Bemak, 2013; Ciftci et al., 2013; Walpole et al., 2013). Many women may avoid seeking help for mental health conditions out of fear of negative evaluations from family members (Alissa, 2021). Additionally, studies demonstrate that Arab Muslims are able to recognize the presence of social stigma (attitudes towards those with mental illness maintained by a social group) and associative stigma (attitudes towards those related to someone with a mental illness) among their families and communities as well as its potential for negative consequences in relation to an admission of mental health problems (Al-Laham et al., 2020; Alhomaizi et al., 2018; Burford-Rice et al., 2022). Therefore, a fear of community abandonment may also deter help-seeking behavior among this population (Abu-Raiya et al., 2015; Youssef & Deane, 2006).

In Middle Eastern cultures, help-seeking is often viewed as a family decision with individuals placing their personal needs aside for the sake of maintaining a positive reputation for the family as a whole (Alhomaizi et al., 2018). For example, findings of a study examining Muslim views on mental health showed that participants expressed dubious attitudes towards treatment practices when questioned about the relevance of mental health services (Weatherhead & Daiches, 2010). However, among those that felt that services were necessary, respondents cited the importance of being able to use mental health services to treat conditions particularly experiencing prejudice from their own communities (Weatherhead & Daiches, 2010). Middle Eastern migrants may be at risk of being stigmatized from their communities in the form of judgement and social isolation in response to an admission of mental health problems, addiction, or suicide ideation (Rassool, 2015). Furthermore, the effects of shame and stigma in relation to mental illness can be especially detrimental to women.

Considering gender, an admission of mental illness may be viewed as shameful and may lower a woman's potential for marriage (Chaleby, 1988; Corrigan & Miller, 2004). This notion can be partly attributed to the increased cultural value that is placed on a woman's role in the home in some Arab cultures (Wieland et al., 2012). Thus, an admission of mental health struggles may place a woman's reputation as a caretaker in jeopardy as perceived by other members of the community (Khan et al., 2019; Tobah, 2018). In a study examining women's mental health in the Muslim world, women stated that in addition to regular employment, they also felt accountable for household responsibilities including

childcare and housecleaning duties (Douki et al., 2007). Therefore, in many cases, a woman may be incentivized to avoid seeking mental health treatment, when necessary, in order to avoid family and community judgement as well as to maintain her own reputation as a wife and mother.

Mental Health Literacy: Implications for Social Work

Considering the array of barriers to help-seeking, targeting mental health literacy is an important direction for future research in the field of social work as this approach may serve as the best method for addressing help-seeking behavior among Middle Eastern migrant women.

Recognition of mental health disorders. Addressing mental health literacy can serve as a mechanism for increased help-seeking behavior among migrant women by improving upon the ability to recognize mental health symptoms when they arise. The first component of the etiology of mental health problems demonstrates a direct link between beliefs about what causes mental illness and rates of mental health service use among Arab migrants with a refugee background (Fakhr El-Islam, 2008; Wieland et al., 2012). In an evaluation of factors affecting the attitudes of Muslim Americans towards help-seeking, findings suggest that cultural beliefs significantly account for the way in which perceptions of those with mental illness are formed (Khan et al., 2019). In collectivistic cultures and Arab Muslim communities, mental health issues may be conceptualized through alternative religious-based perspectives (Aloud & Rathur, 2009; Weatherhead & Daiches, 2010; Youssef & Deane, 2006). Specifically, mental illness can be viewed as the result of a lack of faith, as punishment or a test from God, or a product of supernatural forces such as “jinn” (spirits) and “seher” (magic; Knifton, 2012). On the contrary, it is important to note that many Middle Eastern migrants also attribute mental illnesses to genetic, environmental, and social causes such as the availability of community networks (Abuelezam et al., 2018; Bagasra, 2014).

Subsequently, peer-led interventions aimed at improving the recognition of mental health literacy may be effective when implemented across group and community settings. Studies assessing peer-led interventions provide support for the use of migrant leaders and community social workers in disseminating information related to mental health among migrant communities (Im & Rosenberg, 2016; Piwowarczyk et al., 2013; Yun et al., 2016). Migrant women across all cultures are more likely to trust and absorb health information from people with congruent cultural, ethnic or lingual backgrounds as their own (Perry et al., 2014). Peer-led interventions that take place in communal settings such as mosques or community centers can effectively disseminate curriculum content by allowing a space for migrant women to form social networks that spread information throughout the community (Im & Rosenberg, 2016; Pejic et al., 2016). This method of intervention may prove particularly beneficial in collectivistic cultures where stigma towards mental illness can lead to an internalization of negative attitudes that results in shame and de-incentivizes help-seeking.

