Trauma-Informed & Culturally Responsive Practices for the Care and Support of Refugees: The Case of Middle East and North Africa

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Abstract

Most refugee research is done in the West. Few research focuses on refugees abroad. To fill this information vacuum, this study investigates Middle Eastern refugees' problems. Conflict and instability in the region have led to enormous numbers of refugees seeking protection in adjacent nations. Due to social isolation, lack of basic amenities, and sexual and gender-based psychological abuse, these refugees typically struggle to find relief. Trauma, separation, and loss affect many refugees' mental health. Refugees in the Middle East face different challenges than those in the West, but trauma-informed care should be used by care providers to improve mental health outcomes and give refugees hope and security. This study aims to define a trauma-informed treatment system for Middle Eastern clinicians to help displaced people restore self-esteem and empowerment. Our goal is to help refugees cope with the psychological and mental strains of relocation and forced migration, not physical injuries.

Keywords: refugees, Middle East, mental health, trauma-informed care, trauma

For over seven decades, the phrase "refugee crisis" has been inextricably linked to the tumultuous events in the Middle East. The displacement of millions of Palestinians during the Arab-Israeli War in 1948 has left a lasting impact on global politics to this day. As Peretz (1996) reports, the Palestinian refugee issue has been a recurring topic at every U.N. General Assembly session since 1949, resulting in more resolutions than most other items discussed at the United Nations (pp. 6-7).

The Middle East region has been plagued by deep-seated and widespread turmoil. While the Palestinian issue has gained more attention, clan violence and civil wars in Yemen since the 1950s have kept the region unstable and contributed to a significant number of displaced persons (Aratani, 2019; Lamb, 2015). Since the Saudi-led coalition intervened in Yemen in 2015, the conflict has escalated, leading to around 38,000 Yemeni asylum seekers in Djibouti, a small country located across the Bab-el-

Mandeb from Yemen. Currently, between 4,400 and 6,800 asylum seekers live in Djibouti, which is a poor country where 23% of the nearly 1 million population live in abject poverty and 35% of rural communities have no access to water (Elnakib et al., 2023).

Iraq has suffered from political and social unrest for many years, including a prolonged war with Iran and invasions by the United States and its allies in 1991 and 2003. This instability has had a significant impact on the region. During the Second Gulf War, almost 2 million Iraqis fled the country, making them the third-largest refugee population in the world at that time, following Afghans and Palestinians (Sassoon, 2009). A majority of these refugees sought refuge in Syria, with around 1.2-1.4 million people, followed by Jordan with 0.5 million refugees. Saudi Arabia and the Gulf States also took in 200,000 refugees. It is worth noting that the wealthiest and most educated individuals were the first to leave. Nonetheless, Syria, Jordan, Egypt, and Lebanon were cautious of the Iraqi refugees and did very little to integrate them. These states were concerned about Iraq's polarization and the potential contagion effects, as well as the possibility that the refugees might never return (Sassoon, 2009, p. 6).

Since gaining independence in 1946, Syria has seen hundreds of thousands of individuals flee the country. Before the Syrian Civil War in 2011, approximately 400,000 Syrians were living abroad. However, their numbers were balanced by the roughly half a million Palestinians and their offspring residing in Syria. Since the conflict began, around 4 million to 4.5 million

Syrians have been displaced to surrounding countries due to the conflict spillover into Lebanon.

The first civil war in Sudan lasted from 1955 to 1972, while the second war started in 1983 in the south and 2003 in Darfur. These wars led to the displacement of over 4 million people. Recently, fighting in Sudan between the Sudanese military and the paramilitary Rapid Support Force has forced several thousand individuals to flee war zones. This has led to a steady increase in the number of internally and externally displaced people. As of August 2023, over 1 million individuals have left the country while over 3.7 million have been displaced to other areas within Sudan.

The Middle East has seen a staggering number of refugees, with more than 6.7 million of the 26 million refugees worldwide belonging to the region. However, most studies on Middle Eastern refugees focus on those residing in the West, as very few studies focus on non-Palestinian refugees settling in the Middle East itself (Al-Krenawi, In Progress). For this study, a refugee refers to a forcibly displaced person who crosses international borders.

Background

The issue of refugees cannot and should not be ignored. Their sheer numbers have the potential to destabilize governments around the region. According to Iranian authorities, around one million refugees have crossed the border from Afghanistan since the Taliban regained control in the late summer of 2021. The United Nations High Commissioner for Refugees (UNHCR) reports that over 3.6 million documented and undocumented

Afghans are now living in Iran, which marks the eastern border of the Middle East.

