Stigma on mental illness in the Arab world: beyond the socio-cultural barriers

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Abstract

Purpose – Research on mental illness stigma in the Arab world has traditionally focused on socio-cultural barriers that deprive persons with mental illness from their fundamental human right for privacy and informed consent. The purpose of this paper is to address the question whether or not mental health legislations in a number of Arab countries effectively safeguard the human rights of people with mental illness and protect them from stigmatizing and discriminatory practices.

Design/methodology/approach – A qualitative review of literature was performed over two rounds of search, targeting published research on mental illness stigma in the Arab world from year 2000 until now and existing national mental health legislations in the Arab world, using English and Arabic databases.

Findings – The review reveals that beyond society and culture, persistence of mental illness stigma in the Arab world may be explained by absent or inefficient monitoring mechanisms of mental health legislations and policies within the health-care setting. Although integration of mental health services into the primary health care system is being gradually implemented as a step toward de-stigmatization of mental illness, more remains to be done to change the stigmatizing behavior of the health personnel toward mental illness.

Originality/value – Mental health authorities in the Arab world need to be more aware of the public perceptions explaining people’s fear and reluctance to seek mental health care, so as to ensure that the control and monitoring mechanisms at both the primary and mental health care levels foster a human rights, culturally competent, patient-friendly and non-stigmatizing model of mental health care.

Keywords Human rights, Mental health, Stigma, Health care, Mental illness

Paper type General review

Introduction

Despite medical advancements in mental health, mental illness continues to be stubbornly coupled with a concoction of misconceptions and negative attitudes (Pescosolido et al., 2013), and people with mental illness continue to remain subject to stigma that restricts their full inclusion in community life (Ditchman et al., 2013) and deprives them of their right for a dignified and productive life (WHO, 2003).

In the Western world, the source of mental illness stigma has been traced back to the New Testament in which the diagnosis of demonic possession was commonly attributed to people who exhibited signs of mental illness (a dissociative identity disorder, an epileptic seizure, or even Gilles de la Tourette’s syndrome) (Kemp, 1985). Several reports, published during the nineteenth century, depicted the deplorable state of the European and UK “asylums” catering for “lunatics” (Haslam, 1817; Hill, 1838; Manning, 1868). In the Arab world, mental illness has been viewed as a curse from the “evil eye” or a “Jinn” possession for Muslim believers (Ahmad et al., 2016), a “devil-possession” for Christian believers (Waldmeier, 1897), a state of holy awakening translating a message from God (Mehraby, 2009; Scull et al., 2014), or a case of contamination, as in Morocco, where it is believed that mental illness can be “contracted” by accidentally stepping on sorcery or drinking it (Stein, 2000; Mehraby, 2009).

Mental illness is a two-edged sword on the afflicted person, where one has to struggle with the symptoms and simultaneously cope with the stigma surrounding it (Corrigan and Watson, 2002;
Corrigan et al., 2004; Rüsch et al., 2005). The internalization of these public stereotypes (self-stigma) by people with mental illness leads them to refuse treatment or, if in treatment, discontinue it (Corrigan et al., 2014; Ciftci et al., 2013), thus reducing opportunities for reinsertion into the community (Gulliver et al., 2010).

Mental health legislations protect the civil rights of people with mental illness “against any form of inhuman treatment and discrimination” by ensuring the legal and regulatory framework for mental health services and mental health care providers (WHO, 2003, p. viii). Yet, the mere existence of a mental health legislation in any country does not necessarily guarantee that the human rights of people with mental illness are protected, and in some countries, “mental health legislation contains provisions that contribute to the violation of their rights” (WHO, 2003, p. 2). Among the many difficulties in the implementation of any mental health legislation in any country is the lack of awareness of the existence of such a legislation, not just in the general public, but also among professionals and the different types of caregivers (WHO, 2003, p. 6).

