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"A Multi-Country Perspective of the Adult Mental Health Status of Middle Eastern Women: A Review of the Literature"

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“A Multi-Country Perspective of the Adult Mental Health Status of Middle Eastern Women: A Review of the Literature”

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Abstract

"A Multi-Country Perspective of the Adult Mental Health Status

of Middle Eastern Women: A Review of the Literature"

By: Elizabeth R. Fullerton

In Arabic countries, health disparities exist between males and females. In particular, a combination of cultural issues and a lack of social and medical support have been linked to the prevalence and management of women's mental health issues. Lack of effective mental health treatment has been shown to increase rates of disease and disability. Thus, cultural values, social support, and the presence of available clinical care must be addressed when discussing women's health.

The objective of this thesis is to analyze the available literature on the theme of mental health care and support for adult Middle Eastern women. The medical database PubMed was used to search for published articles on this topic, and 41 articles were used in the final review. Search parameters incorporated all English and recent articles that discussed relevant topics. Such themes included, but were not limited to, postpartum depression, domestic violence, depression, and access to care. Permission from the IRB was not pursued as this paper did not involve human subject research.

The results of this study show that health disparities in this region are directly related to gendered health care issues. Middle Eastern women are not only less likely that Middle Eastern men to receive adequate care for their mental disabilities; they are also at greater risk of developing them. In addition, women with these issues are more likely to be stigmatized, have less access to care and end up suffering with a worse medical and social outcome. Prevalence of postpartum depression and domestic violence are of particular concern.

Women in Arabic countries are at a high risk of developing a mental illness, being physically abused, or in having limited to no mental health care. This greatly affects the quality of life of females in this area and is experienced throughout life. Increased access to health facilities, changes in social structure that support a woman's right to safety, and an overall increase in understanding, recognition, and de-stigmatization of mental health issues are called for as a means to decrease these disparities. This paper also revealed a lack of public health literature on these topics.

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Introduction and Objectives

Throughout the world of Public Health, mental health is a neglected topic. However, it is especially so for women living in Arabic countries. These women have a high risk of being physical abused and/or developing a mental illness. However, they are unlikely to have access to care or to have their issues even recognized as problems. In fact, an Arabic woman might be considered property—where physically abuse as discipline is considered acceptable behavior by the men in her life.

The levels of equality between men and women vary greatly from country to country—and even within countries from region to region or from rural to urban areas. However, the patriarchic social design in most Arabic countries tends to limit the opportunities available to its female population. In this type of social construct the women are raised and educated according to very conservative attitudes and constraints. These women are also more likely to have a lower social and economic status.

These contrasting values between genders have lead to a dearth of knowledge surrounding the mental health issues facing Arabic women. This paper seeks to understand what studies have been conducted on these issues. Three subjects are of particular interest in this literature review. The first in concerned with evidence of gendered mental health issues among female Arabic nations. The second studies postpartum depression and its surrounding issues. The third investigates the acceptance and frequency of physical violence against

Middle Eastern women. In all of these issues, access to health care is studied. Limitations will be discussed at the end of this paper.

Background

Incidences of mental health and physical violence are poorly documented throughout the Middle East. While studies have increased over the last decade, sociological, epidemiological, and medical research is severely lacking. In addition, the studies that are available tend to focus very heavily on what diagnostic tests are effective in Middle Eastern culture. Less is known about the causes behind an illness or ways to prevent or treat it.

Traditionally, Arabic cultures have been severely patriarchal, with the oldest able-bodied male acting as the primary authority. This has also been the case in public areas—be it in the academic study halls, the bazaar, or in medical care. Men are considered the defenders of the family honor and responsible for monitoring and maintaining the relationships between siblings, spouses, and parents. This social structure calls for a strict separation of public and private behavior. Gender roles are also strictly defined and adhered to. Women are supposed to cook meals, clean the house, care for elderly parents, and raise the children. Men economically support the family, defend the family honor, act as head authority, make major decisions, and discipline when necessary (Keenan 1998).

Given these role differentials, Arabic women are frequently less educated than their male counterparts. Since the goal of a Middle Eastern girl's life is to be

a good home maker, unless the family is affluent, the male heirs are more likely to be educated. As a side effect of both these social norms and lack of education, Arabic women are much less likely to ever enter the workplace (World Bank Group 2007). If one does and is working at the time of her marriage, she is more likely to quit (El-Zanaty 1996). In addition, she has severe restrictions placed on her ability to move about within society. This makes it more difficult to create and maintain supportive relationships outside of the family—especially if maintenance of those familial relationships requires a lot of time and effort (Yount 2008).

These social interactions and ties to the family are also directly related to a family's honor. Thus, a woman's actions can affect the social standing of her husband or male relatives. If she attempts to break out of her traditional role, she might threaten the honor of her family—especially her husband or male relatives. Social norms and her limited access to other social contact then increases her risk for physical abuse by her husband or family members.

Being female, her economic and education levels might also make a big difference in her view of the world. Low status limits her access to education, nutrition, and economic resources needed to pay for medical treatments or family planning services. With reproductive capability defining her social role, she might face tremendous difficulty in changing her status via education, finding employment in the workplace, or finding an understanding doctor.

The congruence of all of these issues, lack of social contact, lack of education and lack of income all increase her chances of becoming depressed.

Great risk of depression especially occurs during her postpartum months. Depending on where she lives, depression may not be considered a true ailment by her family or community. Thus, she might not be able to leave her home in order to seek treatment giving her very limited access to care.

