

# The mental health needs of immigrant workers in Gulf countries

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**The oil-rich member states of the Gulf Cooperation Council (GCC) attract large numbers of migrant workers. The reported rates of psychiatric morbidity among these migrant workers are higher than among nationals, while the mental health services in the GCC countries remain inadequate in terms of both staff and service delivery. The multi-ethnic origin of migrants poses considerable challenges in this respect. The development of mental illness in migrants, especially when many of them remain untreated or inadequately treated, results in their premature repatriation, and the mentally ill migrant ends up facing the same economic hardships which led to migration in the first place. The availability of trained interpreters and transcultural psychiatrists, psychologists and social workers should make psychiatric diagnoses more accurate. Suitable rehabilitation services are also needed.**

Migration and the international mobility of labour have made the Arabian Gulf a unique part of the world. The oil-rich member states of the Gulf Cooperation Council (GCC) – Saudi Arabia, Kuwait, Bahrain, United Arab Emirates (UAE), Oman and Qatar – attract the largest number of international migrants after the European Union and

North America. This has given the GCC countries a unique demographic make-up, where local indigenous populations often constitute a minority of inhabitants. However, despite its overwhelming importance for economies and societies, the mental health of these migrants is underdocumented, underresearched and underreported.

## Demographic characteristics of the GCC countries

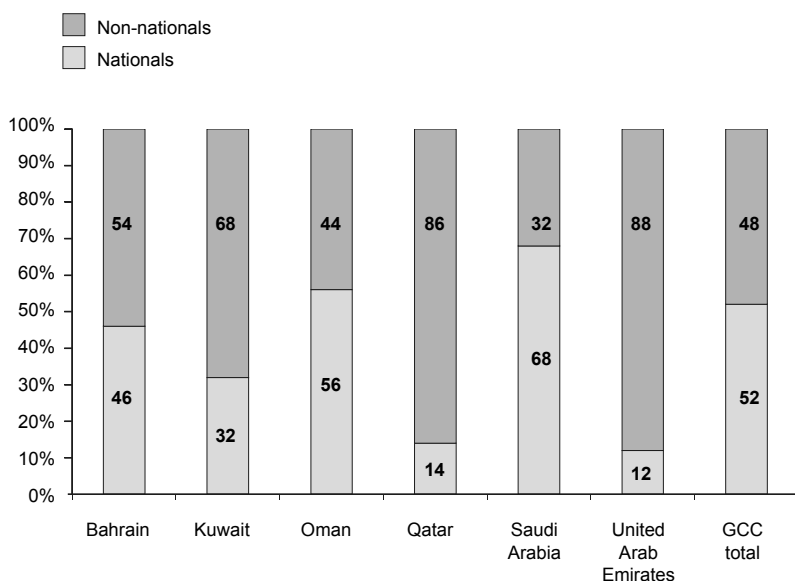
Overall, migrants make up almost half (48%) of the population of the GCC countries (Fig. 1). However, this population parity is mainly accounted for by Saudi Arabia, the most populous of the GCC states, and, to a lesser extent, Oman, where nationals marginally outnumber the migrants. In the remaining four GCC countries, the proportion of migrants ranges from 54% (Bahrain) to 88% (UAE). Most migrants come from the Indian sub-continent and the Middle East. ‘Service workers’, including housemaids and non-skilled workers, constitute the largest subgroup, accounting for about a third of the workforce.

## Mental health services in GCC countries

Mental health services in the GCC countries are provided free of charge for the local population while nominal charges are levied on expatriates. Although efforts to develop modern multidisciplinary mental health services are underway, the services remain inadequate in terms of both staff and service delivery (Table 1). The number of psychiatrists per 100 000 ranges from 0.3 (UAE) to 8.2 (Bahrain) and the number of beds per 100 000 ranges from 1.7 (UAE) to 33 (Kuwait). The shortage of allied mental health professionals, including psychologists and social workers, is even greater. The number of social workers per 100 000 ranges from 0.07 (Oman) to 2.9 (Saudi Arabia). The provision of mental health services is largely hospital based, with out-patient clinic facilities in some selected general hospitals. There have been recent moves towards decentralisation of services with stepwise expansion to the level of primary health clinics. The unique population demographics of the GCC countries pose considerable challenges for the already insufficient resources for provision of mental health services in the host countries.