Discriminatory and stigmatizing practices in the mental health-care setting are not negligible, ranging from arbitrary detention of patients to denial of their right for self-determination in several matters, culminating in reports of physical and sexual abuse (Porsdam Mann et al., 2016). A study on mental illness in low- and middle-income countries reports “gross” human rights violations in psychiatric institutions, mental health service centers, residential facilities for people with mental illness and in hospitals (Drew et al., 2011). One such human right violation is the deprivation of the legal right to make decisions, where such a right is handed to a third person, sometimes the local service provider, who holds the same negative attitudes toward mental illness as the general public. The study notes that people with authority, including health professionals, are “the most resistant groups when it comes to improving the human rights” of people with mental illness (Drew et al., 2011, p. 1669). Reports from different countries of the world have documented the negative attitudes toward people with mental illness among health professionals. Kermode et al. (2009) stressed the need for mental health training to health workers in Indian villages, where mental illness is associated with false beliefs and negative attitudes, so they can model more positive attitudes toward mental illness. A systematic review of stigma-related studies between 1998 and 2010 in Nigeria by Okpalauwaekwe et al. (2017) shows that stigmatizing attitudes and beliefs in supernatural causation still exists among educated health workers (medical doctors, nurses, primary health workers and final-year medical students) who believe that people with mental illness are dangerous, violent and should not be married. An earlier study on the opinions of 144 final-year medical students at a Nigerian university regarding mental illness shows that “medical students are also part of the stigmatizing world,” and that stigma-reduction training ought to be incorporated into medical schools’ curricula (Ogunsemi et al., 2008). Similar findings were obtained from a sample of 308 nurses working in general hospitals in Kuwait (Al-Awadhi et al., 2017), keeping in mind that nurses constitute the vast majority of the mental health workforce in the Arab world, compared to psychiatrists, psychologists and social workers (WHO, 2018). Sahile et al. (2019) found that almost half of a sample of 634 primary health care nurses in a health care facility in Addis Ababa (Ethiopia) held a negative attitude toward people with severe mental disorders, and that the presence of clinical training as well as a higher number of work experience years were associated with less negative attitudes. Stuart et al. (2015) reported the negative opinions of medical (non-psychiatry) teaching faculty in different universities across the world regarding psychiatry, describing the work with people with mental illness as “not rewarding” and “emotionally draining,” and mental illness as not deserving “as much attention as physical illnesses” (Stuart et al., 2015, p. 25). In Switzerland, a survey conducted on 1,073 health professionals (psychiatrists, nurses, psychologists, social workers and physiotherapists) reveals that mental health professionals hold as many negative stereotypes about people with mental illness as the general public, and that social distance (an important component of stigmatization) toward people with mental illness is equally high in all professional groups as in the public (Nördt et al., 2006).

Aim and organization of the paper

This paper argues that the lack of awareness of health professionals and other health caregivers (including those working in the mental health sector) about the rights of people with mental illness is not as much the issue as is the fact that these stakeholders, by holding the same à priori
stigmatizing and discriminatory views about mental illness as the public, contribute to the persistence of mental illness stigma. This argument is specifically elaborated in the context of the Arab world where mental illness stigma still prevails in a significant way (Çiftçi et al., 2013; Scull et al., 2014; Ahmad et al., 2016; Al Alawi et al., 2016; Al-Awadhi et al., 2017), in spite of advances in the mental health profession in the region (Okasha, 2003). Because most of the literature on mental illness stigma in the Arab world has focused on the analysis of social, religious and cultural factors as potential contributors, and rarely on the association between stigma and the distorted, and sometimes absent, implementation of human rights at the health care level by health care providers, it is hoped that this paper’s perspective to mental illness stigma will activate more interest in researching perceptions of mental illness among health care providers, in general, and mental health care providers, in particular.

The first section of the paper presents an analysis of the socio-cultural factors that are commonly believed to be responsible for mental illness stigma in Arab countries. The second section provides a more specific description of how mental illness stigma prevails among health caregivers at both the primary healthcare and the mental health care levels, and the third section examines the status of these countries’ national mental health legislations, their role in protecting the human rights of people with mental illness in the region, and their contribution in preventing or minimizing mental illness stigma. Such a review is of crucial importance today, with most Arab countries being currently exposed to a multitude of stressors (local and regional wars, terrorist activity and the war-refugee crisis), and where mental illness has been on the rise (Okasha et al., 2012).

