



# Adaptation and Innovation in Spiritual-Psycho-Social Support of Displaced Muslim Refugees

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## Abstract

There are over 26 million refugees worldwide, and the majority are Muslims who hail from diverse cultural and geographical backgrounds. It is widely recognized that refugees are at high risk for mental health concerns and are in need of cultural and psychological adaptations to improve their well-being. Given the paucity of data in religio-spiritual adaptation using psychological interventions, the authors propose developing a religio-spiritual training resource that could help humanitarian aid workers and other professionals understand the needs of displaced Muslim refugees (Al-Nuaimi & Qoronfleh, 2020). Here, the authors present a religio-spiritual model that uses evidence-based psychological interventions to provide transcultural religiously and spiritually driven psychological care for displaced Muslim refugees.

**Keywords** Muslims · Refugees · Mental health · Psychological intervention · Psychosocial training

## Refugees and Mental Health

According to the United Nations High Commissioner for Refugees (UNHCR), there are over 84 million displaced individuals, of which 26.6 million are refugees (UNHCR, 2021). Of these, half are displaced from Muslim-majority countries including Syria, Afghanistan, Sudan, Somalia, and Iraq (Lipka & Hackett, 2017). However, this excludes 5.7 million Pal-

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estinian refugees according to the United Nations Relief and Works Agency for Palestine Refugees-UNRWA (UNRWA, 2021). Muslim-majority countries are also the main host countries for refugees. Currently, Turkey, a Muslim-majority country, is the largest host country, with about 3.7 million refugees (UNHCR, 2021).

Refugees are at high risk of developing and suffering from mental health disorders. This is understandable given the various dimensions of loss they experience as well as adjustment difficulties. The literature is quite clear that refugees have high rates of post-traumatic stress disorder (PTSD), depression, and anxiety disorders (Fazel et al., 2005; Tempany, 2009). One may believe that these mental health challenges will simply resolve when the refugees resettle and adjust to their new environment or the situation in their home country resolves and they can resume “normal life” within a reasonable time frame. Unfortunately, this is a rare outcome. Refugees spend more than 20 years on average before they can go back to their home countries (UNHCR, 2015), which is hardly a reasonable time frame. Furthermore, refugee resettlement and adjustment to a new life do not seem to resolve their mental health problems. Long-term mental health studies reveal high rates of depression, trauma-related disorders, and anxiety disorders even many years after resettlement (Bogic et al., 2015).

## Religion, spirituality, and mental health

It is important to recognize that the dominant theory and practice of mental health care, including psychiatry and psychology, has emerged from Western cultural perspectives and understandings of the human conditions (Kenrick et al., 2009). The most prominent aspects of such philosophies include dualism, positivism, and reductionism (Fernando, 2016; Sarafino, 2008). These philosophical underpinnings of modern medicine have contributed to the secularization and removal of religion and spirituality from the study of mental health in the scientific community. While no one can doubt that these concepts have provided very powerful frameworks in the treatment and management of mental disorders, they have also brought significant challenges when applied in non-Western cultural settings (Aroche & Coello, 2004; Fernando, 2014). Positivism, in particular, represents a major challenge for Muslims and other groups of people that accept other forms of knowledge, specifically divine knowledge (theology), as important in their lives. Positivism is an empiricist philosophical theory that affirms that all factual knowledge is based on “positive” data—that a posteriori knowledge is derived from sensory experience only. Beyond this knowledge lies only pure mathematics and pure logic. Therefore, positivism is inherently secular, anti-theological, and anti-metaphysical (Feigl, 2021).

