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RESEARCH ARTICLE

The Relationship Between Internalized Stigmatization and Mental Health Literacy Among Syrian Refugees Using Psychosocial Services

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ABSTRACT

Background: This study aimed to examine the relationship between the internalized stigma of mental disorders and mental health literacy in Syrian refugees receiving psychosocial services.

Method: This cross-sectional, correlational study was conducted with 101 Syrian refugees living in Istanbul, Turkey. Data were collected between October 2023 and May 2024 via self-report using the Arabic-language Information Form, the Internalized Stigma of Mental Illness Scale (ISMI), and the Mental Health Literacy Scale (MHLS).

Results: While no significant correlation was found between the ISMI and MHLS, gender was a statistically significant predictor of the ISMI (R^2=0.05), with women's internalized stigma scores being statistically higher. The status of having received psychoeducation related to mental disorders was a statistically significant predictor of the MHLS (R^2= 0.05).

Conclusion: Psychoeducation could enhance mental health literacy and reduce internalized stigmatization. Future in-depth studies on internalized stigma among Syrian immigrant women are recommended.

Keywords: Community Mental Health, Health Literacy, Social Stigmatization, Refugees.

Introduction

Approximately 5.6 million Syrians have migrated due to war, and Turkey ranks first among countries hosting Syrian refugees [1]. Undoubtedly, war, migration, traumatic experiences, and adaptation to a new country pose challenges for refugees, potentially resulting in symptoms of mental disorders [2]. Providing mental health services to refugees is among the responsibilities of host countries; in Turkey, public institutions and organizations, as well as non-governmental organizations, provide these services [3]. However, in Eastern societies in particular, help-seeking behavior is affected by negative attitudes towards mental disorders. In Eastern cultures, individuals often internalize social judgments about mental disorders and therefore may experience feelings of shame. Such refugees may display low levels of mental health literacy, thereby affecting internalized stigmatization and help-seeking behaviors [4].

Originating from Ancient Greek, the term stigma means "hole," "puncture," "scar," and "black stain" [5]. Sociologically, the term 'stigmatization' is used to refer to discreditation and humiliation [6]. Although

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stigmatization has occurred throughout history, the concept has become increasingly relevant over the last fifty years. Since time immemorial, individuals with mental disorders have been the most frequently stigmatized and victimized group. During the periods in which the symptoms and causes of mental disorders were not understood, patients' behaviors commonly aroused fear and anger in others, causing more stigmatization. Unfortunately, this situation continues today [5, 7].

Stigma types are categorized as social, structural, institutional, and internalized [5]. Social stigma refers to the exposure of the stigmatized person to stereotypes, prejudice, and discriminative behaviors in society; structural stigmatization refers to the systematic stigmatization of individuals; institutional stigmatization refers to stigmatization encountered in institutions such as hospitals, workplaces, and public institutions/organizations; and internalized stigmatization refers to the internalization of social stigma and abuse. Individuals' acceptance and adoption of social stereotypes decreases their self-esteem and self-efficacy [8], and internalized stigma refers to the social and psychological effects of social stigma on individuals. People who believe that society views those with differences as worthless and rejects them may cope by isolating themselves when they display similar differences or when society attributes such differences to them [9].

Mental health literacy was first defined by Jorm et al. in 1997 [11]. The concept of mental health and its importance has been on the agenda in recent years [10]. The seven elements of mental health literacy are: the ability to recognize diseases, knowledge of how to access information about mental health, knowledge of the risk factors and causes related to mental health, knowledge of self-treatment, knowledge of how to seek professional help, the ability to seek appropriate help, and awareness-raising attitudes [10, 12]. According to Kutcher, the four components of mental health literacy are: understanding of how to achieve and maintain good mental health, understanding of mental disorders and their treatments, reduction of stigma associated with mental disorders, and increased help-seeking effectiveness (knowing when, where, and how to seek good mental health care, as well as developing the necessary competencies for self-care) [12, 13]. Increasing mental health literacy requires that individuals' mental disorders are detected at an early stage, that individuals are directed to professional help, and that individuals are restored to health through appropriate care and treatment. Increasing mental health literacy can also reduce internalized stigma [12].