On the northern border of the Middle East, Turkey is currently hosting almost four million refugees, with the majority being Syrian nationals (Zaccara & Conçalves, 2021). Many of these Syrians are trying to enter the European Union, which has raised concerns about the stability of Greece, according to its prime minister (Fargues & Fandrich, 2012). The millions of Syrians fleeing the civil war have also placed a significant social and financial burden on Lebanon, Jordan, Iraq, and, to a lesser extent, Egypt. Lebanon, already one of the poorest countries in the region, is struggling to provide basic water, sanitation, food, healthcare, housing, and electrical services to the influx of refugees. Despite dealing with internal chaos since 2019, Lebanon has recently recorded the highest per capita rate of refugees worldwide.

Further, Lebanon is currently facing a major challenge in meeting the demands on its infrastructure, as it far exceeds its capacity to meet the needs (Ostrand, 2015, p. 262). Similarly, Jordan is also struggling to provide necessities to approximately 0.75 million Syrian refugees (Zaccara & Conçalves, 2021). These refugees, both registered and unregistered, make up about 10% of Jordan's population (Al-Krenawi & Bell, 2023). Additionally, one-sixth of the Syrian refugees living outside official camps survive on less than USD 96 per month and almost half of them do not have access to

heating. Iraq, which has nearly 2 million internally displaced people, is also hosting around a quarter million Syrian refugees, which has led to competition for resources. Egypt initially welcomed refugees, but this changed after a change in political leadership (Ostrand, 2015). Despite this, more than 380,000 refugees have crossed into neighboring countries, such as Egypt, South Sudan, Chad, Ethiopia, and the Central African Republic (UNHCR, 2023b).

Challenges Faced by Refugees

Refugees from the Middle East, like refugees from other parts of the world, face a range of challenges. These include a lack of access to necessities such as food, clean water, and shelter. The COVID-19 pandemic has further exacerbated the hardships experienced by refugees. This includes the suspension of travel and other services associated with seeking asylum, economic difficulties (with refugees being 60% more likely to lose their jobs or income due to COVID-19), and a higher vulnerability to disease (particularly in low-income settings where many resettled refugees live) (Brickhill-Atkinson & Hauck, 2021). In addition to facing challenges related to their physical well-being and health, refugees also deal with multiple mental health concerns and emotional reactions to victimization such as confusion, hopelessness, anxiety, fear, and depression. After reviewing numerous studies published between 2003 and 2020, Blackmore et al. (2020) concluded that the prevalence of post-traumatic stress disorder

(PTSD) among over 5,100 refugees in 15 countries was 31.46% (95% CI 24.43–38.5). The prevalence of depression was 31.5% (95% CI 22.64–40.38), while the prevalence of anxiety disorders was 11% (95% CI 6.75–15.43). The prevalence of psychosis was 1.51% (95% CI 0.63–2.40). According to the authors, these numbers highlight the need for ongoing, long-term mental health care. Similar numbers were found in a 2009 study, which showed a prevalence rate of 30.6% for PTSD and 30.8% for depression among 82,000 refugees (Rodriguez & Grumbine, 2020).

Although younger age appears to serve as a protective factor against mental health crises (Al-Krenawi & Bell, 2023), children and adolescent refugees are not immune. A meta-analysis of eight studies of child and adolescent refugees and asylum seekers by Bürgin (2022) indicated a 22.7% prevalence of PTSD, 13.8% of depression, and 15.8% of anxiety disorders (p. 847). According to a study carried out by Sirin and Rogers-Sirin (2015), in a Turkish refugee camp named Islahiye, 45% of Syrian refugee children experienced PTSD symptoms, 20% had clinically diagnosable levels of depression, and many experienced daily psychosomatic symptoms such as pain in the arms and legs (25%) or headaches (20%) (Hadfield et al., 2017).

However, for refugees resettled in the Middle East, finding mental health care can be more challenging than for their counterparts in other parts of the world. Mental health expenditures in Arab countries, as a percentage of total government health budgets, already tend to be low: from just 2% in Syria and Egypt to 5% in Lebanon, compared to, for example, 11% in

Germany and the Netherlands (Sijbrandij, 2017). This suggests that it is more difficult for refugees living in the Middle East to receive the mental health care they need to manage the trauma they have experienced. In addition, many, if not most, of the refugees from Iraq and Syria do not live in refugee camps; this makes it even more challenging to provide mental health care (Sassoon, 2009; Sijbrandij et al., 2017).