Setting

Gendered Mental Health Issues

In Arabic countries, a combination of cultural issues have been linked to the prevalence, clinical health, and management of psychological problems in women. The subordinate position of females is particularly responsible for this. Women are at a higher risk for depression, anxiety, eating disorders, and suicidal behaviors. In addition, women suffering from mental health issues are stigmatized, and have less access to care and are more likely to endure social complications. Religious beliefs are also commonly used as a way to justify the subjugation of women—including more extreme forms like female genital cutting (Douki 2007).

Post-partum Depression

An increasing awareness about the importance of mental health during the perinatal period is only just beginning to emerge in Arabic countries. In some places, it is not seen as a medical issue, but as a curse from a “jinn” or “evil eye.” In others, there is simply not enough social and emotional support in the

community for new mothers suffering from mental health issues. Some studies have also found that efforts should be made to ensure that clinicians have available resources and are encouraged to recognize postpartum depression (Ghubash 2009).

Domestic Violence

Domestic violence is a major public health concern. In studies conducted in the United States and other western countries, domestic abuse has correlated with serious emotional issues and other potential health concerns for all family members. Initially western scholars spent a great deal of time studying the health effects of domestic violence on those involved in an effort to help understand the emotional and physical cost. Since then, scholars in other countries have begun conducting research in their own home states (Kennan, 1998).

Domestic violence occurs around the world in every culture, country, socioeconomic class, and historical period. The level of the violence depends on many factors, including the tolerance of the family members themselves, cultural norms, societal determination of gender roles, and situation-specific triggers. These all vary from country to country and from region to region.

In Arabic and Islamic countries, however, domestic violence is not yet considered a topic of concern—despite its prevalence and serious consequences. Surveys conducted in Egypt, Palestine, Israel, and Tunisia show that at least one

out of every three women is beaten by her husband. Domestic violence is seen in these cultures as a private matter and is even justifiable given perceived "misbehavior" by the wife. Particularly in Islamic areas, excerpts from the Koran are used to justify these beatings and to prove that the men are only carrying out God's commandments. Thus, with religious sanctions, and the social importance of preserving the family honor, abusers, victims, police and health care professionals work together in keeping domestic violence a silent problem. Nevertheless, it is worth noting that a careful reading of the Koran reveals that the beatings are more socially than religiously ordained (Douki 2003).

Data and Methods

Identification of relevant documents

My research began by conducting a literature review of articles published focusing on the health of women in Arabic countries. The age restrictions began around child-bearing years or after the birth of a first child and ended with death. PubMed, a database for public health literature, was used in all searches.

The search terms for Arabic countries were, "arab OR egypt OR iraq OR jordan OR lebanon OR saudi arabia OR syria OR yemen OR libya OR sudan OR morocco OR tunisia OR kuwait OR algeria OR UAE OR bahrain OR qatar OR oman OR mauritania OR somalia OR palestine OR djibouti OR comoros OR middle east." Each search topic included a subject and the above mentioned country searches. My search topics included terms relevant to the health of

women in this time frame. They were, “domestic violence,” “gender and depression,” “chronic disease,” “cognitive functioning,” “access to care,” “postpartum depression and resilience,” “nutrition,” “physical disability,” “life expectancy,” “HIV/AIDS,” “aging,” “infectious disease,” “diabetes,” “abuse,” “anxiety,” “hypertension,” and “arthritis.” 104 articles were found with relevant information on these topics.

After the more extensive search, the findings for the mental health issues were found to be of particular interest. Thus, the articles that centered on “depression,” “anxiety,” “domestic violence,” “postpartum depression,” and “gender and depression” were pulled out of the primary group.

Study selection

All articles were published in English in medical or public health journals. Articles dated back to 1995, with most dating from 2001 forward. Thus, this data is as current as possible in an effort to stay relevant with current public health knowledge. Both quantitative and qualitative studies were used. Articles were initially selected due to their gender-disaggregated data and relevance to searched topics. There were 85 of these articles. However, after further research, they were separated into three areas: post-partum depression, domestic violence, and access to care. Articles that dealt with specialized circumstances, such as an earthquake or recent war were not included in order to get a more generalized view of the region. There were 41 of these articles. Five of these articles dealt with Turkey, two with Tunisia, five with Egypt, three with Jordan, one with

Djibouti, one with Sudan, four with Lebanon, seven with Iran, three with Syria, five with multiple countries, two with Ethiopia, one with Israel, one with the United Arab Emirates, and one with Morocco.

Data Collection

Articles were accumulated and inserted into an Excel spreadsheet. They were thus accorded information according to their Author, Title, Publication, Year, and content. Their country and gender aggregation were also noted. The age range and key findings were also listed. It was categorized by subject. These subjects were access to care, chronic disease, chronic disease-diabetes, chronic disease-hypertension, chronic disease-arthritis, cognitive function and impairment, domestic violence, HIV/AIDS, aging, postpartum depression and resilience, abuse, and anxiety.

Results

Gendered Mental Health Issues

There is a great deal of evidence pointing to differences in the quality of and access to medical care between the genders. Social and economic differences play a part in these discrepancies.

Women at greater risk for mental health issues

Muslim women are not only likely to be less likely to receive adequate care for their mental disabilities; they are also at great risk of developing them. A

comprehensive study of the region found that women are at a greater risk of developing disorders such as depressive, somatoform, anxious or eating disorders. Some of the predictors in women of depression include heart disease, hypertension, and kidney disease. Arabic women are also more likely to exhibit suicidal behaviors. To compound difficulties, women suffering from mental health issues are more stigmatized, have less access to care and end up suffering from a worse social outcome. Cultural risk factors such as work, education, sexuality, marriage status, and infertility work to significantly contribute to triggering mental disorders in females, as well as worsening their course and outcomes (Douki 2007).