Methodology

For the first and second sections of the paper, an initial literature search for articles on mental illness stigma in the Arab world was completed using electronic databases such as PsycARTICLES, Taylor and Francis Online, PubMed, Academic Search Premier, JSTOR and Google Scholar, in addition to Arabic databases such as Al-Manhal, Dar Al-Mandumah and periodicals in Shamaa (Arab Educational Information Network), on keywords such as mental health in the Arab world, mental illness stigma in the Arab world, mental healthcare in the Arab world, Arab culture and Arab family, yielding more than 100 articles both in English and Arabic. To ensure consistency in the definition of mental illness across all the works of literature, the search excluded all articles dating before the year 2000, because they were based on older editions (I–III and IV-R) of the Diagnostic Statistical Manual (DSM) in which diagnostic categories were different from those used in mental health literature of 2000 and above (using DSM editions IV-TR and 5). The search for latest literature on the topic, as well as the removal of duplicate studies, led to a total of 89 articles.

For the third section of the paper, a second round of search targeted the national mental health legislations in the Arab world on new keywords such as mental health legislation, mental health policy, human rights of people with mental illness. After eliminating duplicate reports and excluding documentation on mental health, which did not clearly delineate the difference between mental illness and intellectual/cognitive impairments, a total of 32 documents were identified as eligible and relevant to our topic; these were obtained from the United Nations and World Health Organization (WHO) databases and other documentation from gray literature.

No study was found, in any of the two search stages, differentiating between Muslim and Christian communities living in the Arab world, as mental illness stigma was studied, in most articles, in its general socio-cultural context without distinguishing between the two religious groups. A considerable part of the present literature did, however, specifically deal with the role of Islam in the context of mental health and mental illness.

The definition that was used for “Arab world” was based on both the WHO’s classification of the world’s country regions and sub-regions, and membership in the Arab league. The former classification was adopted, because it allowed easy access to statistics on mental health, whereas the latter was used for socio-cultural identification purposes (similarity of cultural, religious and linguistic affiliations). Countries within these two classification schemes where relevant literature was available consisted of Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syria, Tunisia and the United Arab Emirates.
The term “mental illness” is used in the same general way that was used across all reviewed studies, without diagnostic specifications.

Overview of the prevalence of mental illness in the Arab world

The Arab world is a very heterogeneous region where member states vary significantly in terms of their socio-demographic profiles, and health system modalities and coverage. Over the past two decades, the region as a whole has witnessed tremendous improvements in health status, translated in increased life expectancy and reductions in child mortality (Okasha et al., 2012). The region has also witnessed for the last 25 years a complex emergency situation due to political and economic unrest, and in some countries, civil war. War and violence, displacement, refugees, terrorist threats and activity and other factors are causing mental health problems such as post-traumatic stress disorders (PTSD), depression and various anxiety disorders (Global Burden of Disease 2015 Eastern Mediterranean Region Mental Health Collaborators, 2018; Pocock, 2017).

In Lebanon, for example, about one-fourth of a nationally representative sample met criteria for at least one of the DSM-IV mental health disorders at some point in their lives (Karam et al., 2008), and in the capital Beirut, one in four adolescents are reported to suffer from anxiety and attention-deficit hyperactivity disorder (Maalouf et al., 2016). The prevalence of mental illness among Qatari nationals is around 20 percent (Zolezzi et al., 2017). In the WHO-defined group as the Eastern Mediterranean Region (EMR), observed mental disorder rates in 2015 (of which depression and anxiety disorders are most frequently reported) exceed expected age-standardized mental disorder rates. Mental disorders contribute to 4.7 percent of total disability-adjusted life years and to 15.9 percent of total years lived with disability (Global Burden Disease, 2018). In 2013, all EMR countries had a higher mental disorder burden compared to the global level – except for Egypt – with Palestine ranking highest, as almost half of Palestinian youth were estimated to have emotional and behavioral disorders, due to the chronic exposure to trauma and military violence (Charara et al., 2017). Itani et al. (2017) reported that 30 percent of school adolescents living in the city of Mosul (Iraq) in 2006 presented symptoms of PTSD, and in Baghdad, 14 percent of a sample of 600 primary school children had PTSD. With respect to the Syrian crisis, the only available research to date relies on data obtained from Syrian refugees in neighboring countries, for example, 56 percent of a sample of 547 Syrian refugee children and adolescents attending public schools in Lebanon showed symptoms of anxiety-related disorders (Karam et al., 2016).