Reducing shame and stigma. The second component of mental health literacy, stigma towards mental disorders, may serve as a barrier to help-seeking as a result of negative

attitudes and discrimination towards those in need of mental health services (Wei et al., 2015). For example, Arab Muslims who endorse alternative religious perspectives of mental illness are more likely to have negative attitudes towards the use of mental health services. Subsequently, they are more likely to have lower rates of help-seeking as a result of internalization of shame in relation to mental illness (Aloud & Rathur, 2009). Likewise, qualitative findings among Arab-Muslim populations confirm that the presence of social stigma dissuades help-seeking behavior among this population as women may avoid treatment services to evade the shame of being labelled as a person who has something “wrong” with them (Alhomaizi et al., 2018). Subsequently, these beliefs may affect their willingness to seek mental healthcare when needed.

In order to decrease shame and stigma in relation to mental health among Middle Eastern women, family-based interventions, as implemented by social service agencies, appears to be effective (Murray et al., 2010; Qadir et al., 2013). Multi-educational group interventions, often comprised of presentations followed by informal discussions between family members (Qadir et al., 2013), have been found to increase mental health service utilization and medication adherence among participants (Weine et al., 2008; Yun et al., 2016). By targeting the family system as a whole, these interventions can address the stigma towards mental illness found among families in collectivistic communities. Additionally, considering the ubiquity of technology, future research examining the effectiveness of web-based phone applications can serve to assess alternative ways to decrease stigma in relation to mental illness using psychoeducational methods. For example, as demonstrated using the Step-by-Step (SbS) app, the anonymous nature of phone applications has been found to increase knowledge regarding depression, anxiety, and PTSD as well as help-seeking behavior among migrants with refugee backgrounds (Burchert et al., 2019). Future studies can therefore assess whether phone applications can be used to normalize mental health terminology and decrease stigma among Middle Eastern migrant women. Exploring and addressing the use of digital technology through needs assessments can improve the access and dissemination of health information among migrant populations (Paarlberg, 2023).

Systems knowledge. The third component of mental health literacy refers to an individual’s familiarity with the mental health services in their community. Studies across various groups of migrant women demonstrate that women face difficulties knowing where to make appointments for mental health care, who to call, and how to find out what benefits they are eligible for under their insurance plan (Clark, 2018; Simpson & Carter, 2008; Tulli et al., 2020; Whittaker et al., 2005). These findings indicate a need for education regarding the practical steps that constitute the process of getting connected with formal treatment services.

Cultural competence (i.e., the ability to acknowledge the values, customs, and beliefs of other cultures) of service providers may help improve knowledge and familiarity of mental health services among migrant communities. This method of intervention seeks to place the onus on the healthcare centers that engage with migrant communities by strengthening patient-provider relationships (Cheng et al., 2015; Kakoti, 2012; Nazzal et al., 2014). Higher levels of cultural competence are often associated with greater levels of trust in the patient-provider relationship (Islam et al., 2017). Thus, providing a space for

migrant women to explore conversations related to mental health in a way that is culturally sensitive can improve knowledge of services that are available and ways to access necessary treatment through discussion and information giving with providers (Hassouneh & Kulwicky, 2007). Suggested approaches to fostering a culturally competent environment include employing social workers in the provision of adequate interpreter services, appropriately translated health materials, and access to websites with mental health related information, all of which are methods that may increase engagement with the healthcare system (Im & Rosenberg, 2016; Laverack, 2018). Furthermore, when examining mental health literacy and help-seeking through a structural lens, it is important to encourage collaborations between social workers employed at primary care centers and resettlement agencies to promote familiarity and engagement with the mental healthcare system (Cheng et al., 2015; Nazzal et al., 2014). For example, community-based partnerships can be used to provide informational resources regarding the availability of mental health services, insurance eligibility, and the importance of addressing mental health through webpages, appropriately translated handouts, and community point persons. These resources can be disseminated throughout primary care and mental healthcare centers, social service agencies, mosques, and local Arab and Muslim organizations. Furthermore, through these connections, coordinated efforts can be made to mobilize resources, create outreach programs for mental health education, and facilitate referrals to specialists for women in need.

Conclusion

Addressing mental health literacy to improve mental health outcomes can alleviate symptoms that affect Middle Eastern women across all facets of their daily lives including household chores, childcare, and marital relationships. Promoting educational awareness as to what constitutes mental illness can aid women and other family members in initiating and supporting the treatment process. Recognition of symptoms is therefore critical to the prevention and treatment of various mental health disorders. For example, social workers in primary care settings can advocate for training providers to ask patients general questions about stress, emotional health, and interpersonal violence during routine appointments. Additionally, social workers at immigrant and refugee social service agencies can organize workshops facilitated by community leaders to promote mental health literacy. These workshops can be implemented in community centers, mosques, or other shared spaces where women can form social networks to support help-seeking among their communities. In conclusion, it is imperative to increase levels of knowledge and understanding of mental health and care options in order to promote healthy psychological outcomes among Middle East migrant women. Enhancing mental health literacy among migrant Middle Eastern women can result in the early detection and treatment of psychological and medical health conditions as well as improvements in familial and social relationships that result in positive long-term outcomes in overall health and well-being.

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