In Arab and Muslim immigrant communities, mental disorders are often stigmatized, and individuals may internalize prejudices that may embarrass themselves or their families when seeking help [4]. In a study conducted by Fuhr et al. [3] in Turkey, stigmatization was reported as one of the barriers to seeking treatment for Syrian refugees. The literature shows that Syrian or Arabic-speaking refugees display low mental health literacy [14, 15]. According to a World Health Organization (WHO) report, the health literacy of Syrian refugees living in Turkey is limited, with 9.4% of refugees displaying the ability to read and understand patient rights, and 14.4% displaying the ability to write their name or provide informed consent [16]. Undoubtedly, this negatively affects the mental health outcomes of Syrian refugees [2]. Similarly, a study examining the barriers to Syrian refugees accessing mental health services in Jordan determined that refugees displayed low mental health literacy [17]. Likewise, a qualitative study

on mental health, psychosocial services, and the coping skills of Syrian refugees living in Germany found that refugees experienced barriers to accessing MHPSS services, experienced stigmatization, and displayed a lack of knowledge about MHPSS [18].

Previous studies have found a negative relationship between mental health literacy and stigmatization and have highlighted the importance of increased mental health literacy [19-21]. However, no study to date has examined the relationship between internalized stigma and mental health literacy among Syrian refugees. Therefore, this study aimed to determine the internalized stigma of mental disorders and the mental health literacy levels of registered Syrian refugees receiving psychosocial support in Turkey, as well as to examine the relationship between these two variables.

Method

Study Design

This study is cross-sectional and correlational. The reason for choosing this design is to examine the main independent variables and the relationship between internalized stigma and mental health literacy over a specified period [22].

Research Questions

The study's research questions were:

- Is there a relationship between internalized stigma and the mental health literacy of Syrian refugees receiving psychosocial support?
- Do Syrian refugees receiving psychosocial support display differences in internalized stigma and mental health literacy according to their sociodemographic and mental health-related characteristics?

Setting

The research data were collected from non-governmental organizations, such as Community Health Centers and Red Cross Refugee Support Associations, which Syrian refugees in Istanbul frequently visit between October 2023 and May 2024. The reason for choosing these centers is that refugees receiving psychosocial support can be reached more easily.

Participants

The study's research universe consisted of Syrian refugees receiving psychosocial support at designated community health centers. Because the number of individuals in the universe was unknown, data was collected between October 2023 and May 2024, resulting in a total number of 101 participants. Sample calculations may not be possible initially, especially in groups with unknown populations. The study's power can be determined after it is completed [23]. This analysis was also done to clarify whether the lack of a significant relationship in the study was related to sample size. At the end of the study, a power analysis was performed to assess the sample's representativeness, yielding a power of 0.86, a confidence interval of 0.95, a margin of error of 0.05, and an effect size of 0.30. Inclusion criteria required that participants be between 18 and 65 years of age, be of Syrian nationality, be receiving psychosocial support/care, be literate in Arabic, and agree to participate in the study. Those who did not complete the data collection forms in full or did not volunteer to participate in the study were excluded.

Measurements

Data were collected in Arabic, using self-report scales including the Information Form, the

Internalized Stigma of Mental Illness Scale, and the Mental Health Literacy Scale.

Information Form: Prepared by the researchers, this form was designed to collect information about participants' age, gender, economic status, level of education, reason for receiving psychosocial support, duration of receiving psychosocial support, medications used, duration of migration, family history, and background information regarding mental disorders [4, 24-25].

Internalized Stigma of Mental Illness Scale (ISMI) – Arabic Version: Developed by Ritsher et al. (27), the ISMI is a 29-item self-report scale that assesses internalized stigma. The scale includes five subscales: alienation (six items), stereotype endorsement (seven items), perceived discrimination (five items), social withdrawal (six items), and resistance to stigma (five items). Responses to items in the ISMI are scored on a four-point Likert-type scale, ranging between "strongly disagree" (one point), "disagree" (two points), "agree" (three points), and "strongly agree" (four points). The "Resistance to Stigma" subscale items are scored in reverse. The scale's total score is obtained by adding and averaging the scores of the five subscales. Higher scores indicate that the individual's internalized stigma is more severe. Validity and reliability of the scale in the Arabic language were conducted by Kira et al. [4]. Cronbach's alpha coefficient was 0.94 for the total ISMI score, 0.86 for alienation, 0.79 for confirmation of stereotypes, 0.81 for experience of stigma, 0.86 for social withdrawal, and 0.61 for resistance to stigma [4]. In the current study, Cronbach's alpha coefficient was 0.55 for the total ISMI score.