The scientific community has only recently started to study the relationship between religion/spirituality and health (Koenig, 2004; Koenig et al., 2012). Studies have clearly demonstrated the positive impact religion and spirituality have on our mental well-being. Greater religiosity or spirituality is associated with lower rates of depression and reduced risk of suicide (Cotton et al., 2006). Similar findings have also been reported in a study of depressed Afghan refugees, where a higher degree of religiosity was associated with less suicidal planning or attempts (Jahangir et al., 1998). Furthermore, religiosity and spirituality may help individuals cope with life stressors (Bonelli et al., 2012; Silton et al., 2014.) and are associated with fewer symptoms of post-traumatic stress (Arevalo et al., 2008). In other

situations, such as natural disasters, increased religiosity has been a potential buffer from the distress that arises from such disasters (Stratta et al., 2013). In addition, religiosity reduces signs of prolonged grief, suicidal behavior, nightmares, and other physical and mental illnesses that occur after death and burial ceremonies (Rosenblatt et al., 1976).

## Adaptation and innovation

Bernal et al., (2009) define cultural adaptation using aligned interventions as “the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that is compatible with the client’s cultural patterns, meanings, and values.” Religious and spiritual adaptations to psychotherapy provide some evidence that such adaptations are beneficial to individuals (Smith et al., 2007).

Muslim-majority countries have diverse cultures with differences in languages, customs, and traditions (Kenrick et al., 2009; Lipka & Hackett, 2017). However, they all share Islam as a religion and way of life. We propose to develop a transcultural, religio-spiritual, and psycho-social training manual by using Islamic theological and prophetic traditions in established psycho-social training protocols to provide guidance for trainers and aides working with displaced Muslim refugees. The preliminary framework for such a training manual has been published (Al-Nuaimi & Qoronfleh, 2020).

Various adaptation models discussed in the literature include the ecological validity model (EVM) that guides cultural adaptations across eight dimensions—persons, language, metaphors, content, concepts, goals, methods, and context—and generates high ecological and external validities of an intervention (Bernal et al., 1995). Another model that provides greater depth regarding the intervention process is called the heuristic framework for cultural adaptation (HFCA). HFCA proposes a frame of reference for conducting adaptations that includes information gathering, preliminary adaptation design, preliminary adaptation tests, and adaptation refinement (Barrera & Castro González, 2006). This framework also allows the integration of dimensions from other models in a systematic and operational manner (Ferrer-Wreder et al., 2012).

The design implementation monitoring and evaluation (DIME) model offers a comprehensive framework for humanitarian organizations that culturally adapts to mental health interventions (Applied Mental Health Research Group, 2013). The DIME approach incorporates qualitative methodologies such as involving experts, community members, and leaders in the cultural adaptation process itself (Applied Mental Health Research Group, 2013). However, despite the strengths of the DIME, it does have major drawbacks, such as being resource and time intensive. Finally, the cultural sensitivity (CS) model proposes that changes can be made to the surface (content and messages) and deep (relationships, social, cultural, and historical environments) structures that influence health behaviors of an intervention (Resnicow et al., 2000). One of the main challenges of these models is the lack of specific processes that describe how to culturally adapt an intervention. Furthermore, there is no evidence to suggest that one model is better than another model for cultural adaptation (Domenech Rodríguez & Bernal, 2012).

We intend to use the Perera et al., (2020) model, which combines aspects of other models, including the EVM, HFCA, and DIME models and is based on a four-step process to adapt a low-intensity psychological intervention in humanitarian settings. The four steps are

information gathering, adaptation hypotheses, local consultation, and external evaluations. We propose utilizing this four-step process to religiously and spiritually adapt the psychosocial interventions of two evidence-based training manuals to provide low-intensity psychological interventions for Muslim populations afflicted by an emergency setting. The two training manuals to be adapted are the Mental Health Psycho-Social Support training manual developed by the World Health Organization (WHO) and the Community-Based Psychosocial Support Training Kit developed by the International Federation Reference Centre (IFRC) for Psychosocial Support.

### **Step 1: Information gathering**

The first step in the four-step process to develop the manual involved gathering peer-reviewed and non-peer-reviewed literature (by the lead author) to accomplish the following:

- listing pertinent and important psychological and psychosocial interventions used for displaced Muslim refugees,
- documenting established and proposed work in religious-spiritual adaptation of psychological interventions for afflicted Muslim populations, and,
- reviewing the classic Islamic theological sources and references related to psychology, mental health well-being, refugees, displaced persons, and crisis/emergency settings. This part was completed by a religious scholar (Imam) in the Ministry of Religious Affairs (Qatar) who is bilingual in Arabic and English.