A study at a family health center affiliated to a health insurance organization in Alexandria, Egypt also found that mentally ill women in Arab communities were more stigmatized. These women were at a greater risk of developing mental disorders—such as depressive, somatoform, anxious or eating disorders. They were also at high risk for exhibiting suicidal behaviors. This study also found that cultural risk factors such as employment, education, sexuality, marriage, and infertility significantly contribute to triggering and exacerbating mental health issues. Thus, this study concluded that social issues must be treated along with psychological symptoms in order to truly help Arabic women (El-Mahalli 2005).

Low status was also a correlate found in a comprehensive review in 2007. It found that experiences of low self worth, lack of competence or autonomy, and inadequate income were potent mental health risks. In addition, it noted that a

sense of physical, sexual, and psychological safety and security is essential to good mental health—but not frequently found among Arabic women with low status. In fact, they are often systematically denied these qualities. In addition, the frequent violation of women's rights, especially according to their reproductive health, directly correlates to an increase in mental health issues and disability burdens. The author found that an inter-disciplinary action to set policies which protect and promote women's autonomy and mental health issues was not only important to their well-being, but that also of the state coffers (Afifi 2007).

In 1998, in Alexandria, Egypt, male cases of adult depression were found to occur earlier in life than female cases. Male cases also had a higher mean score on the depression scale. Genders differed significantly in psychopathological parameters related to hopelessness, low self esteem, loss of sexual interest, loss of pleasure, guilt, self reproach and suicidal ideation (Khatwa 1999).

Co-morbidity of depression with chronic diseases

A study in Syria also evaluated participants for co-morbidity of depression with chronic diseases. In women, predictors of depression were heart disease (OR = 3.95, 95% CI: 1.50-10.40), hypertension (OR = 2.92, 95% CI: 1.53-5.55), and kidney disease (OR = 2.96, 95% CI: 1.64-5.32). Depression co-morbidity with any chronic disease decreased in higher socio-economic status (middle vs. low: OR = 0.28, 95% CI: 0.12-0.65; high vs. low: OR = 0.20, 95% CI: 0.05-0.81). In

men, predictors of depression were rheumatism (OR = 7.10, 95% CI: 2.58-19.60) and respiratory disease (OR = 3.77, 95% CI: 1.23-11.60) (Kilzeih 2008).

Summary of gendered mental health issues

Women in Arabic countries are at great risk of developing mental health issues based on gendered societal norms. They are also less able to access adequate health care in order to care for these medical problems. Women with mental disorders are more likely to be ostracized, be at risk for co-morbidities, be suicidal, and end up with worse life outcomes. In end, however, there is a serious dearth of studies on this topic. Given the seriousness of these findings, it is a field that deserves closer scrutiny.

Post-partum Depression

The articles found during this literature review on post-partum depression found that women in Arabic countries suffer from high rates of post-partum depression. Social support and medical care postpartum can make a difference in the level of depression. In addition, several western tests are found to be effective in evaluating the level of depression among Middle Eastern women.

Prevalence of postpartum depression

A Tunisian study of the prevalence of postpartum depression found that levels of intense postpartum blues vary throughout two stages. In first stage,

prevalence of the intense postpartum blues, according to EPDS, equaled 19.2%. In second stage, prevalence of the postpartum depression equaled 13. 2%. The overall frequency of postpartum depression was high. This difference in rates of prevalence between the two stages of evaluation has been noted in other studies. They conclude that a relatively high rate during the first stage would be contaminated by an intense postpartum blues. However, a high rate also persists in the 6-8th weeks, indicating the importance of tracking postpartum depression. It is possible by using EPDS, which is available in an Arab version and which should be generalized for the new mothers. This detection should be done early in postpartum or else in the later postnatal consultations. This allows an adequate treatment for the mothers, for the mother-newborn relationship and later, for the psychological equilibrium of the child (Masmoudi 2008).

A postnatal depression among mothers in the United Arab Emirates looked at the socio-cultural and physical factors. They divided the levels of depression into three categories: No Depression (scores of 0-9), Borderline Depression (scores of 10-12), and Depression (scores of 13+). At 3 months, 22% of mothers fell into the Depression category and 22% equaled Borderline Depression. At 6 months, this fell to 12.5% in the Depression category and 19.6% in the Borderline Depression category. The study found that the relationship between higher depression scores and risk factors included: not breastfeeding, giving birth to a first child, poor self body image and view of weight, poor relationship with mother-in-law, and an older age at marriage. (Green 2006).

Another study asked if unintended pregnancy was a risk factor for depression in Iranian women. Of unintended pregnancy, 43% reported attempting to abort the fetus. Depression at 37 weeks' gestation was slightly higher in the unintended than the intended pregnancy group (53.4% versus 41.0%; relative risk = 1.3) and depression 10 days postpartum was much higher in the unintended group (48.7% versus 25.6%; relative risk = 1.9). Thus, they recommend screening for depression for pregnant women with an unintended pregnancy. (Iranfar 2005)

Using the Mini International Neuropsychiatric Interview and the Arabic version of the Edinburgh Postnatal Depression Scale, another study found that 18.7% of the women studied met DSM-IV criteria for depressive disorder in the second week after childbirth. Using a cut-off score of 12, the EPDS indicated a sensitivity and specificity of 92% and 96% respectively. Depressive disorder was significantly associated with pregnancy complications, stressful life events during pregnancy, baby's health problems, and poor marital relationship. The subsequent point prevalences were 6.9%, 11.8% and 5.6% respectively at 6 weeks, 6 and 9 months. Postnatal visits were found to be effective in decreasing the depression of Moroccan mothers. (Agoub 2005).