Mental Health Literacy Scale (MHLS) - Arabic Version: Developed by O'Connor and Casey [28], this scale consists of 35 items and measures individuals' mental health literacy. The validity and reliability of the Arabic scale used in Syria were assessed by Alshehri et al. [25], who reduced the number of items to 28. Factor analysis of the Arabic version resulted in the identification of four factors of scale: (1) attitude towards mental disorders (eight items), (2) attitude towards individuals with mental disorders (seven items), (3) diagnosis of mental disorders (nine items), and (4) knowledge of how to seek help for mental disorders (four items). A four-point Likert-type scale was used for the mental disorder diagnosis subscale. A five-point Likert-type scale was used for the remaining three subscales, with responses ranging between "strongly disagree" (1), "disagree" (2), "undecided- neither agree nor disagree" (3), "agree" (4), and "strongly agree" (5). 10, 12, 15, and 20-28 on the scale are reverse-scored, and the scale ranges from 28 to 140, with higher scores indicating greater mental health literacy. In the Arabic version, Cronbach's alpha coefficient was 0.85 for the attitudes towards mental disorders subscale, 0.89 for the attitudes towards individuals with mental disorders subscale, 0.79 for the diagnosis of mental disorders subscale, and 0.72 for the knowledge of how to seek help for mental disorders subscale. In the current study, Cronbach's alpha coefficient was 0.66 for the total scale score.

Data Analysis

Research data for this study were analyzed using SPSS 25.00, and descriptive statistics (numbers, percentages, means, and standard deviations) were used. Kurtosis and skewness values (-1.96/1.96) were used to determine whether the scale scores and numerical variables showed normal distribution [29]. Pearson's correlation test was used to determine the relationship between the two scales; Student's t-test was used to compare scales for nominal sociodemographic variables; and ANOVA was used for three or more

variables. In addition, simple linear multiple regression was performed in JAMOVI to determine the effect of gender, marital status, status of having children, and number of children, with significant relationships found between groups according to the ISMI total score, family history, and psychoeducation-related mental disorders according to MHLS. The backward method was also used to determine significant predictors. In the backward method, the most influential predictors are identified and presented in the established model. All findings were examined at a $p<0.05$ significance level.

Ethical Consideration: This study adhered to the Helsinki Declaration at every stage. Before beginning the study, ethics committee approval was obtained from the Non-Interventional Clinical Research Ethics Committee of Fenerbahçe University, with number 2023/11-1-fbu and date 03th November 2023. Since the study was conducted in the field, institutional permission was not required. In addition, individuals participating in the study were informed of the study's purpose before providing written informed consent.

Results

Participants' Characteristics

Participants' sociodemographic characteristics are shown in Table 1. The mean age of the participants was 32.45 years (SD: 10.25), 55.4% were male, and 68.3% were married. Approximately half (53.5%) of the participants were literate or primary school graduates; 69.3% perceived their economic status as mid-range; 54.5% worked in a job that generated income; and 63.4% had children, with an average of 2.64 (SD: 2.43) children. On average, participants had been living in Turkey for 104.55 months (SD: 32.21). Comparison of scale scores between groups revealed that the ISMI total score means were significantly different by gender, with women's ISMI total score means statistically higher than men's. The ISMI total score means were also statistically different by marital status, with married individuals' total ISMI scores higher than those of single individuals, and those with children's scores lower than those without children. A weak, positive, statistically significant relationship was found between the number of children and the total ISMI score (Table 1).