In addition, we completed focus group discussions with various Muslim professionals working with Muslims affected by an emergency situation or refugees. These included mental health psychosocial specialists working with the WHO in Syria and Iraq, mental health practitioners from North America and Europe, and local consultants with Qatar Red Crescent (QRC) project managers and program implementers.

### **Step 2: Adaptation hypotheses**

We reviewed the Mental Health Psycho-Social Support Training Manual for Psycho-Social Workers in Iraq and Syria (World Health Organization, 2018) and the Community-Based Psychosocial Support Training Kit (International Federation Reference Centre for Psychosocial Support, 2009) to identify components that could be adapted for our manual. These components will then be cross-referenced with the classic Islamic theological sources drawn on step 1, and the draft manual will be printed in English and Arabic and given to the expert focus groups for local consultation (step 3).

### **Step 3: Local consultation**

Local consultation involves discussion with religious leaders, mental health professionals, and implementing partners (such as Qatar Red Crescent), which will allow for a rigorous review of the material in the draft manual.

## Step 4: External evaluations

This validation will be done differently compared to Perera et al., (2020) and will involve a robust comparison of current secular interventions to establish the utility of the proposed manual in the field. The draft manual will be tested in the field in two phases. The first phase will consist of a field pilot study that will test the efficacy and effectiveness of the manual. In the second phase, randomized control trials will be conducted at multiple sites to compare the training manual's outcomes to current standard interventions.

## Examples of similar approaches

The availability of culturally sensitive and faith-informed resources at an appropriate level of detail will result in resilience and other beneficial outcomes. Indeed, the value of using faith-based approaches is recognized in crises involving Muslim refugees. We offer here two examples that demonstrate successful initiatives.

*Example 1 COVID-19 crisis:* There has been an effort to reestablish the role of faith-based organizations within global health programs. The National Muslims COVID-19 Response Committee in Kenya has used verses and sayings from Islamic texts to help Muslim communities understand the COVID-19 pandemic better and encourage people to adhere to public health measures (<https://www.devex.com/>).

*Example 2 Mental health crisis:* There is mounting interest in integrating religiously informed approaches and/or interventions in distressed communities. For instance, two organizations (the Lutheran World Federation-LWF, and Islamic Relief Worldwide-IRW) have published a faith-based mental health guide titled *A Faith-Sensitive Approach in Humanitarian Response: Guidance on Mental Health and Psychosocial Programming* (IRW and LWF, 2018), which proves the acceptance of spirituality by mainstream international agencies and humanitarian projects.

## Conclusion

Muslim refugees, like all other refugees, are at high risk of suffering from mental illnesses. Though Muslim refugees come from diverse backgrounds, cultures, ethnicities, and geographic locations, they all subscribe to Islam and believe in Islam's inner value that can help restore mental health among refugees dealing with the agony of displacement. A transcultural, religio-spiritual, psycho-social training manual is proposed where work has been initiated for steps 1 & 2, and can be used by professionals to improve the mental health needs of Muslim refugees and displaced Muslims.

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**Data Availability** All data generated or analyzed during this study are included in this article.

## Declarations

**Competing/conflicts of interest** None. The authors declare that there are no competing interests or conflicts of interest.

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**Consent for publication** Not applicable.