Analysis of findings

Mental illness stigma in the Arab world is analyzed in the following section through three different perspectives, namely, the general socio-cultural fabric, the healthcare setting and the legislative dimension.

Mental illness stigma at the socio-cultural level

The family paradox regarding mental illness. On the one hand, for Muslims as well as Christians in the Arab world, the family is sacred and individuals are raised to depend on it as a continual source of support. One’s behavior is a mirror of one’s family values and reputation. In times of crisis, all family members are expected to be involved and consulted (Al Krenawi and Graham, 2000), and when a family member has a mental illness, the illness and the treatment become a “family matter” (Okasha, 2008, p. 94). This is true for Muslim families, both within and outside the Arab world. When seeking treatment, patients are most commonly accompanied by family members who show zealous interest in the patient’s well-being and often act as “co-therapists” (El-Islam, 2008).

On the other hand, this manifest good-willed family embracement of the “identified” patient is impregnated with the deep-rooted fear of the shattering of the family’s reputation and the collapse of its cohesion. In the Arab world, when the individual deviates; the entire family is afflicted, due to the spillover effect of “stigma by association” (Lefley, 1989; Ostman and Kjellin, 2002), which could damage the family’s marital prospects, increase the likelihood of divorce...
The ambivalent perception of medicine and the “doctor”. On the one hand, Arabs have always taken pride in remiscing the Islamic practice of medicine and the “therapy of the psyche” (Sarhan, 2018) by illustrious Islamic scholars and scientists in the era between the seventh and the fourteenth centuries (Haque, 2004). In the collective memory of modern-day Arabs, lies the legacy of Avicenna who pioneered neuropsychiatry by studying psychological disorders or Al-Razi (Rhazes) who wrote what would be considered today the first classification manual of diseases (Okasha, 2001). Such collective memory leads Arabs to consider medicine and the people who practice it with awe and respect (most Arab families yearn to see their offsprings pursue a medical career).

On the other hand, seeking help for one’s health problems is not perceived as solely the doctor’s business; the worldview of Muslims toward health issues is based on the notion of receiving illness and death with patience, meditation and prayers, for illness, suffering and dying are a part of life and a test from God (Rassool, 2000). Adhering to the belief that God wills illness and healing is a great source of comfort to Muslims; thus, suffering from illness is not meaningless, there is a spiritual reason for it. Cinnirella and Loewenthal (1999) investigated religious influences on beliefs about mental illness among different religious groups in the UK (Christians, Muslims, Hindus and Jews), and found that the Muslim group agreed the most that religion could help treat depression and schizophrenia, expressing comfort in the belief that God will respond to one’s requests for help in prayer. Likewise, Muslim Americans are significantly more willing to seek help from a religious leader than from mental health professionals (Ciftci et al., 2013).

“Good” Muslims do not slip into mental illness. In the Arab Gulf countries, Muslim patients readily discuss their depressive symptoms using somatic metaphors (“having a dark life,” the “heart falling down” and “oppression in the chest”) (Al Krenawi and Graham, 2000; Sayed, 2015). For example, hopelessness is not a prominent symptom of depression among Kuwaiti patients because giving up hope is considered a blasphemy, as one’s suffering is rewarded in the afterlife; thus, depression is commonly expressed as “heartache” (El-Islam, 2008). In Arab Muslim society, somatization of psychological symptoms is a common practice (Okasha, 2003), resulting from the prevailing stigmatizing perception of persons with mental illness as “bad” Muslims (Cinnirella and Loewenthal, 1999).

The God-centric approach to the treatment of mental illness. For Muslims, illness can be overcome by faith and prayers (Ahmad et al., 2016). Yet, in the context of mental illness, this God-centric view does not exclude seeking care for ailments from various God-promoted human agents in the community (Padela et al., 2012). In the most traditional families, such agents are informal healers who provide amulets to ward off evil spirits (Al Krenawi and Graham, 2000; Okasha, 2008; Scull et al., 2014). In more modern Arab families, the family practitioner is consulted first. Very few families turn to psychiatrists, and if they do, it is only after the symptoms have become publicly recognized (Meer et al., 2013; Scull et al., 2014; Dardas and Simmons, 2015). A survey of attitudes of Qatar university students toward treatment of mental illness revealed that more than 80 percent respondents would turn to family and friends for support, rather than a health professional, because involving “strangers” in one’s mental health issues is not acceptable (Zolezzi et al., 2017). A study on Muslim Arab female university students in the United Arab Emirates showed that the higher the public stigma and self-stigma against mental illness, the greater is the reluctance to seek professional psychological help (Vally et al., 2018). Even for Arabs (Muslims and non-Muslims) residing in Sydney, mental health services are sought less due to the cultural prohibition of any personal disclosure (Youssef and Deane, 2006).