Social support and symptoms of postpartum depression

Social support and symptoms of postpartum depression among new mothers was studied in Eastern Turkey. EPDS mean score related to age, woman's education, woman's occupation, socioeconomic status of family,

spouse's education, number of years married, parity, planned pregnancy, method of delivery, knowledge of infant care, sharing of problems with a close person, past psychiatric history and family support during the postnatal period. Symptoms of postpartum depression negatively correlated and were associated with the level of social support. The prevalence of postpartum depression was found to be higher in Eastern Turkey than in the published reports regarding most regions of Turkey, with the exception of Northeastern Turkey (Ege 2008).

Studies of Traits of Postpartum Depression

Another study looked to see if there was a correlation between their maternal attachment style and the duration of their breastfeeding activity on postpartum psychological adjustment. All of the mothers began breastfeeding their infants postpartum. 91% and 68.1% continued exclusive breastfeeding at 1 and 4 months, respectively. The first-month median EPDS score of mothers who breastfeed at the fourth month was statistically significantly lower than those who were not breastfeeding (6 and 12, respectively) ($P = 0001$). The first-month median EPDS score of mothers with secure attachment was lower than the median score of mothers with insecure attachment (5 and 9, respectively) ($P < 0001$). Exclusive breastfeeding rate was not statistically different among mothers with secure and insecure attachment styles. The median state and trait anxiety scores and social support scores of mothers were not different between groups according to breastfeeding status. This study demonstrated an association

between higher EPDS scores and breastfeeding cessation by 4 months after delivery. (Akman 2008)

Validity of Western tests

Another whole section of studies performed on postnatal depression study whether or not western depression scales or criteria are valid for use in Arabic countries. Some of their studies follow.

The first study found evaluated if the Edinburgh Postnatal Depression Scale (EPDS) was valid for use in an Iranian sample. It found that a Persian version of EPDS is a reliable and valid measure for detecting postpartum depression. Furthermore, it was found to be acceptable to patients and a valid screening instrument for depression in postpartum women in Iran. (Mazhari 2007).

Another study conducted a long term follow-up of patients with postpartum psychosis in order to assess if DSM-IV criteria was valid in the Middle East. Among postpartum women, 73.9% developed psychosis during their 1st parturition. The postpartum psychosis and control groups were followed-up for 4.00 +/- 1.62 (range: 2-6) and 3.96 +/- 1.24 (range: 2-6) years, respectively. During the follow-up period, 21.7% of the postpartum patients developed a mood disorder, and 77.9% developed schizophrenia & other psychotic disorders. Among those in the control group, 32.0% were diagnosed with a mood disorder and 68.0% with schizophrenia & other psychotic disorders. The distribution of final diagnoses in the two groups was similar. Patients with

postpartum psychosis experienced more confusion than the control subjects. During the follow-up period, 65.2% of the patients with postpartum psychosis and 72% of the control patients had recurrence. The course of postpartum psychosis was similar to DSM-IV diagnostic criteria, except for the presence of confusion. During the follow-up period, most of the patients in both groups were diagnosed with schizophrenia and other psychotic disorders. This result indicated that there is no need for other diagnostic criteria for postpartum psychosis other than those presently contained in DSM-IV (Kisa 2007).

A last article also evaluated the Postpartum Depression Screening Scale for its reliability and validity for the Turkish population. Research suggests that its validity and reliability of the Turkish PDSS is satisfactory, and that it can be used in Turkey (Karacam 2008).

Postpartum depression and association with number of antenatal clinical visits

Patterns of antenatal care in low-versus high-risk pregnancies were studied in Lebanon. Most women had 9 antenatal care visits with an obstetrician, starting in the first trimester. Care for high-risk and low-risk pregnancies was similar in terms of type of provider, number of visits and timing of first visit. More high-risk women had advice about special diets, supplements and laboratory tests. Maternal and fetal outcomes showed that, controlling for area and pregnancy risk, more antenatal visits were associated with fewer preterm deliveries, more caesarean sections and fewer cases of postpartum depression. Overall, differences between risk groups were small (El-Kak 2004).

Summary of post-partum depression

The literature reviewed here found that Arabic women suffer from high rates of post-partum depression. Levels of social support and medical care given after birth can seriously decrease the chances of a new mother experiencing this unhealthy mental state. Breastfeeding for the first four months after birth also decreases rates of post-partum depression. While Western psychological tests have been proven to accurately evaluate the mental health of Arabic women, a study on rates throughout the region would be helpful.

Domestic Violence

Domestic violence is an expression of dominance and control in family relationships. Physical force or the treat of severe physical harm is employed, usually by the physically stronger person to maintain control over weaker or more vulnerable family members. Violent behaviors include actions such as punching, hitting, slapping, kicking, throwing objects, or wielding weapons.

Domestic violence is a serious issue facing women in Middle Eastern countries. Physical violence against women is commonly accepted as a form of discipline or control.

In general, the term domestic violence refers to the physical, emotional, or verbal abuse that occurs among co-habitating people. It often occurs because of stress

put on the role relations of those involved and lack of good communication skills (Keenan 1998).

The incidence of domestic violence in Middle Eastern countries overall is not well documented. Little epidemiologic, medical, or sociologic research has focused on this problem, despite its serious nature. Physical punishment of wives by their husbands is found to be acceptable in almost all of the widely diverse Middle Eastern cultures.