Participants' Characteristics Related to Mental Health

Participants' characteristics related to mental health are shown in Table 2. Almost half (46.5%) of the participants received mental health services through counseling, 17.8% were diagnosed with a depressive disorder, and 12.9% were diagnosed with an anxiety disorder. Participants diagnosed with mental disorders had been monitored for an average of 34.28 (SD: 43.55) months. Almost half (46.5%) of the participants were not using a psychotropic agent, and 43.6% were using antidepressants. Participants' average duration of medication use was 17.88 (SD: 29.84) months, and 9.9% of the participants had been hospitalized in a psychiatric clinic due to a mental disorder, with an average number of hospitalizations of 0.20 (SD: 0.66). Approximately one fourth (22.8%) of participants' relatives used psychosocial services, with 14.9% of participants reporting a family history of mental disorders. Participants' relatives included mothers, fathers, siblings, spouses, and children. More than half (68.3%) of the participants had not received any mental disorder psychoeducation from hospitals, municipalities, or non-governmental organizations. No difference was found between groups in terms of the characteristics related to mental health found in the ISMI. The Total MHLS score averages

Table 1: Characteristics of the Participants (n=101)

Characteristics	Mean (SD)	Min-Max	ISMI (Test/p)	MHLS (Test/p)
Age	32.45 (10.25)	18-63	r: 0.18 p: 0.06	r: -0.08 p:0.41
Gender	**n (%)**			
Female	45 (44.6)		**t: 2.52** **p: 0.01**	t: 0.71 p: 0.47
Male	56 (55.4)			
Marital Status				
Married	69 (68.3)		**t: -3.09** **p<0.001**	t: -0.99 p: -0.32
Single	32 (31.7)			
Educational Status				
Literate or Primary School	54 (53.5)		F: 2.64 p: 0.07	F: 0.63 p: 0.53
Middle or High School	31 (30.7)			
Bachelor or Graduate	16 (15.8)			
Economic Status				
Good	16 (15.8)		F: 0.59 p: 0.55	F: 0.82 p: 0.44
Middle	70 (69.3)			
Poor	15 (14.9)			
Having a Child				
Yes	64 (63.4)		**t: 3.73** **p< 0.001**	t: 0.32 p: 0.74
No	37 (36.6)			
	Mean (SD)	**Min-Max**		
Number of Children	2.64 (2.43)	0-12	**r: 0.32** **p< 0.001**	r: 0.06 p: 0.51
Employment	**n (%)**			
Yes	55 (54.5)		t: -0.74 p: 0.45	t: 0.29 p: 0.77
No	46 (45.5)			
	Mean (SD)	**Min-Max**		
Duration of Staying in Turkey (months)	104.55 (32.21)	24-192	r: 0.16 p: 0.10	r: 0.06 p: 0.55

MHLS: Mental Health Literacy Scale, ISMI: Internalized Stigma of Mental Illness Scale, SD: Standard Deviation, F: One Way ANOVA, r: Correlation, t: Student t test

were statistically significantly different according to relatives receiving psychosocial services, the presence of mental disorders among relatives, and the status of having received psychoeducation related to mental disorders. The total MHLS scores of those whose relatives received psychological support were statistically higher than those

Table 2: Participants Characteristics Related to Mental Disorders (n=101)

Characteristics	n (%)		ISMI (Test/p)	MHLS (Test/p)
Diagnosis				
Depressive Disorders	18 (17.8)			
Bipolar Disorders	4 (4)			
Anxiety Disorders	13 (12.9)			
Trauma-Related Disorders	7 (6.9)		F:1.15	F: 1.42
Obsessive Compulsive Disorders	5 (5)		p: 0.33	p: 0.20
Others (Eating Disorders, Substance Use Disorders, Personality Disorders)	7 (6.9)			
Counselling	47 (46.5)			
	Mean (SD)	**Min-Max**		
Duration of Mental Disorders (months)	34.28 (43.55)	0-180	r: 0.09	r: 0.12
			p: 0.35	p: 0.20
	Mean (SD)	**Min-Max**		
Duration of Medication Use (months)	17.88 (29.84)	0-180	r: 0.04	r: -0.01
			p: 0.63	p: 0.92
Psychotropics	**n (%)**			
Antipsychotics	10 (9.9)		F: 0.14	F: 2.81
Antidepressants	44 (43.6)		p: 0.86	p: 0.06
NA	47 (46.5)			
Hospitalization				
Yes	10 (9.9)		t: -0.41	t: -0.64
No	87 (86.1)		p: 0.67	p: 0.51
Number of Hospital Administration				
	0.20 (0.66)	0-3	r: 0.04	r: -0.04
			p: 0.64	p: 0.68
Family member Using Psychosocial Services				
Yes	23 (22.8)		t: -0.14	**t: -2.20**
No	78 (77.2)		p: 0.88	**p: 0.03**
Family Member Have Mental Disorders				
Yes	15 (14.9)		t: -0.57	**t: -2.68**
No	86 (85.1)		p: 0.56	**p< 0.001**
Psychoeducation related to Mental Disorders				
Yes	32 (31.7)		t: -0.22	**t: -2.69**
No	69 (68.3)		p: 0.82	**p< 0.001**