Apart from a lack of and limited access to mental health services, refugees from the Middle East also face some additional risks. For example, hypertension caused by increased salt intake, physical inactivity, and smoking "represents a major burden among refugees" in the Middle East (Zibara et al., 2021). In addition to hypertension, Syrian refugees are more afflicted by chronic and costly diseases, such as diabetes, heart disease, and cancer when compared to their refugee counterparts from Africa, who suffer more from endemic and epidemic infectious diseases and malnutrition (El Saghir et al., 2018). Two issues exacerbate the problem for Syrian refugees with cancer. First, according to a 2018 report, "only 23% of functional public hospitals in Syria provided cancer treatment services" (El Saghir, 2018, p. 434). This suggests that several Syrian refugees with cancer have not been receiving treatment. In addition, cancer patients among refugees often have poor outcomes due to "poor hygiene and living conditions, as well as the limited health education, limited access to care, and limited resources" (El Saghir, 2018, p. 434).

Based on a study conducted in Norway, oral health also appears to be of greater concern to Middle Eastern refugees, who had more extensive oral challenges than refugees from Africa (Høyvik et al., 2019).

Another concern that cannot be ignored is the link between mental health and heat. In a systematic review of connections between heat and mental health outcomes, Thompson et al. (2018) established the links between high ambient temperatures and increased risk of suicide and mental-health-related admissions. In a later systematic review and meta-analysis, Liu et al. (2021) detected a positive relationship between elevated temperatures and negative mental health outcomes. In another 2021 study, researchers found that as temperatures rose above 79 degrees Fahrenheit, "activity in the parasympathetic nervous system, the anti-stress system that can help us stay calm and relaxed, was lowered" (Aubrey, 2023).

Unfortunately, projections by Lelieveld et al. (2016) have suggested that heat extremes in the Middle East will accelerate with global climate change, possibly reaching 46 degrees Celsius (114.8 Fahrenheit) on the hottest days. Since Kuwait hit 53.2 degrees Celsius in 2021, making it the hottest place on the earth that year (Haddad, 2021), 46 degrees Celsius might seem like a cold front. Three other countries in the Middle East also joined the 50 degrees Celsius club in June 2021: the U.A.E., Iran, and Oman (Cappucci, 2021). The only country outside the Middle East to reach 50 degrees Celsius was Pakistan.

Negative health consequences among refugees can also be attributed to the rise in child marriages (defined as the marriage of a girl under 18) and child pregnancies. In a study on refugees conducted in Djibouti, Yemen, Lebanon, Iraq, Bangladesh, and Nepal, the average number of child marriages was found to be significantly higher among the displaced when compared to the host population (Elnakib et al., 2023). In Jordan, the number of females under 18, who were being impregnated, increased from 5% at the beginning of 2013 to 8.5% in 2014 (Sahbani et al., 2016). For the most part, researchers have agreed that child marriage is a health (Hampton, 2010), economic (Parsons et al., 2015), and quality of life issue (Mim, 2017). In particular, girls who got married below the age of 18 were found to be at an increased risk for sexually transmitted diseases (Bartels et al., 2018), spousal violence (Mourtada et al., 2017), “cervical cancer, malaria, death during childbirth, and obstetric fistulas,” and their offspring were “at increased risk for premature birth and death as neonates, infants, or children” (Nour, 2006, p. 1644). In addition, girls who married young were often prevented from receiving a proper education, thereby limiting their career potential and economic independence (Bartels et al., 2018).

While it is true that when people are hungry, thirsty, or sick, mental health is not a priority (Wells et al., 2020), it is also true that Middle Eastern refugees have suffered the kind of trauma that can have a negative impact. For example, over 34% of Syrian refugees in Jordan have been separated from a member of their family (Al-Krenawi & Bell, 2023). Family separation

is a major source of distress for refugees, related to depression, PTSD, and psychological quality of life. This reflects only one type of trauma in a list of 26 types covering all three measures of mental health (Miller et al., 2017). For example, children from Syria — and other countries — might have experienced war-associated stressors, bombings, torture, poverty, and malnutrition, the adverse effects of which could last up to 9 years (Hadfield et al., 2017). Butler et al. (2011) estimate that between 5% and 35% of the world's refugees have been tortured.