The stereotype that psychiatry is for the “insane” is prevailing in the Arab world, both in Muslim and non-Muslim communities, and the person who seeks psychiatric services is assumed à priori
to be “insane.” In Kuwait, for example, the importance of one’s reputation and social standing, and the culture of “gossip” prevent seeking treatment, and some people prefer consulting a foreign over a local psychiatrist to ensure greater privacy (Scull et al., 2014). In a survey of the prevalence of psychiatric disorders among adolescents residing in Beirut, Maalouf et al. (2016) revealed that although about one in four adolescents present symptoms of at least one psychiatric disorder, there is an alarmingly low percentage of professional help-seeking. A study on the attitudes of Jordanian university students regarding psychiatric help-seeking showed that, in contrast to medical services, mental health services are negatively viewed due to the fact that disclosing personal issues and breaking family privacy are not acceptable (Rayan and Jaradat, 2016). A survey at a public hospital in Riyadh (KSA) revealed that 98 percent of patients with physical illness thought that the will of God was the most important factor responsible for their recovery; however, none attributed recovery to medical treatments. When patients were asked what they thought was the cause for auditory hallucinations, they listed Satan, curse, pretending, bad childhood and damage to the ear in that order of importance. Reading the Quran was significantly recommended for best treatment, as opposed to surgery, treatment of the ear, medication or psychotherapy (Koenig et al., 2014).

Underlying all the above-listed socio-cultural factors is the deeply engrained universal fear of mental illness (losing one’s ability to make wise judgments) and the equally deep and fearful perception of the mental health institution, where, in people’s minds, the person with mental illness loses the control over one’s life, as he/she is reduced to a passive recipient of medical treatment and he/she is deprived of one’s most fundamental human rights, that is taking decisions concerning one’s life.

**Mental illness stigma in the health-care setting**

Contributing to the persistence of stigma in the Arab world is the presence of stigma at the very place where mental illness is being diagnosed and treated, and by the people who diagnose and treat it: the health-care setting. As discussed above, when dealing with mental illness, most Arab families prefer to consult the family physician or a primary care physician (PCP) rather than referring to a mental health specialist. However, even among healthcare service providers at the primary care level, stigmatization of people with mental illness exists where care for mental illness is considered to be too specialized to be part of primary care (Meer et al., 2013). If stigma and discrimination are experienced at this very first help-seeking step, then chances for seeking further mental health treatment are reduced or blocked. If, on the contrary, the person’s illness is not stigmatized at this first step, then chances for mental health help-seeking and recovery are increased. A study by Chahine and Chemali (2009) assessed the status of mental health care in Lebanon through surveillance of current mental health services and interviews with PCPs; it identified several barriers to the optimal delivery of mental health services, such as rampant negative attitudes by physicians toward patients with mental illness. A study on the attitudes of medical students toward mental illness in Oman (Bahrain) reveals that the majority preferred that facilities for psychiatric care be located away from the community (Al Adawi et al., 2002), and a study on the attitudes toward mental illness of 303 general practitioners (GPs) and family physicians at various health centers in Bahrain showed that the less experience the GP had with mental illness, the more likely he/she is to believe that treatment of mental illness should be in psychiatric hospitals and not in health centers (Meer et al., 2013). Such attitudes serve to further segregate people with mental illness, thus contributing to the perpetuation of stigma about mental illness and mental health treatment.