## Mental health of migrants in GCC countries

Migrants’ mental health in the GCC countries remains underinvestigated and few studies have addressed this important subject. A Scopus literature search, for instance, using the search terms



**Fig. 1**

Percentage of nationals and non-nationals in member states of the Gulf Cooperation Council (GCC). Figures for around 2010. Source: Most recent national data from the database of the Gulf Labour Markets and Migration (GLMM) programme (2013), European University Institute (EUI) and Gulf Research Center (GRC). Updated 8 November 2013

**Table 1**

Psychiatric services (beds and professionals per 100 000 population) in Gulf countries

	Hospital beds	Psychiatrists	Psychologists	Social workers
Kuwait	32.78	2.62	2.29	0.66
Saudi Arabia	11.43	2.91	1.66	2.9
Oman	2.2	2.31	0.17	0.07
Qatar	3.98	1.66	1.26	0.46
Bahrain	28	8.18	0.5	0.87
United Arab Emirates	1.7	0.3	0.51	0.25

Data from World Health Organization (2011).

'GCC countries AND mental health OR mental disorder' and 'refugees AND mental health OR mental disorder' for the period 2010–13 revealed 8 and 291 citations, respectively. Zahid *et al* (2002, 2003, 2004), in a 2-year prospective study of hospitalised housemaids, reported that psychiatric morbidity was twice as common among them than in the local population. The researchers identified pre-immigration risk factors and precipitating factors, and described the nature of psychiatric disorders in this subgroup of immigrants. The pre-immigration risk factors included a history of psychiatric disorder, physical illness or hospitalisation. Almost half (48%) of the housemaids required interpreter assistance for assessment. Stress-related disorders were the commonest (49%) type of disorder; more than half of the housemaids had a breakdown within the first 3 months of their arrival; and the lack of contact with the family back home and harassment at work were identified as the commonest precipitating factors. Most (81%) of the housemaids were prematurely deported following their discharge from hospital (Zahid *et al*, 2002, 2003, 2004). Many housemaids, especially those with young children back home, and engaged in looking after employers' young children, may experience guilt for having 'abandoned' their own (similar) children. Such a conflict may add to the distress of the already homesick housemaid. In another study, from the UAE, rates of depression and suicidal ideation were found to be higher in immigrant workers than in the native population (Al-Maskari *et al*, 2011). In view of the sample selection bias inherent in these studies and the dearth of methodologically sound studies, it is difficult to draw firm conclusions.

Given the psychosocial stresses surrounding the act of migration, coupled with the adjustment difficulties in the new environment, a considerable number of migrants develop mental illness. It is possible that many migrants with mild to moderate mental illness, especially in the absence of significant occupational impairment, simply pass unnoticed. The development of mental illness in migrants, especially when many of them remain untreated or inadequately treated, results in their premature repatriation. In addition to causing considerable inconvenience to the employer, mentally ill migrants end up facing the same economic

hardships which led to their migration in the first place. The resultant migration failure perpetuates their difficulties as they have now to pay back the considerable sum of money, usually borrowed, paid to the immigration agent prior to the migration.

### Mental health needs of migrants

The atypical presentation of some psychiatric disorders in migrants coupled with the reported mismatch between the various diagnostic criteria and phenomenology of the disorder, as described by migrants who are mentally ill, within the specific cultural context, present unique challenges for mental health service providers. Depressive illness in migrants, for example, has been reported to present with comorbid somatoform, anxiety and dissociative features (Saraga *et al*, 2013). The diagnostic process is further complicated by the cultural differences between the migrant and the therapist. All cultures develop processes that facilitate adjustment and conflict resolution, as well as pressures that foster conflict, deviation and maladjustment, defining thereby the spectrum of 'normal behaviours' as well as thresholds for tolerance of psychosocial stresses resulting in 'abnormal behaviour'. Similarly, the culture-specific stresses and the beliefs and rituals used to cope with psychological tension underline the importance of diversifying the mental health staff resources in the GCC countries to include professionals familiar with, and sensitive to, the culture-specific spectrum of behavioural disturbances in subgroups of migrants with mental disorder. In a survey of European migrants, most thought that healthcare providers underestimated their language problems and that language difficulties made them more aggressive and paranoid towards the care provider (Watters, 2002). The availability of trained interpreters, transcultural psychiatrists, psychologists and social workers should make psychiatric diagnoses more accurate. Suitable rehabilitation services will help migrants receive mental healthcare and thereby gain either re-employment or settlement of deportation terms as stipulated in their contract of employment.