MHLS: Mental Health Literacy Scale, ISMI: Internalized Stigma of Mental Illness Scale, SD: Standard Deviation, F: One Way ANOVA, r: Correlation, t: Student t test

who did not. Scores of those whose relatives had mental disorders were statistically higher when compared to those who did not, and scores of those who received psychoeducation about mental disorders were statistically higher when compared to those who did not.

Correlation and Regression Analysis

Scale total score averages are shown in Table 3, with no significant relationship found between the ISMI and MHLS total score averages. A simple linear multiple regression analysis was conducted to determine the effects of gender,

Table 3: Means and Correlations of Scales

	Mean (SD)	Min-Max	r/p
ISMI	68.93 (7.25)	54-88	r: -0.07
MHLS	78.15 (8.20)	52-91	p: 0.46

MHLS: Mental Health Literacy Scale, ISMI: Internalized Stigma of Mental Illness Scale, SD: Standard Deviation, r: Correlation.

marital status, having children, and number of children on the ISMI, revealing that the model was statistically significant ($F = 5.11$, $p < 0.001$). Accordingly, gender was a statistically significant determinant of the ISMI (explanatory power) (R^2=0.06). In this model, the variables of gender explained 5% of the ISMI (Adjusted R Square = 0.05) (Table 4). In addition, the model including gender, marital status, status of having children, and number of children explained 14.1% of the ISMI (Adjusted R Square = 0.14). The model, including family history of mental disorders, status of receiving psychosocial support, and status of having received previous psychoeducation in the MHLS, was determined to be statistically significant (F: 3.24, p< 0.001). In this model, the status of having received psychoeducation for mental disorders was a predictor of the MHLS and explained 5.8% of the MHLS score (Adjusted R Square = 0.05).

Discussion

In this study, examining the relationship between internalized stigmatization and the mental health literacy of a group of Syrian refugees living in Turkey, no significant relationship was found between the two dependent variables. According to the literature, mental health literacy is low among refugees [30-32], mental health literacy affects attitudes towards mental illness [14, 32, 33], low mental health literacy increases stigmatization [34], and increased mental health literacy designed to combat stigmatization is recommended [14]. Possible reasons for this study's results may be related to the low reliability of the measurements. For this reason, the validity and reliability of these scales used among Syrians living in Turkey should be assessed. Another reason could be cultural differences across studies [4, 15, 16]. heterogeneity of participants' educational level and MHPSS type, such as therapy and counseling, psychoeducation level, and being familiar with mental disorders.

This study found that participants' mean internalized stigma scores were moderate. Syrian individuals often do not seek treatment for mental disorders and believe that it is a part of life, often labeling those with mental disorders as "crazy" or "insane" [18]. A study conducted by Kira et al. [4] with Arabic-speaking refugees in Michigan found a mean ISMI score similar to that found in the current study. The literature generally supports the current study's findings, indicating that both the host culture and the refugees' own culture affect individuals' internalized stigmatization.

This study also found that participants' mental health literacy was at an intermediate level. Slewa-Younan et al.'s study [14] examining the knowledge and help-seeking behavior related to posttraumatic stress disorder (PTSD) among Iranian refugees living in Australia found that refugees did not sufficiently recognize the symptoms of PTSD due to the influence of cultural elements; however, they also showed that participants' mental health literacy was positively affected after application of a mental health promotion program. Likewise, Moses and Holmes [38] stated that increased mental health literacy among refugees may reduce stigmatization and increase treatment adherence. Such evidence suggests that community mental health professionals should increase refugees' mental health literacy by