More negative than positive attitudes toward patients with mental illness were revealed by various professionals at a psychiatric hospital in Bethlehem, thus suggesting that education and direct contact with patients with mental illness may not be enough to foster positive attitudes toward mental illness (Ahmead et al., 2010). In Saudi Arabia, GP and specialists play a pivotal role in the management of psychiatric patients who feel more comfortable with physicians because they do not want to be stigmatized for visiting a psychiatrist. Al-Atram (2018) evaluated non-psychiatric physicians’ knowledge of and attitudes toward psychiatric disorders in various hospitals in Riyadh (Kingdom of Saudi Arabia), and pointed to the existence of negative attitudes among GPs and specialists toward mental illness, a tendency not to refer patients to psychiatrists and a lack
of interest in psychiatry. Interestingly, most health professionals in Saudi Arabia who were surveyed about their perceptions of complementary and alternative medicine (including spiritual healing, medical herbs and nutritional supplements) in the treatment of both physical and mental illnesses reported positive attitudes toward such practices in view of safety and effectiveness (Al Bedah et al., 2013).

Soliman et al. (2016) investigated the preferred future specialty and attitudes toward psychiatry in a sample of 300 fifth-year medical students attending psychiatric rounds at a university hospital in Cairo, Egypt. The psychiatric round included intensive training on psychiatric disorders in the form of lectures, clinical demonstrations, case discussions and role-play. Comparison of data before and after the round showed that students with an initial positive attitude ended up with a significantly more negative attitude toward psychiatry and mental illness, and only 4 percent of the students chose psychiatry as a future career, compared with 35 percent and 25.7 percent who chose internal medicine and surgery, respectively. The authors concluded that the duration of the psychiatric round was not long enough for students to acquire sufficient knowledge or skills, and that their poor attraction to the field of psychiatry as a future career choice may be due to à priori cultural and personal misconceptions that unfortunately persisted after the round.

In Tunisia, given the uneven geographical distribution of psychiatrists in the country and the scarcity of mental health nurses, integrating mental health in primary healthcare settings has become a must. Spagnolo et al. (2018) evaluated the preparedness and willingness of a sample of 112 PCP to address mental illnesses in the Greater Tunis area. Gaps were found in their knowledge about mental health (in the identification of symptoms and the acknowledgment of myths related to mental illness). Further, most PCPs had unfavorable attitudes toward mental illness (perceived as “dangerous”), as well as the interaction with people having mental illness during PCP practice. Very few PCPs expressed confidence in their ability to detect and treat mental health problems. The authors stressed the role played by mental illness stigma to explain the disinterest of PCPs, which contributes to under-diagnosis, under-reporting and limited treatment options for people with mental illness.

In contrast to these findings, a study by Alahmed et al. (2018) on the perception of the etiology and treatment of schizophrenia by a sample of 400 undergraduate Saudi students in health sciences (pharmacy, public health, nursing and applied medical sciences) revealed that “mental illness” was reported by the overwhelming majority of participants to be the main cause for psychosis. As for treatment preference, the majority of students chose visiting a psychiatrist (77 percent), followed by reciting the Quran for protection (52 percent) and visiting a family physician (49 percent). The authors suggested that exposure to behavioral sciences within the health sciences curriculum is a crucial factor in influencing students with respect to their understanding of mental illness. Investigating medical students’ attitude toward psychiatry is important since it not only affects their later career choice but also the quality of care they will provide to patients with mental problems in the future. Hayat et al. (2017) examined attitudes of 60 male medical students before and after a six-week psychiatry rotation in a medical university in Saudi Arabia, as well as their perception of the psychiatrist as a role model. Results showed a significant positive impact of psychiatric training on students’ attitude toward psychiatry, the psychiatrist as a role model and psychiatry as a future career choice. Further, the authors emphasized the significant positive change between pre- and post-training attitudes toward prognosis of mental illness, interpreting it as an important step toward nullifying the stigma toward psychiatric illnesses that they are untreatable (Hayat et al., 2017, p. 57).