Service Plan

Given the turbulent history of the Middle East, countries in the region likely to host refugees should make plans for future influxes of displaced persons. These plans should be guided by some form of trauma-informed mental health care, to help victims and survivors manage the psychological distress they suffer as a result of forced displacement.

Initial efforts to care for refugees must focus on providing basic services (Bürgin et al., 2022). These include food, shelter, water, and security. The latter two deserve special mention. Given the consequences of global climate change and the lack of water in several parts of the Middle East, having enough water for simple hydration, let alone cooking and cleaning, is a matter of basic survival as well as mental health. Current findings related to the relationship between hydration status and cognitive performance and mood "suggest that particular cognitive abilities and mood

states are positively influenced by water consumption" (Masento, 2014, p. 1841).

Refugees' mindsets are often consumed by fear, danger, and insecurity. Thus, safety is an essential component of the healing process for refugees. Further, avoiding re-traumatization is an integral aspect of trauma-informed care (TIC). Post-emigration violence/abuse can exacerbate mental health problems. As young women raped in post-emigration settings are often unable to find suitable husbands, their guardians may seek to marry them off as soon as possible. Child brides are also motivated by a desire to escape poor family conditions or feelings of confinement (Bartels et al., 2018). Although logistically it is easier to get services to refugees in camps rather than to those integrated into communities (Ostrand, 2015), refugees in camps are placed at greater risk for poor sanitary conditions, lack of privacy, and intense heat (Shearlaw, 2013). As a compromise solution, Bartels et al. (2018) suggested the creation of a "safe place," a location where girls and their families can find security. Sponsored by NGOs, these centers can also raise awareness about sexual and reproductive health and autonomy.

Due to forced displacement, refugees are likely to perceive that they are socially isolated. Therefore, once the basic needs of the refugees are met, host countries can begin to look at various forms of community support to invalidate the victim's assumption that the world is now a threatening place (Bürgin et al., 2022; Im et al., 2020). For example, athletic fields can

be created for both physical and mental health. Schools can also be established, although instructors need to recognize that trauma can impair cognitive development and create challenges for displaced youth (Hadfield et al., 2017).

Once service providers have a handle on necessities and have created spaces for the community's mental health, they can focus on the mental health needs of the community and individuals by becoming informed about their pre-emigration status, their lives while on the run (the loss of their homes; treatment of sub-populations, such as women and children; and separation of families), and the "resettled community" (Pandalangat & Kanagaratnam, 2021).

Regarding pre-emigration status, one study found that higher levels of education may be linked to greater mental health challenges among refugees (Al-Krenawi & Bell, 2023). Healthcare providers also have to understand that neighbors and trusted adults before the forced relocation may have turned into enemies (Björn & Björn, 2004). An important aspect of the healing process is to support refugees in their search for meaning, in finding some purpose in their forced displacement and relocation, and in redefining themselves from victims to survivors, thereby re-establishing trust and a sense of self-coherence and control over their environment that is a crucial element of any refugee mental health plan.

While considering sub-populations, Al-Krenawi and Bell (2023) found that marital satisfaction, self-esteem, and life satisfaction were significantly

better for male Syrian refugees in Jordan than their female counterparts. The authors concluded that Syrian female refugees face unique factors that "place them at increased risk of mental health problems" (p. 714).

Regarding the resettled community, researchers in Canada found that Syrian refugees were more likely to access government resources; therefore, they might not need as much incentive as other nationalities to seek care (Pandalangat & Kanagaratnam, 2021). Care providers also need to honor refugee concerns about repatriation (Björn & Björn, 2004). However, regional refugee programs need to be established to re-establish family reunification (Fargues & Fandrich, 2012). The more family reunification refugees have, the sooner and better they cope with the post-traumatic stress of victimization.

The next step towards adaptive adjustment is managing the mental health needs/stressors of individuals by implementing a TIC framework. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (p. 7). SAMHSA outlines the four dimensions or Rs of TIC. Service providers must *realize* that there is a widespread impact of trauma on refugees and that there are different paths toward healing and recovery (Ford-Paz et al., 2021). Next, they must

recognize the signs and symptoms of trauma in both their clients and staff. Third, they must *respond* with policies, procedures, and practices that integrate knowledge about trauma. Finally, they must actively *resist* "traumatization" (Butler et al., 2011; Ford-Paz et al., 2021). As Ellis et al. (2008) have reported discrimination in host countries intensifies initial PTSD associated with war and displacement, a safe environment not only provides physical security but freedom from xenophobia and racism (Miller et al. 2019).