## References

- Al-Nuaimi, S., & Qoronfleh, M. W. (2020). Mental health and psycho-social-spiritual support for Muslim populations in emergency settings. *Journal of Muslim Mental Health*, 14(1), 53–58. <https://doi.org/10.3998/jmmh.10381607.0014.105>
- Applied Mental Health Research Group. (2013). *Design, implementation, monitoring, and evaluation of cross-cultural HIV-related mental health and psychosocial assistance programs: A user's manual for researchers and program implementers (adult version)*. Johns Hopkins University
- Arevalo, S., Prado, G., & Amaro, H. (2008). Spirituality, sense of coherence, and coping responses in women receiving treatment for alcohol and drug addiction. *Evaluation and Program Planning*, 31, 113–123. <https://doi.org/10.1016/j.evalprogplan.2007.05.009>
- Aroche, J., & Coello, M. J. (2004). Ethnocultural considerations in the treatment of refugees and asylum seekers. In J. P. Wilson, & B. Drozdek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, and war and torture victims* (pp. 53–80). Routledge
- Barrera, M., & Castro González, F. (2006). A heuristic framework for the cultural adaptation of interventions. *Clinical Psychology: Science and Practice*, 13(4), 311–316. <https://doi.org/10.1111/j.1468-2850.2006.00043.x>
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Psychology*, 23(1), 67–82. <https://doi.org/10.1007/BF01447045>
- Bernal, G., Jiménez-Chafey, M. I., & Domenech-Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, 40(4), 361–368. <https://doi.org/10.1037/a0016401>
- Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15, Article 29. <https://doi.org/10.1186/s12914-015-0064-9>
- Bonelli, R., Dew, R. E., Koenig, H. G., Rosmarin, D. H., & Vasegh, S. (2012). Religious and spiritual factors in depression: Review and integration of the research. *Depression Research and Treatment*, 2012, Article 962860. <https://doi.org/10.1155/2012/962860>
- Cotton, S., Zebracki, K., Rosenthal, S., Rosenthal, S. L., Tsevat, J., & Drotar, D. (2006). Religion/spirituality and adolescent health outcomes: A review. *Journal of Adolescent Health*, 38(4), 472–480. <https://doi.org/10.1016/j.jadohealth.2005.10.005>
- Domenech Rodríguez, M. M., & Bernal, G. (2012). Bridging the gap between research and practice in a multicultural world. In G. Bernal & M. M. Domenech Rodríguez (Eds.), *Cultural adaptations: Tools for evidence-based practice with diverse populations* (pp. 265–287). American Psychological Association. <https://doi.org/10.1037/13752-013>
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: A systematic review. *Lancet*, 365, 1309–1314. [https://doi.org/10.1016/S0140-6736\(05\)61027-6](https://doi.org/10.1016/S0140-6736(05)61027-6)
- Feigl, H. (2021, Dec. 14). “Positivism.” In *Encyclopedia Britannica*. Retrieved May 14, 2022, from <https://www.britannica.com/topic/positivism>
- Fernando, S. (2014). Globalization of psychiatry—A barrier to mental health development. *International Review of Psychiatry*, 26, 551–557. <https://doi.org/10.3109/09540261.2014.920305>