A rising demand for highly skilled people will increasingly expose the GCC states to what has become a global competition for talent. Nonetheless, low-skilled or unskilled manual workers will also be needed due to non-availability of local nationals to carry out such jobs. It is time now to regulate the flow of migrants, with stringent controls on recruitment procedures. Pre-immigration orientation programmes aimed at familiarising migrants with their prospective job responsibilities, and basic linguistic instruction, can help allay some of the anxieties related to working conditions in the new environment. Similarly, facilitation of regular contact with families back home, especially during the first few weeks after arrival, may help minimise psychiatric breakdown and migration 'failure'. Lastly, given the limitations of the GCC countries in coping with the multicultural mental healthcare needs of migrants, collaboration with

organisations such as the Red Cross and Red Crescent may help overcome some of these difficulties.

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GUEST  
EDITORIAL

# What's so special about military veterans?

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**The mental health of military veterans has been, and continues to be, a topic of heated political and journalistic debate. There is a well-documented impact of conflict upon the mental health of service personnel, and most nations have aimed to provide effective care for individuals who have fought for their country. However, as the three thematic papers in this issue demonstrate, the realities of service-related mental health are rather more complex than they initially appear.**

The mental health of military veterans has been, and continues to be, a topic of heated political and journalistic debate. Because of the well-documented impact of conflict upon the mental health of service personnel (Hunt *et al*, 2014), most nations have, for wholly understandable reasons, aimed to provide effective care for individuals who have fought for their country. Thus the argument for nations providing services for the mental health of war veterans, whether arising out of gratitude or of moral duty, seems to be simple common sense.

However, as the three thematic papers in this issue demonstrate, the realities of service-related mental health are rather more complex than they initially appear. First, it seems that although one might expect the main burden of operational stress injuries to occur during or soon after deployment, while individuals are still serving, it appears that mental health problems may in fact be more common once personnel have left service, months or years later.

Secondly, most of the authors note that the link between deployment and poor mental health is less clear than might be expected. There is now considerable evidence that soldiers who have served

on peacekeeping (rather than combat) operations also experience traumatic stress-related disorders (Greenberg *et al*, 2008) and indeed that a significant proportion (about half) of post-traumatic stress disorder (PTSD) in the military is not related to deployment (Jones *et al*, 2013).

Thirdly, while not discussed in detail in the thematic papers in this issue, there is considerable evidence that pre-enlistment factors such as childhood adversity and sociodemographic factors significantly affect the risk of developing mental health problems during or after service. For instance, a UK study of post-deployment violence showed that pre-enlistment violent offending was the most influential risk factor (adjusted hazard ratio 3.85), whereas deployment itself was not an independent risk factor (MacManus *et al*, 2013).

Fourthly, while the debate about veterans' mental health often appears to centre on how to increase the scope, efficiency or availability of mental health services for veterans, there is considerable evidence that most veterans who suffer with mental health problems do not in fact seek any help at all for them. This lack of help-seeking seems to result both from a lack of recognition of the existence of mental health problems and from fears or concerns about the consequences of seeking help, which may be practical (e.g. regarding the impact of receiving treatment for a mental health problem on career prospects) or perceptual (e.g. regarding self-perception as a resilient person or the perceptions of others). Research has shown that these concerns are not in any way unique to the military and a reluctance to seek help seems just as common within the general population as among those who have served in the military.

Lastly, there seems to be a general consensus among researchers that the process of transition