SAMHSA (2014) goes on to recommend that TIC programs are implemented by designating a leader, screening for trauma, providing written policies that are transparent and a safe physical environment, engaging clients with peers and family members, providing culturally sensitive training to staff and partners, monitoring progress, and evaluating results. Available screening measures, such as the Generalized Anxiety Disorder 7-item scale, can be used to screen for trauma (Miller et al., 2019). Cultural humility or honoring the client's culture (Adams & Kivlighan III, 2019; Loomis et al., 2018; Wells et al., 2020), for example, by learning about and respecting family hierarchy (Björn & Björn, 2004) or by asking permission to discuss difficult subjects (Miller et al., 2019) is a highly recommended therapeutic skill. In addition, Clervil et al. (2013) note that disorders such as PTSD may be expressed differently across cultures. Without knowledge of cultural variations, professional mental health providers may miss critical information.

Adams and Kivlighan III (2019) expanded the concept of cultural knowledge by suggesting that besides cultural humility, service providers learn to take advantage of cultural opportunities: they should not miss the chance to discuss a client's cultural values. Providers also need to develop cultural comfort, which details the ease with which the therapist can engage with the culture of the client. Dorado et al. (2016) posited that the most important training when dealing with the traumatized is to get providers to ask, "What has happened to you?" instead of "What is wrong with you?" Thus, refugees need to know that traumatic reactions are normal reactions to an abnormal situation.

In addition, clinics should integrate and co-locate medical, legal, socioeconomic, and mental health services, which are culturally affirmative and holistic (Harlow et al., 2023). This form of muti-expert integration is easier to achieve in refugee camps, especially when large numbers of refugees make it practically impossible to deliver to individuals dispersed across urban areas.

Taking a similar approach, Im, Rodriguez, and Grumbine (2020) add that mental health service providers should make a distinction between the average traumatized individual and the relatively small percentage of refugee populations with severe problems. They also warn that service providers need to consider linguistic problems. since some languages do not have words available for mental health diagnoses. Apart from finding ways to translate Western terms for mental health diagnoses and care, Miller et

al. (2019) noted the need to sometimes destigmatize the use of appropriate medications and cognitive behavioral therapies.

In addition to the TIC practices mentioned above, Butler, Reinfrette, and Critelli (2011) emphasized the strength-based service delivery orientation and the utilization of an empowerment model that strives to maximize client choices and control of their recovery and emphasizes the client's strengths, assets, and resilience. According to the authors, choice and control for refugees may mean walk-in appointments and evening hours for mental health clinics. Cordes (2021) added that language barriers might have to be addressed by providing longer appointment times.

Clervil et al. (2013) outlined a similar empowerment model to Butler, Reinfrette, and Critelli's (2011), suggesting that TIC integrates consumers' voices in treatment, identifies their strengths, and rebuilds social support systems in a safe environment. Miller et al. (2019) noted that consumers' strengths include sports, household tasks, and reading.

Lack of training in culturally adaptive cognitive behavior therapy can be a barrier to serving traumatized victims (Wells et al., 2020). One effective approach to dealing with a paucity of trained service providers is to provide consultation services and recruit non-professional helpers within the community. For example, Sijbrandij et al. (2017) recommended a Problems Management Plus (PM+) intervention that can enable these helpers to develop the required skills and techniques following 10 days of training. Here, participants are taught breathing relaxation techniques and

problem-solving skills along with ways of strengthening social support, to re-engage with positive activities in individual or group settings. Individual versions are delivered over five weekly sessions of 90 minutes each for individuals or 120 minutes for groups. A pilot program in Pakistan was shown to be effective in reducing anxiety, depression, and post-traumatic stress. Group interventions for Syrian refugees were slated for Jordan and Turkey, and a smartphone-based program was set for Egypt.

Not all researchers are enamored by a TIC approach. Westoby and Ingamells (2010) contend that trauma work is “overemphasized and over-legitimized” because refugees who learn that identifying themselves as traumatized can gain resources might get trapped in an approach that does not help (p. 1766). The authors added that TIC forces a “Western therapeutic model on other societies” (p. 1768). They also argued that it places heavy emphasis on individual needs. Terrana et al. (2022) provided evidence for such a viewpoint in a study on Somalis living in San Diego. The authors found that community-based interventions are more effective than individual coping mechanisms. Murray, Davidson, and Schweitzer (2010) stressed the need to develop culturally responsive intervention programs that “rely less on medical models of psychological distress that unduly emphasize stress-related trauma and more on psychosocial models that develop a sense of stability, safety, and trust” (p. 582).