There has been some research (Babcock 1993) that promotes the idea that a power-differential in a relationship where the husband is subordinate to the wife can increase the risk of physical violence against the wife. In a situation in which the wife earns more or had more decision-making power, there was evidence to state that the wife was more susceptible to violent behavior when compared to other volatile couples. In general, physical abuse of the wife is considered acceptable behavior in a wide variety of social and economic groups in Middle Eastern countries (Keenan 1998).

For example, one study in Kermanshah city, Iran, asked a convenient sample of women aged 25-45 years of age who have been married for at least five years regarding potential causes of intimate partner violence against women (IPVAW). These questionnaires were delivered in 48 public health centers scattered around the city that provided free health services to mothers and children under 6 years old. Respondents were interviewed onsite by trained, female questionnaires. The response rate was 94.3%. The study found that the women mostly “agreed” or “agreed very much” about their potential as a cause or

trigger of IPVAW. In individual-related potential causes, the agreements were stronger. Thus, the same opinions were expressed overall regardless of a woman's socio-demographic characteristics or prior victimization. However, for some triggers, a woman's own occupation or her husband's educational level affected how much they were in agreement. In general, the women believed that most of the potential causes and triggers would, at some point, lead to IPVAW. This study proposes interviewing married men or women who have been married for a shorter time span to see what correlation there is in the responses of all groups (Hamzeh 2008).

In a Lebanese study, low-income families were studied. The contextual factors for violence were unmet gender role expectations, conflict with the husband's relatives, and alcohol abuse. Family stressors, such as emotional, financial, and work-related ones tended to exacerbate the conflict. In order to effectively deal with the abuse, women reacted with three types of conflict management—negotiation, taking initiative, and passive resignation. The study results noted that culturally-specific nursing interventions should be directed toward bolstering strong family and social resources to cope with family stressors and to modify patterns of maladaptive communication (Keenan 1998).

A second study in Iran focused on women who attended gynecological outpatient clinics. Out of 1,000 women who had some sort of violence, 590 participated in the study. Of these, 196 described some form of controlling behavior and 361 were physically threatened. Out of these interviews, it was discovered that a woman's risk of domestic violence was drastically increased by

certain factors. These were a low level of education, a nongovernmental job, psychiatric disorders in the men, previous custody, and coercive marriages (Nojomi 2007).

In 1995 17.5% of married women in Egypt experienced wife beating in the last 12 months, in 2005--18.9% or 16.0%, using different measures. The association between socio-demographic differentials and wife beating was weaker in the newer survey. The 12-month prevalence of wife beating was lower only when both partners were educated, but the differences across education levels were less pronounced in 2005. Based on the information available in the 2005 survey, more educated women experienced less severe forms of wife beating than less educated women. Different measures used in both surveys make a direct comparison difficult. The observed patterns indicate that the changes in prevalence may be masked by two opposite processes occurring in the society: a decrease in (severe forms of) wife beating and an increase in reporting of wife beatings. Improving the access to education for women and raising education levels in the whole society may help reducing wife beating (Akmatov 2008).

A study in Jordan in 2009 looked at experiences of Jordanian women who were abused by their husbands. Thirteen women who were married to abusive husbands were interviewed at a major primary healthcare center. Types, intensities, and after effects of the abuse were described during these consultations. The women decried the abuse, but also excused it. The study determined that nurses could be more effective in helping the abused women if they could help identify them, empower them, help them design interventions,

and work with other health care providers to increase knowledge of abuse in the area (Oweis 2009).

Of 1418 participants participating in a study at a Lebanese primary health care facilities, 494 (35%) reported experiencing domestic violence and 307 (22%) had family members who had been exposed to domestic violence. Among the women exposed to violence, verbal abuse or insult was most common (88%) followed by physical violence (66%); 57% reported their experiences to family, friends or authorities, whereas the remainder kept silent. Women who were exposed to domestic violence had higher frequencies of reported physical symptoms than those who were not exposed. Generally, analyses showed that women's education levels, work status, health status, and familial violence predicted domestic violence (Usta 2007).

Another survey conducted with 500 women aged 18-50 years in the Zigzag area of Egypt collected data on the socio-demographic characteristics of the women and men living there. The interview also looked at the husbands' attitudes, habits, and history of chronic illnesses. The questionnaire also looked at the types of domestic violence encountered, women's reactions to it, and its bearing on the mental health of the females. The results found that 62.2% of the women experienced domestic violence, the most common form was psychological abuse (74.0%), social (26.8%), physical (22.4%), and sexual (19.6%). A significantly higher percentage of women who were younger, non-educated, low income, and those having any property ownership were more exposed to violence. Husbands who were younger, non-educated, drug abusers, skilled-

workers, and with a positive history of chronic illness and family troubles were more likely to be abusive. Most women said they reacted to violence by screaming or crying loudly, with a smaller percentage seeking help from the police or medical community. The most frequent issues encountered with exposure to violence included anxiety (69.2%) and depression (52.2%) (Fahmy 2008).

Another study in Egypt examined sexual abuse experienced by married Egyptian women. Conducted in clinics and hospitals, the study interviewed 936 married women from the Dakahlia Governorate between the ages of 16 and 49. The most commonly reported sexual frequency was two to four times a week. 36.2 % of women thought this was too often, and 11.5% reported sexual abuse. Education levels of the women, genital cutting, gynecological health care access, and a history of gynecological interventions had a significantly or highly significant association with sexual abuse. This study also found that the husbands' level of education and age were highly associated with sexual abuse, especially if the man is illiterate, smoked, or used drugs (Elnashar 2007).