The role of mental health legislation in consolidating the rights of people with mental illness in the Arab world

Mental health legislations provide a legal framework for overcoming stigma and discriminatory practices through the provision of guidelines for integrating mental health services within the community, definition of governmental and professional responsibilities and liabilities, and establishing human rights-based criteria for the protection of patients and prevention of abuse (Okasha, 2003). The WHO (2003) mandates that mental health legislations should guarantee the right for privacy, informed consent, confidentiality, freedom from abusive treatment and the right for non-discrimination.
The Mental Health Atlas 2017 (WHO, 2018) assessed the status of mental health legislations and national mental health policies in the Arab countries within the EMR. Slightly more than half of all EMR countries (55 percent) have enacted laws on mental health. El-Islam (2008) talked about a ‘legislation-free professional-family-patient liaison approach’ in some countries such as Qatar and Kuwait, where it is extremely rare for a hospital or a family to be taken to court by patients for illegal detention or violation of human rights. Of the EMR countries that have a mental health legislation, only 24 percent implement regular monitoring inspection, and 47 percent lack a mechanism to ensure compliance of the legislation with human rights criteria (such as the promotion of community-based mental health services, the right to exercise legal capacity and regular inspections of human rights conditions in mental health facilities by an independent body) (WHO, 2018). The absence of any control or monitoring mechanism allows for different types of malpractices in mental health care. Okasha (2003) and El-Islam (2008) reported that it is quite common to find private practitioners with online degrees from unaccredited institutions or even just a bachelor degree in psychology delivering mental health care. In Palestine, mental health care is provided by psychologists with bachelor’s and master’s degree, and social workers who lack proper clinical exposure and are unable to handle patients with complicated psychiatric conditions (Jabr et al., 2013). This inevitably affects the quality of mental health services and increases the likelihood of professional maltreatment, which, in turn, serves to further exacerbate the stigma against such services. In Lebanon, patients’ rights and dignity are often violated through their isolation from their community for long periods of time and through the practice of unpaid labor within the institution, coined as occupational therapy by hospital personnel (Kerbage et al., 2016). Although the Lebanese mental health law (created in 1983 and is in the revision process) dictates the creation of a mental health authority to monitor and control the treatment of persons with mental illness according to international human rights standards, this authority has not yet been established (WHO, 2015). In the United Arab Emirates, three mental health laws are currently under development (mental health in general, health of the elderly and child protection law), entailing the protection of the human rights of the patient and regulating compulsory admission to mental health facilities; however, no unified procedure has yet been identified to ensure consistent implementation of these laws (Alhassani and Osman, 2015).

Mental health services should be based on a robust mental health policy/plan, defined as an official governmental statement of the values, principles, objectives and areas for action (strategies, timelines and resource allocation) to improve the mental health of a population (WHO, 2018). Only half of the EMR countries have compiled mental health data in the last two years for the public sector, and only 13 percent did so for both the public and the private sectors. Although more than 70 percent of EMR countries said they have a mental health plan, which has been revised over the last five years, only 53 percent said their mental health plan endorses human rights criteria (such as promoting transition toward community-based mental health services, independent living and community inclusion, and participation of patients in decision-making processes).

Compared to other WHO regions (the Americas, Europe, South East Asia and the West Pacific region), the African and the EMR countries are still lagging behind when it comes to the existence of a mental health policy, the updating of that policy, whether the policy fully complies with human rights criteria, and whether there is an authority to monitor this compliance. Thus, more vigorous work is needed in these four areas to enhance the professional status of mental health services and to give mental health care more credibility and trust, thus reducing the stigma against mental illness (WHO, 2018, p. 15).

Discussion

De-stigmatizing mental illness requires change on several fronts; one good place to start is research. More mental health research is needed in the Arab world, as a wide gap in mental health research productivity is noted (Jaalouk et al., 2012; Karam and Itani, 2015). Most research topics to date have focused on the prevalence of mental disorders, psychometric properties of instruments, culture and the effect of war on mental health, genetic and pharmacological studies on mental disorders, mental health services suicide, and abuse of children or women (Karam and Itani, 2015). Although “mental illness stigma” is discussed in each of these studies, no study has been exclusively devoted to study people’s and patients’ perceptions of the mental health service
provider(s) or the mental health-care setting. Given the rife evidence, worldwide and in the Arab world, in particular, that stigmatization of mental illness does take place in the health-care setting, it is an important area to investigate in the Arab world. Investing in people’s and patients’ perceptions will allow to assess the areas in the health-care setting (primary health care and mental health care) that need to be changed or acted upon. Socio-cultural change can happen when a patient with mental illness is brought by his/her family to a health-care setting where his/her human rights are openly respected and his/her condition is embraced by a health professional who has no stigmatizing value judgments about the patient and his/her family.