Westoby and Ingamells (2010) concluded:

> Anthropological tradition requires that intervention programs build on local resources and strategies so that the community's existing abilities to deal with difficulties, illness, suffering, and stress are strengthened. The starting point is to establish what these resources are, identify where they have been disrupted, and facilitate the re-establishment of these resources and processes for strengthening them. (p. 1766).

Conceptualization of Trauma in the Arab Word: Implications for Practice with Refugees in the Middle East

A large body of literature uses Western-based diagnostic frameworks (for example, the International Classification of Diseases: ICD-11 or the Diagnostic and Statistical Manual: DSM-5) and tools to assess for universal symptoms and expression of PTSD. A growing yet confined body of literature is questioning the appropriateness of such frameworks and tools to conceptualize the etiology and the phenomenology of traumatic stress for Arab refugees or in other non-Western contexts.

The decontextualization of traumatic experiences from cultural contexts results in a limited and categorical understanding of traumatic distress across the world (Kleinman, 1987). The literature often includes a set of pre-determined assumptions defined by Western psychiatric nosology of a traumatic event as a single event or a string of single events that happen to a single individual, ignoring a wider understanding of how

trauma is experienced across diverse communities and cultures. Given the fluid use of the term ‘culture’, it is important to note that the term ‘cultural’ is deeply intertwined with several social factors (for example, socioeconomic conditions, gender, generation gaps, and political settings) that shape the experiences of psychological distress as also its symptomatic expression and sequelae.

The conceptualization of trauma within the Arab world focuses solely on problems located within the individual and lacks a developed conceptual vocabulary for relational, social, communal, and cultural problems. Yet, remembering and forgetting traumatic events depends on memory systems that carve trauma not only on the body and brain but also on the social and political processes that aim to regulate public and private recollection.

Some studies have aimed to investigate PTSD solely using standardized Western-based tools. On the other hand, four studies looked at culturally relevant idioms of trauma-related distress. In these studies, “context” included both cultural and socio-ecological or structural aspects (for instance, economic, political, and gender-related aspects of living). The question explored was not the presence of symptoms or features of PTSD or other comorbid disorders, but the cultural competence in the conceptualization of such symptoms. The question was as follows: How did participants from the Arab Region make meaning of and express trauma-related distress? One study found that while there was a symptom overlap between PTSD and depression symptoms, idioms of distress were

significantly different statistically (Rasmussen et al. 2011). Two studies included the terms feeling 'broken' (محطمة *muḥaṭṭima*) or 'destroyed' (... مدمرة *mudammira*). Feeling broken or destroyed conveys suffering in terms of a broken spirit, morale, or hopes for the future. These cultural idioms were used in response to not just traumatic exposure but also protracted violence and oppression and were validated by Barber et al. 2016. The authors explored connections among structural violence, psychological distress, trauma exposure, and chronic non-communicable diseases. They reported that participants could not separate the social and political context responsible for their trauma, poverty, and powerlessness from their physical health. Trauma was depicted as integral to social suffering. Consequently, help-seeking was also social and communal rather than an action of an "individual." Two studies reported that Palestinian cultural idioms of trauma – "blow" (*sadma* صدم), "tragedy" (*faji'ah* فاجعة), "calamity" (*musiba* مصيبة), and "catastrophe" (*nakba* نكبة) – were not always diagnostic entities requiring treatment, but rather a vocabulary through which distress is expressed and social support mobilized. While some of these idioms require professional attention, others may not. Their consequences may self-resolve or become normalized as part of the collective experience of violence and its related distress. A few studies highlighted that these distress reactions to occupation and political violence are part of an adaptive response to an extraordinary predicament. They should not be overmedicalized (Afana et al. 2010, 2020; Barber et al. 2016b; Hammad & Tribe, 2020). .....

presented two idioms of distress: “deep sadness” (*Hozun* حزن) and “madness” (*Majnun* مجنون), in a Darfuri sample. The two idioms included multiple symptoms. When symptoms were cross-listed against Western PTSD and depression symptoms, there was an overlap, but the differences were significant.