In Saidon, Lebanon, 349 pregnant women in an antenatal clinic were interviewed for domestic violence during pregnancy. 240 women (68.8%) had a history of at least one form of physical, emotional, and sexual abuse in their marriage. 40 women (11.4%) experienced partner violence during their current pregnancy. Violence during the pregnancy was strongly associated with previous issues with physical, emotional, and sexual violence (Hammoury 2007).

In Arda Medical Centre, Omdurman, Sudan, 394 married, literate women were interviewed between October 2001 and February 2002. 164 women (41.6%) experienced some form of violence. Of the 525 reported violent episodes, 194 instances were controlling behavior, 169 were threatening behavior, and 162 were physical violence. The frequency of these episodes ranged from 1 (25%) to >6 (20.7%). 27 women said they were victims of abuse during their pregnancy. Women noted that they tried to defend themselves with crying, resistance, and staying quiet (Ahmed 2003).

The WHO managed to undertake a ten country study on women's health and domestic violence. Conducted between 2000 and 2003, 24,097 women between the ages of 15-49 were interviewed about personal experiences with physical and sexual violence. When all of the results were pooled and analyzed, significant association was found between experiences with intimate partner violence and self-reported poor health (Odds ratio of 1 to 6). There was also a correlation with health problems reported four weeks earlier, such as difficulty walking (1 to 6), problems with daily activities (1 to 6), pain (1 to 6), memory loss (1 to 8), dizziness (1 to 7), and vaginal discharge (1 to 8). In all areas, previous reporting of intimate partner violence by women correlated with higher rates of emotional distress, suicidal thoughts (2 to 9), and suicidal attempts (3 to 8) (Ellsberg 2008).

A 2006 study on domestic violence against women in Egypt revived the 1995 Egyptian Demographic and Health Survey, which was a nationally representative household survey. In the study, 6,566 married women age 15-49

responded to both the primary questionnaire and the additional women's component. Thirty-four percent of the sample had ever been beaten by their current husband, and sixteen percent had experienced abuse in the last year. Women who had ever been beaten were more likely to report health problems than those that had not been abused. However, those that were beaten more often had lower uses of female contraception and had lower cases of ante-natal care ($OR = 0.17$, $p < 0.05$) (Diop-Sidibé 2006).

Recognition by medical community

One other major issue regarding domestic violence that was brought to light by a Sudanese study is that the medical community may not recognize domestic violence as an issue. Out of 142 doctors who received the questionnaires, 102 returned it giving a response rate of 71.8%. The respondent's ages ranged from 25-54 years; 53 were female (51.9%); and 32 (31.3%) had experience of more than 10 years. Forty-three doctors (42.1%) had a fair knowledge of the concept of domestic violence, 28 (27.4%) viewed it as a worthwhile health problem and 21 (20.5%) reported encountering 1-2 cases in the last year. Barriers to screen cases included a lack of knowledge and training, insufficient time at clinics and fear of problems with perpetrators. The female gender and long professional experience had positive correlations with a better knowledge regarding violence and the desire to intervene beyond physical treatment ($P<0.005$) (Ahmed 2003). The high risk of domestic violence and it's correlation with poor health issues in the affected women cause this to be a

serious issue in Middle Eastern countries. Health workers should be aware of rates in their area if they are to effectively work with and treat local women.

Legal reaction to honor killings

Another study in Jordan reviewed 16 cases of honor killings in 1995. Honor killings is a term used to describe the murder of a woman when she is believed to have brought dishonor upon her family. While the marriage status made a difference in the sentencing, no concrete opinion on honor killings was revealed. The verdicts varied from almost complicit approval of the act to strict condemnation. Sixty percent of those deaths occurred by multiple gunshot wounds. If the victim was a single, pregnant female, the offender was likely to be acquitted of the murder or receive a reduced sentence. The majority of these murders were committed by the brother of the victim. The actual sentences varied from none to life with hard labor. However, the verdict tended to be harshest if the victim had married without the family's consent (Hadidi 2001).

A 2002 study of honor crimes across the Arab world conducted a review of all court files of women murdered during 1995 in the country of Jordan and the social norms and sanctions against people who enacted violence against women. It sought to understand the cultural context in which violent crimes against women were committed and how the legal and social communities reacted. Of 89 homicide cases reviewed, 38 involved female victims. Analysis of the court files of the 38 murdered women indicated that a male relative of the female victim, primarily the brother, committed the majority of the murders. The most common cause for the murders provided in the files was "honor crime." Honor crime was

defined as crime committed against women by their male family members because the women had violated the honor of their family. Cultural norms and practices including the legal practices related to honor crimes support the practice of killing women for sexual misconduct and excuse perpetrators of the crimes from punishment (Kulwicki 2002).

Summary of Domestic Violence Issues

These studies show that domestic violence is a serious and pervasive issue in the health of women in Middle Eastern countries. The overall ideas that can be gleaned from these domestic violence studies are that men who held lower status levels and less educated were more likely to resort to physical violence. However, IPV can be found at all levels within the community. Domestic violence can also occur in relationships in which the husband is substantially subordinate to the wife—either economically or through education.

Women who had lower education and self esteem levels are more likely to be abused. Stress, unmet gender role expectations, conflicts with other family members (especially the husband's), and alcohol or drug abuse also tend to lead towards IPV. Women who lived with abusive men were more likely to normalize the behavior and find excuses for their abuser. Education of both sexes and empowerment programs are suggested as ways to prevent future physical violence as the levels of violence were only shown to be reduced when both parties were educated. In addition, social change is needed to decrease the instances of this dangerous practice. Active recognition of domestic violence as a

problem by both the community-at-large and medical clinicians is needed for instances of IPV to drastically decrease.