- Fernando, S. (2016). *Race and culture in psychiatry*. Routledge
- Ferrer-Wreder, L., Sundell, K., & Mansoor, S. (2012). Tinkering with perfection: Theory development in the intervention cultural adaptation field. *Child & Youth Care Forum*, 41(2), 149–171. <https://doi.org/10.1007/s10566-011-9162-6>
- International Federation Reference Centre for Psychosocial Support (2009). Community-based psychosocial support: Trainer's book. PS Centre Publications. <https://pscentre.org/?resource=community-based-psyhosocial-support-trainers-book-english&selected=ingle-resource>
- Islamic Relief Worldwide (2018). Islamic Relief and Lutheran World Federation launch manual on Faith-sensitive Humanitarian Action. <https://islamic-relief.org/news/islamic-relief-and-lutheran-world-federation-launch-manual-on-faith-sensitive-humanitarian-action/>
- Jahangir, F., Rehman, H., & Jan, T. (1998). Degree of religiosity and vulnerability to suicidal attempt/plans in depressive patients among Afghan refugees. *International Journal for the Psychology of Religion*, 8(4), 265–269. [https://doi.org/10.1207/s15327582ijpr0804\\_6](https://doi.org/10.1207/s15327582ijpr0804_6)
- Kenrick, D. T., Neuberg, S. L., & Cialdini, R. B. (2009). *Social psychology: Goals in interaction* (5th Ed.). Pearson
- Koenig, H. G. (2004). Spirituality, wellness, and quality of life. *Sexuality Reproduction and Menopause*, 2(2), 76–82. <https://doi.org/10.1016/j.sram.2004.04.004>
- Koenig, H., King, D., & Carson, V. B. (Eds.). (2012). Chapter 2: Definitions *Handbook of Religion and Health* (2nd ed., pp. 37–38). Oxford University Press
- Lipka, M., & Conrad, H. (2017, April 6). “Why Muslims are the world's fastest-growing religious group”. Pew Research Center. <https://www.pewresearch.org/fact-tank/2017/04/06/why-muslims-are-the-worlds-fastest-growing-religious-group/>
- Perera, C., Salamanca-Sanabria, A., Caballero-Bernal, J., Feldman, L., Hansen, J., Bird, M., Hansen, P., Dinesen, C., Wiedemann, N., & Vallières, F. (2020). No implementation without cultural adaptation: A process for culturally adapting low-intensity psychological interventions in humanitarian settings. *Conflict and Health*, 14, 46. <https://doi.org/10.1186/s13031-020-00290-0>
- Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of Community Psychology*, 28(3), 271–290. [https://doi.org/10.1002/\(SICI\)1520-6629\(200005\)28:3%3C271::AID-JCOP4%3E3.0.CO;2-I](https://doi.org/10.1002/(SICI)1520-6629(200005)28:3%3C271::AID-JCOP4%3E3.0.CO;2-I)
- Rosenblatt, P. C., Walsh, H. P., & Jackson, D. A. (1976). *Grief and mourning in cross-cultural perspective*. HRAF Press
- Sarafino, E. P. (2008). *Health psychology: Biopsychosocial interactions* (6th ed.). Wiley & Sons
- Silton, N. R., Flannelly, K. J., Galek, K., & Ellison, C. G. (2014). Beliefs about God and mental health among American adults. *Journal of Religion and Health*, 53(5), 1285–1296. <https://doi.org/10.1007/s10943-013-9712-3>
- Smith, T. B., Bartz, J., & Richards, P. S. (2007). Outcomes of religious and spiritual adaptations to psychotherapy: A meta-analytic review. In *Database of abstracts of reviews of effects (DARE): Quality-assessed reviews [Internet]*. <https://www.ncbi.nlm.nih.gov/books/NBK73529/>
- Stratta, P., Capanna, C., Riccardi, I., Perugi, G., Toni, C., Dell'Osso, L., & Rossi, A. (2013). Spirituality and religiosity in the aftermath of a natural catastrophe in Italy. *Journal of Religion and Health*, 52, 1029–1037. <https://doi.org/10.1007/s10943-012-9591-z>
- Tempany, M. (2009). What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: A literature review. *Transcultural Psychiatry*, 46(2), 300–315. <https://doi.org/10.1177/1363461509105820>
- UNHCR (2015). World at war: UNHCR global trends forced displacements in 2014. United Nations High Commissioner for Refugees, Geneva, Switzerland. <https://www.unhcr.org/statistics/country/556725e69/unhcr-global-trends-2014.html>
- UNHCR (2021). UNHCR Mid-year trends 2021. United Nations High Commissioner for Refugees, Geneva, Switzerland. <https://www.unhcr.org/statistics/unhcrstats/618ae4694/mid-year-trends-2021.html>
- UNRWA (2021). UNRWA Health Department Annual Report 2021. United Nations Relief and Works Agency for Palestine Refugees. Amman, Jordan. <https://www.unrwa.org/resources/reports/unrwa-health-department-annual-report-2021>
- World Health Organization (2018). Standard training manual for psychosocial workers in northern Syria. [https://www.cmimarseille.org/sites/default/files/newsite/6\\_manuel\\_de\\_lara\\_world\\_health\\_organization\\_mhps\\_in\\_northern\\_syria.pdf](https://www.cmimarseille.org/sites/default/files/newsite/6_manuel_de_lara_world_health_organization_mhps_in_northern_syria.pdf)

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