Studies looking at variations within the concepts of psychopathology and resilience documented interrelated themes integrating sociocultural, historical, structural, political, and, at times, religious contextual aspects. They presented idioms of resilience such as (a) *muqawam* مقاومة / resistance to military siege and occupation; (b) *awda* عودة / return to cultural roots despite historical and ongoing settler colonialism; and (c) *sumud* صمود / perseverance through daily adversities and trauma accumulation. All these concepts are integrated within the social fabric of the context of trauma. They are vital to the process of understanding and expressing/resolving distress. They also presented religious idioms of resilience, for example, “perseverance” (*sumud* صمود) and “surrender to God’s will” (*taslim* تسليم) that attribute meaning to ongoing traumatic and violent exposure and past historical and transgenerational trauma. Such meaning-making processes contextualize trauma in a wider context and ascribe meaning to suffering. The studies concluded that, in this context, categories of distress, for example, PTSD, do not hold much meaning. Associated symptoms are viewed as part of the overall state of being. It is important to note that in seven of these articles, traumatic exposure was not conceptualized as a

single event that posed a threat to self, but rather as an ongoing part of a local setting.

It is important to gain an understanding of Arab culture-specific expressions of distress, traditional and religious healing practices, and coping strategies. For example, there is a need for community initiatives to promote resilience and increase the use of positive coping mechanisms such as cultural, religious, and traditional healing rituals, skills, and strategies (Al-Krenawi, 2016). Arab clients in the mental health service may express their distress through metaphors and proverbs. Culture-specific idioms of distress and explanatory models of illness and health are crucial to understanding this process of meaning-making (Kleinman, 1988), as well as the considerations of social context and power structures (Kirmayer, 2006). Individuals and practitioners need to co-construct a shared understanding of the focus of treatment. Among Arab persons, common idioms of distress may include the sorrow of one's whole life or being tired, an unbearable sense of pressure, or the world closing all doors on the face (Al-Krenawi, 2000). Somatic therapy aims to treat mental and emotional health issues through a connection among mind, body, and spirit. This body- and spirit-centric approach works by helping to release stress, tension, and trauma from the body. Unlike global mental health treatment, such as cognitive behavioral therapy (CBT), which focuses prominently on the mind, somatic therapy incorporates body-oriented modalities such as breathwork and meditation to support mental healing. In addition, somatic therapy sessions

include healing rituals and mind-body-spirit exercises. Mental health practitioners in the primary health center should come up with cultural projects, such as embroidery, through which women can talk about their psychosocial, emotional, and familial problems. For instance, the term *fadfada* means the creation of a safe environment to express their emotional problems through storytelling, while working on embroidery or another cultural project. Oral storytelling is very much used and acceptable in Middle Eastern society, not just to preserve history and culture. Additionally, Arab people use storytelling as a way of coping with distress and collective trauma. Arab cultural healing practices of *hikaya* (oral storytelling) are used to cope with collective trauma and loss (Atallah, 2017) as well as other emotional pains and difficulties. Oral storytelling involves people sharing tales of joys, sorrows, life, and memories of sacred places, linking the past to the future; it involves people bearing witness to each other's stories in a supportive environment (Zarifi, 2015). Given the stigma attached to the mental health systems in Arab society (Fahoum & Al-Krenawi, 2023), mental health workers can initiate group work in the public health center (PHC) in collaboration with the general practitioner (GP) at least in the first session. This process will provide the women with a good opportunity to speak about their emotional and familial problems using the cultural strategy of *fadfada,* wherein the group leader needs to bring a cultural and religious context to the group dynamic (Al-Krenawi, 1996; Banawi & Stockton, 2008). As stated by the prophet Muhammad, "Those

who interact with people and tolerate their hardships are better than those who do not interact with people and do not tolerate their pains" (Mohammad, 570-622 C.E., cited in Ibn Majah, 1975). Another strategy that may be used with the Arab clients in the PHC is the photovoice strategy. As part of this intervention, patients discuss their problems as in other forms of mental wellness therapies (Wang & Burris, 1994). Rather than just talking about them, somatic intervention guides patients to focus on their underlying physical sensations.