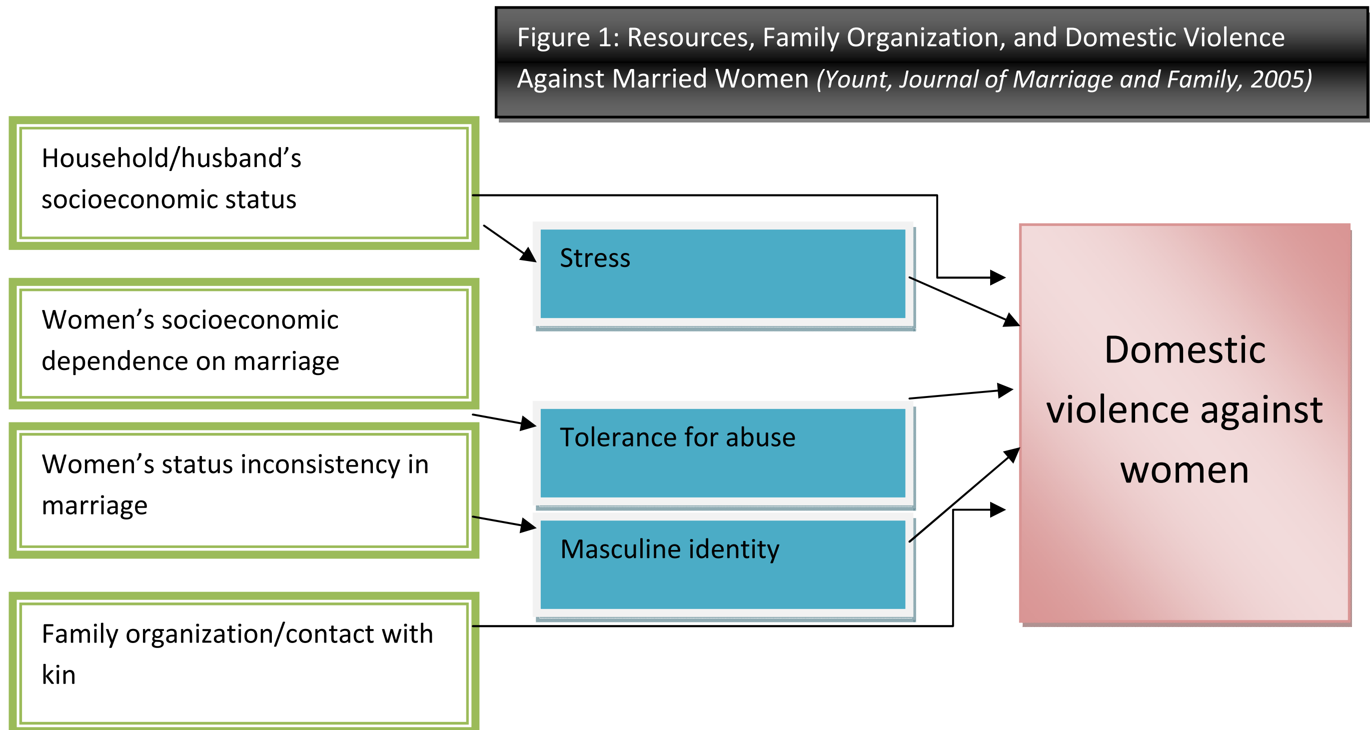

Figure 1: Resources, Family Organization, and Domestic Violence Against Married Women *(Yount, Journal of Marriage and Family, 2005)*

Conclusion and Discussion

The primary goal of this literature is to show the lack of available resources or understanding of the mental health issues facing women in Arabic countries. The high risk of developing a mental illness, being physically abused, or in having limited to no mental health care greatly affects the quality of life of the female members of Arabic countries. These inequalities affect all areas of life from

childhood to death. Increased access to health facilities, changes in social structure that support a woman's right to safety and better understanding and recognition of emotional issues are all needed. Further research is also required on all of these topics in order to have a better understanding of what programs are needed or may be the most effective.

These issues are engrained in many of the Arabic societies. Thus, the cooperation of politicians and governments, societal leaders, and other major players must be engaged if any meaningful understanding or change is to take place. The Western psychiatric and psychological views exhibited in these papers must be tempered with the values of the individual societies in order to create effective resources for those at risk. In addition, resources published in native tongues (or in any other language that English) should be considered when proposing interventions. Other databases than PubMed might also be used to gain a better understanding of additional existing literature.

Also, one should recognize that most of these aforementioned studies focus on particular countries or on particular areas of one country. The wide diversity of social and economic structures found in the Middle East should also be considered in any future actions or research.

It is also worth noting that many of these studies primarily focus on whether or not a particular mental health test is valid for use in a given country. These do not provide any insight into why a particular illness or issue might be common in a particular area, nor does it note how to prevent or treat them. Thus, it reveals an area that needs to be studied.

Due to the lack of studies across countries and topics, this paper points how great of a need there is for further research. A woman's mental illness is more than a personal tragedy--it represents an enormous cost to her nation, her community, and her family. Her ability to care for and nurture her family and her productivity both inside and outside of the home greatly diminish. Learning more about how female mental health issues are handled, the access women have to quality care, the levels and acceptance of domestic violence, and issues surrounding post-partum depression across Arabic nations are just a few of the topics that can be used to increase the quality of life of Arabic women.

Limitations

There were several limitations inherent in this literature review. First, there is a dearth of articles written about women in Arabic countries. Even among the articles that have been published, many focus on only a few countries. Thus, some countries have little to no data available.

In addition, this review only included articles that were published in English and were placed on the PubMed database. Some articles were found written in Arabic or other languages which the researcher was unable to understand. Thus, they were left out of the search. It is possible that these articles might have included relevant information.