In the Arab world, integration of mental health services into the primary health care system is happening at a slow pace. Building up the human resources for the delivery of these services is an important challenge to such integration (WHO, 2011). Okasha et al. (2012) noted that psychiatric services in the Arab world are gradually being replaced by psychiatric units with both inpatient and outpatient facilities in general hospitals, and mental health training for GPs and other health personnel at the primary health care level is becoming available in a large number of countries. However, this integration does not necessarily mean that the human rights of people with mental illness will be respected as long as nothing is being done to change the negative attitudes and stigmatizing behavior of the health personnel toward mental illness. It was suggested earlier that the lack of awareness among health personnel of the human rights of people with mental illness is a stigmatizing factor. It is even more stigmatizing when health authorities who are in charge of implementing mental health legislation overlook such a lack of awareness.

Another important area to investigate is that related to diagnosis and treatment. Good mental health practice in the Arab world ought to embed the complexities and intricacies of Arab culture if it is to be accepted by the people of the region. Most diagnostic and therapeutic interventions used in the Arab region are exported from more developed nations; these need to be adapted in a culturally sensitive fashion (Global Burden of Disease 2015 Eastern Mediterranean Region Mental Health Collaborators, 2018). Standardized assessment tools ought to be developed in specific accordance with the Arab culture, and nuanced treatment modalities ought to be initiated to address specific issues/crises within the Arab socio-cultural fabric (Haque, 2004). Graham et al. (2009) suggested that prayer practices, which play a significant role in the Muslim lifestyle, may be incorporated in intervention modalities.

An altered image of the mental health care provider, namely, the psychiatrist, is recommended in the Arab world. The psychiatrist in the Arab world faces the dilemma of integrating respect of the local religious and cultural values with the ethical guidelines of the profession. In the family-oriented Arab society, decisions are taken in the community’s interest, and what is viewed in Western standards as patient empowerment and respect for patient’s rights is perceived, in the Arab society, as an insult to the patient’s family (Okasha, 2008). In line with what Ciftci et al. (2013) suggested, good psychiatry in this part of the world would require the psychiatrist to let go of the rigid adherence to professional Western standards and create a parallel frame of ethical and professional practice that takes into account the values and concerns of the local population. Culturally competent psychiatry is needed for the de-stigmatization of mental illness and mental health treatment. A more people-friendly image of the psychiatrist ought to be promoted, one that is concordant with local social, religious and cultural values and concerns (appreciation of and investment in family cohesion, fear of confidentiality breaches, fear of gossip, etc.). Evaluating attitudes of health professionals toward religious medical practices in Saudi Arabia, Al Bedah et al. (2013), in their study, recommended that religious and spiritual care should be an integral part of patient care, for awareness and understanding of the patient’s beliefs will facilitate discussions between the therapist and the patient, deepen the relationship between the service provider, the patient and his/her family, and ultimately affect the way intervention decisions are made. Such a recommendation is in line with the WHO’s (2013) definition of traditional medicine as “the sum total of knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures that are used to maintain health as well as to prevent diagnose improve or treat physical and mental illnesses” (p. 1).

Conclusion
The way to reduce mental illness stigma in the Arab world is long and arduous. Stigma is deeply engrained in the familial and socio-cultural fabric of the Arab society, and it is resulting in the
continuous blatant violation of fundamental rights of people with mental illness. This situation is expected to worsen with the rising prevalence of mental disorders in this part of the world due to political and economic unrest, civil wars, terrorism threats, displacement and problems of refugees. It seems that the mere presence of a national human rights-based mental health legislation is not enough to halt stigmatization and discrimination against people with mental illness. What is needed is a robust consistent monitoring mechanism that would ensure the implementation of basic human rights criteria in the management of mental illness both at the primary health care level and in the mental health setting. Such monitoring mechanisms should target the attitudes of the personnel in charge of diagnosis, referral and treatment, where stigma seems to be as common as among the general public. Unfortunately, such mechanisms seem to be missing in the Arab world.

References


Students’ attitudes towards psychiatry, psychiatry as a career choice and psychiatrists as role models on Saudi medical students.


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