It is essential to incorporate Islamic principles into the treatment of Arab individuals. Western models of treatment often refer to meditation, philosophy, and poetry to enhance well-being (Kabat-Zinn, 1990; McMahan & Braun, 2017). Likewise, visualization, meditation, and mindfulness are also basic approaches constituting Islamic spirituality and wellness. Islamic ritual prayer or *salah* involves principles of meditation. *Salah* incorporates Qur'anic recitations with different physical postures, such as standing, bowing (*ruku*), sitting (*tashahud*), and prostration (*sujud*). Muslims are enjoined to perform *salah* five times a day, with each *salah* being divided into repeated units of prayer (*rakahs*) that vary slightly based on the *salah* being performed. The first step is to make the intention (*niyah*) to pray. While standing for prayer, Muslims are taught to visualize Allah in front of them and to take account of the angels who join them. To facilitate visualization, Muslims pray in the direction of the *Kaaba,* ending each set of *rakahs* by acknowledging angels, others present in the congregation, and

the one leading the prayer. Prayer rugs often contain a picture of the Kaaba to help Muslims center their intentions. The acknowledgment of the self, others who are present, and intentions to a higher deity, connect the physical, relational, and spiritual aspects of each person. Additional Islamic mindfulness practices include the use of the words *in shaa Allah* (God willing) as part of daily vernacular when speaking of intentions, as well as utilizing the *tasbeeh* or prayer beads. Other Arabic terms, such as *subhan Allah* (glory to God) and *Alhamdulillah* (praise be to God), also acknowledge and express mindfulness of self, actions, intentions, and gratitude as one engages in daily affairs. Islam's practices of ritual prayer, Qur'anic imagery, *dhikr* (rhythmic devotions), *dua* (supplication, request, gratitude, prayer), *hadith* (traditions and saying of the Prophet Muhammad), as well as Islamic poetry, can be used to enhance behavioral therapies, specifically, mindfulness practices and cognitive frameworks found in ACT and DBT (Ahmed & Amer, 2013).

In summary, it is hard to maintain a positive outlook on the future in the Middle East, especially considering how global climate change is impacting the region. Given the existing conflicts based on geography, religion, ethnicity, and politics, scarcity of water leading to food insecurity is only going to make things worse. It is difficult to be kind to others when you are hungry, thirsty, and hot. Hence, governments worldwide must plan for an influx of refugees who will cross borders in search of a better life. It

would be a smart strategy to prepare for the physical and mental health needs of refugees, should they be forcibly displaced in the future.

It is the responsibility of Middle Eastern and Western governments, international organizations, civil society, and the community at large to work together to prevent the Middle Eastern refugee crisis by addressing the underlying causes of displacement. If that fails, everyone must take responsibility for providing essential services and creating a more inclusive and welcoming environment for refugees in the Middle East.

Providing food, water, and shelter for large numbers of refugees is challenging but possible. However, providing necessary mental health care is a more complex issue. Trauma often leads to negative self-images, making refugees feel helpless, frightened, and powerless. By providing trauma-informed practices that are culturally sensitive to refugees from the Middle East, we can help them regain self-coherence, self-equilibrium, strength, and a sense of control and resiliency. More research is needed, however, as refugee studies are still relatively unfamiliar to Middle East area specialists (Fábos, 2015).

Conclusion

This study highlights the substantial beneficial effects of group counselling on emotional regulation, self-esteem, stress management, and assertiveness among female refugees who have experienced Sexual and Gender-Based Violence (SGBV). The results of our research highlight the crucial importance of employing counselling methods that are culturally

sensitive and trauma-informed when addressing the distinct difficulties experienced by female refugees from various cultural backgrounds. The study highlights the significance of group counselling that combines self-centered rational emotive behavioural therapy and art therapy in improving self-awareness, emotional effectiveness, and overall psychological well-being among this vulnerable population. The study's results emphasize the need for more focused and comprehensive support networks for female refugees experiencing SGBV, promoting the wider adoption of such programs in comparable situations. The findings have significant consequences, underscoring the necessity of ongoing advocacy, policy formulation, and allocation of resources to promote the mental well-being and successful integration of refugees, especially women, into host communities.

List of abbreviations

U.N.: United Nations

PTSD: Post-Traumatic Stress Disorder

NGO: Non-Governmental Organization

TIC: Trauma-Informed Care

SAMHSA: Substance Abuse and Mental Health Services Administration

ICD-11: International Classification of Diseases, 11th Revision

CBT: Cognitive Behavioral Therapy

PHC: Public Health Center

ACT: Acceptance and Commitment Therapy

DBT: Dialectical Behavior Therapy

SGBV: Sexual and Gender-Based Violence.

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