In addition, while some of these studies had large sample sizes, few have population-based representative sampling techniques. Thus, there are limits to

the extent in which these findings can be broadly applied to an entire country or region. These articles also focus heavily on the perspective of conservative, Islam communities. Consequently, other religious or non-religious groups, such as Christian, Jewish, or Atheist communities, may have very different social organizations and health outcomes.

It is also difficult to account for the cultural bias of the authors of these articles. That bias could account for the questions asked. In any case, the studies do focus on a conservative view of gender roles that show power differentials and negative health outcomes. Do to the diversity of the Middle East, and given that many of these articles come from more educated nations, it is likely that these schisms are a great deal larger.

Some of these articles are also more than five years old. Given the cultural and social demographic changes in some Arabic countries over this time period, it is possible that the cultural assessments are no longer as valid.

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Appendix A Initial Search Results

Search Term	Articles Yielded	Articles Selected
"access to care"	10	2
"chronic disease"	14	
"diabetes"	5	
"domestic violence"	18	18
"gender and depression"	13	10
"hypertension"	2	
"infectious disease"	4	
"life expectancy"	3	
"nutrition"	5	
"postpartum depression"	11	11
TOTALS	**85**	**41**

Note: All search terms included "AND (arab OR egypt OR iraq OR jordan OR lebanon OR saudi arabia OR syria OR yemen OR libya OR sudan OR morocco OR tunisia OR kuwait OR algeria OR UAE OR bahrain OR qatar OR oman OR mauritania OR somalia OR palestine OR djibouti OR comoros OR middle east)"

Appendix B Final Search Results

Countries	Number of Articles
Djibouti	1
Egypt	5
Ethiopia	2
Iran	7
Israel	1
Jordan	3
Lebanon	4
Morocco	1
Multiple Countries	5
Sudan	1
Syria	3
Tunisia	2
Turkey	5
United Arab Emirates	1

Topics	Summary	Nations where studies were conducted
Abuse	men who are blue-collar and less educated are more likely to approve of IPVAW; women living with an abusive husband were more likely to normalize and excuse spousal abuse; education and empowerment interventions recommended; prevalence of wife beating only lower when both parties are educated; but more educated women overall experience less beatings; seen as a societal problem--education of entire society needed to change behavior	Iran, Jordan, Egypt, Multi
Access to care	women at greater risk of developing mental disorders; women are more stigmatized; informal access to care and payment hurts government from knowing where to take action (Turkey); women have less access to care; there are multiple social barriers to accessing care; social issues must be addressed in order to better access to care--decrease of stigmatization; change in attitudes of doctors towards female patients	Turkey, Tunisia, Egypt, Jordan, Dijibouti
Aging/Life expectancy	Comprehensive; see study by K. Yount	
Anxiety	lack of information on anxiety disorders in Arabic world; women experienced higher anxiety and somatic symptoms compared to men who attempted suicide, but no signficant differences; possible corolation between signficiant life events and breast cancer	Multi, Iran, Israel
CD-diabetes	Main sociodemographic factors affecting diabetes knowledge= old age, low level of education & limited family income.; family history has positive impact on knowledge of; higher rates of metabolic syndrome in women than men; education has only positive association on decreasing risk;	Iran, Saudi Arabia, Kuwait, Israel
CD-hypertension	equal association between self reported hypertension and hpyer cholesterolaemia significantly associated with MI and diabetes for both sexes; diabetes and hypertension becoming major problems for women in Turkey.	Jordan, Turkey

Topics	Summary	Nations where studies were conducted
CD-arthritis	psoriatic arthritis in men not statistically different from women; not many sex-differentiated studies on arthritis	Iran
Chronic Disease	women use 'modern" meds more often; differences between men and women in morbidity and disability; economic differences = women use more medication; females in turkey had poor behaviors (exercise, eating habits and weight control)--chronic issues had the largest impact; among women, higher rates due to circulatory disease, cancer and diabetes mellitus; predictors of depression for women are heart disease, hypertension, and kidney disease; no difference in trauma patients between sexes; diabetes knowledge affected by old age, low level of education and limited family income; low income can equal poor pt./doctor communication and pt. ability to self manage; relative with chronic disease=increase in pt. knowledge; multiple studies focusing on one particular illness; socio economic features effected almost across the board knowledge	Palestine, Syria, Turkey, Egypt
Cognitive functioning and impairment		See paper by K. Yount
Domestic Violence	doctors tend to not recognize or treat DV; low status, low self worth, competetence, autonomy, income, sense of security (economic, physical and psych) = higher rates of and acceptance of DV; sense of family respect connected to impressions of and rates of DV; Conflict management by women=negotiation, taking initiative, and passive resignation; low level of education	Sudan, Jordan, Lebanon, Iran, Egypt, Turkey, Syria,

Topics	Summary	Nations where studies were conducted
Gender and depression	Depression predictors in women were heart disease, hypertension, and kidney disease; social economic also played a part in both sexes; illiteracy, headaches, lumbar pain, varicose veins and depression more frequently reported among women; some studies found little difference between depression rates of women and men; women can have mroe severe pyschological reactions to violent events	Egypt, Turkey, Syria, Lebanon, Iran, Ethiopia, Multi
HIV/AIDS	Harm reduction strategies have proven some success; however, no big difference in rates between women and men subcoming to the illness.	Ethiopia, Iran
Post partum depression and resilience	multiple studies of tests of PPD; postpartum blues frequent; postpartum psychosis	Turkey, Tunisia, Iran, UAE, Lebanon, Morocco