Table 4. Regression Analysis

Independent Variable	**Predictors**	**Estimate**	**SE**	**t**	**p**
ISMI	Intercept	82.851	10.607	7.811	<.001
	Gender	-3.155	1.378	-2.290	0.024
	Marital Status	-2.258	3.257	-0.693	0.490
	Having a Child	-4.759	3.692	-1.289	0.201
	Number of Child	0.487	0.478	1.018	0.311
ISMI	Intercept	74.48	2.31	32.26	<.001
	Gender	-3.57	1.41	-2.52	0.013
MHLS	Intercept	72.645	2.07	35.103	<.001
	Family member with mental disorders	3.786	3.21	1.178	0.242
	Family member Using Psychosocial Services	0.297	2.72	0.109	0.914
	Psychoeducation related to Mental Disorders	3.018	2.01	1.502	0.136
MHLS	Intercept	70.45	2.97	23.71	<.001
	Psychoeducation related to Mental Disorders	4.58	1.70	2.69	0.008

MHLS: Mental Health Literacy Scale, ISMI: Internalized Stigma of Mental Illness Scale

considering their country of residence's culture and directing them to reliable sources that provide information in their mother tongue.

The current study's results show that gender was a determinant of stigmatization, with stigmatization scores of female refugees being higher than those of male refugees. While males living in Arab cultures have been shown to use MHPSS services less [36] because they hold more negative attitudes towards mental disorders when compared to females, Khatib et al. [32] reported that males are more likely to use mental health services. In some cases, females may use mental health services less frequently due to existing gender roles [33] or anticipated stigmatization [17]. Since the relationship between internalized stigma and gender is complex, future studies examining females' internalized stigma are recommended.

In the current study, married participants had higher internalized stigma scores than single participants. However, a previous study conducted by Bar et al. [34] among Syrian refugees living in Germany found that singles had higher internalized stigma scores. This may be due to the belief that having a mental disorder is an obstacle to marriage. A systematic review conducted by Zolezzi et al. [35] found that in Arab cultures, families of individuals with mental disorders are also

stigmatized, as it may be seen as an embarrassment that compromises the reputation of the family. In the current study, the fact that married participants experienced more internalized stigma may be explained by the fact that individuals are either stigmatized in the family or that they are a source of stigma for the family. As such, both refugees with mental disorders and their family members, especially spouses, may benefit from psychoeducation. Community mental health professionals should provide culturally appropriate care by also considering the family. The current study also found that participants with children had higher internalized stigma scores than those who did not; therefore, the attitudes of refugees with children should be considered and addressed separately.

The majority of the current study's participants had not received psychoeducation, perhaps due to the lack of Arabic-speaking and culturally sensitive community mental health professionals and trained translators. Those who had a family history of mental disorders or whose relatives had received psychosocial services displayed higher mental health literacy. This may be because those whose family members had been diagnosed with mental disorders or who received psychosocial support were informed about the symptoms or treatment of mental disorders by community mental health professionals or accessed this information themselves.

Limitations

The results of this study are limited to the sample and cannot be generalized. The major limitation of this study was the low reliability values of the scales used. Although the scales used have been validated in Arabic, there may be linguistic and semantic differences across Arabic-speaking cultures. In the future, it would be advisable to utilize standardized measurement tools developed in Syrian culture. Because the study was conducted in the field, it does not represent a clinical sample. Future studies conducted among refugees who apply to community-based mental health services are recommended.

Conclusion and Implications

No statistical correlation was found between internalized stigmatization and mental health literacy among Syrian refugees living in Istanbul, a metropolitan city in which Syrian refugees have lived for nearly fifteen years. The internalized stigma scores of females were statistically higher than those of males. In addition, the participants who had received psychoeducation had significantly higher levels of mental health literacy.

For refugees to adequately benefit from mental health services, trained translators and culturally sensitive community mental health professionals are needed [18, 38]. Community mental health professionals should offer training to refugees to improve their mental health literacy and teach them how to access accurate information. Due to the language barrier, refugees should be empowered through access to information in their own language and self-learning methods, as mental health literacy enables them to recognize the symptoms of mental disorders, giving them access to early treatment and intervention [18, 30, 39], thereby improving their functionality. Increased mental health literacy can also result in more positive attitudes toward mental disorders [36].

Refugees should be taught how to access mental health services in the country where they live, and institutions should offer access to information in the native languages of refugees [18]. Evidence-based and tested intervention programs should be routine in community

mental health centers, as such interventions can educate refugees about mental health, thereby resulting in decreased stigmatization, increased motivation for treatment, and increased ability to cope with stress [18].

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Informed Consent: Informed consent was obtained from all participants.

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