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Psychological disorders in women in long-term forced displacement in the Sahrawi refugee camps

Trastornos psicológicos en mujeres en desplazamiento forzoso a largo plazo en los campamentos de refugiados saharauis

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abstract

The present study is an initial exploration of psychological disorders in long-term refugee women living at the Sahrawi camps in Tindouf (Algeria). Thirty-one women with an average age of 43.32 years (SD=12.34) were evaluated through personal interviews, applying *Symptom Checklist-90-R (SCL-90-R)* and one personal clinical interview created for this purpose. In this manner, health professionals were interviewed on the situation of the refugee women in Tindouf. The results show that 80.64% of the interviewed women had received psychological assistance, 100% rated positively on somatization, 90.3% on obsessive-compulsive, 93.5% on interpersonal sensitivity, 96.8% on depression, 93.5% on anxiety, 77.4% on hostility, 87.1% on phobic anxiety, 90.3% on paranoid ideation and 90.3% on psychoticism. The results from the interviews show 32% of the interviewees do not know the meaning of mental health, and 35.48% of them have used traditional medicine even when they admit that they have access to the psychological services at the refugee's camp (61.29%). The loss of hope for the future represented 41.93% of the opinions of the survey and 64.52% expressed feeling scared for the situation of their families living in the Western Sahara, among other results. Interviews with the health professionals reveal there is a growing demand for psychological treatment due to the recent introduction of psychological services in the wilayas (provinces). In spite of this, the rejection and social stigma around mental health disorders in Tindouf contribute to concealing pathologies or using the traditional medicine as a first option.

keywords

Psychopathology, victims, war, refugee, women.

resumen

En el presente estudio se realizó una exploración inicial de trastornos psicológicos de las mujeres en desplazamiento forzoso a largo plazo residentes en el campamento saharaui de Tinduf (Argelia). Se evaluó a 31 mujeres con una edad media de 43.32 años (*DT*=12.34), mediante entrevistas personalizadas, la aplicación del *Symptom Checklist-90-R (SCL-90-R)* y un instrumento diseñado al efecto de confeccionar una historia clínica personalizada. Así mismo, se entrevistó a personal sanitario de los campamentos sobre la situación de las mujeres residentes en Tinduf. Los resultados muestran que el 80.64% de las mujeres evaluadas habían recibido asistencia psicológica, el 100% puntuaron positivamente en somatizaciones, 90.3% en trastornos obsesivo-compulsivos, 93.5% en suspicacia interpersonal, 96.8% en depresión, 93.5% en ansiedad, 77.4% en hostilidad, 87.1% en ansiedad fóbica, 90.3% en ideación paranoide y 90.3% en psicoticismo. Los resultados de las historias clínicas muestran un desconocimiento del significado de la salud mental para un 32% de las entrevistadas y que un 35,48 % habían recurrido a medicina tradicional incluso admitiendo tener acceso a los servicios de atención psicológica de los campamentos (61.29%). La pérdida de esperanza en el futuro representó un 41.93% de la opinión de las encuestadas y un 64.52 % expresaron sentir miedo por la situación de sus familiares en el Sahara Occidental, entre otros resultados. De las entrevistas con el personal sanitario se concluye una creciente demanda de tratamientos psicológicos debido a la reciente implantación de atención psicológica en las wilayas, a pesar de que el rechazo y la estigmatización social de los trastornos mentales en Tinduf contribuyan a ocultar las mismas o a hacer uso de la medicina tradicional como primera opción.

palabras clave

Psicopatología, víctimas, guerra, refugiados, mujeres.

1. Introduction

The current wars and political instability in the Middle East and in certain regions of Africa increase the numbers of displaced persons and asylum seekers. Thus, during the year 2015, 65.3 million people were in a situation of forced displacement around the world, mainly from Syrian Arab Republic, Afghanistan, Somalia, South Sudan and Sudan (UNHCR, 2016).

According to the Geneva Convention Relating to the Status of Refugees, the United Nations (1951) considers a person to be a refugee who because of "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (UNHCR, 2016).

Regardless of the reasoning that makes someone a refugee, it is an expensive process involving displacement from the place of origin or residence as well as human and material losses. We are currently witnessing an unprecedented refugee crisis, which outnumbers even World War II and adds to those that remain unresolved over time.

Human migration is not a new phenomenon, although it has changed significantly in number and nature with the rise of globalization. With greater facilitation of mobility and an increase of migratory processes, it is necessary to consider among other aspects the influence that it has on the health of the individuals and populations (Zimmerman, Kiss, & Hossain, 2011). Different research shows that the displacement of populations as a result of an armed conflict, leads to deterioration in the quality of life and the health of those who suffer (Mogollón, Garcia, & Vázquez, 2003).

Thus, not all migrations are recent, and some political conflicts remain stagnant for years, giving rise to generations born in refugee camps. UNHCR (2015) defines prolonged refugee status in which 25,000 refugees or more of the same nationality have been in exile for at least five years in a given country of asylum.

1.1. Psychological disorders in refugee population

The prolonged permanence of refugees in host countries has allowed the development of research showing a high prevalence of mental disorders in this population that may be associated with a high level of exposure to traumatic situations and post migration factors in host countries, so addressing their health needs can be a challenge for healthcare services (Bogic *et al.*, 2012). A recent systematic review examining long-term refugee mental health concluded that exposure to war had a significant and sustained effect on the mental health of refugees (Bogic, Nojku, & Priebe, 2015).

The context of war, the search for asylum, or prolonged residence in refugee camps, entail difficulties that increase the risk of emotional instability in people. Thus, exposure to long and dangerous journeys makes individuals tend to enter the asylum process with greater anxiety and uncertainty about their future (Buckley, 2013).

In this type of population, research shows persistent levels of post-traumatic stress disorder (PTSD) and other mental problems, as well as a greater deterioration in mental health as compared to internally displaced or non-refugee populations, even after years in the settlements (Schmidt, Kravic, & Ehlert, 2008). In this context, Zimmerman *et al.* (2011) establishes five relevant phases in this type of migratory process: Pre-departure, travel, destination, interception and

return. The pre-departure phase comprises the period prior to migration from the country of origin, where exposure to traumatic events, especially violent acts and war, are highly probable (Gómez-Varas, Valdés, & Manzanero, 2016; Manzanero, López, Aróztegui, & El-Astal, 2015). The travel phase comprises the period of time from when the refugees leave their country of origin until they reach their destination, passing through places of transit where exposure to influential stressors is likely. In the destination phase, the mental health of the refugees will be determined by post migration factors, having observed significant associations between the psychological symptomatology, fundamentally the depressive, and socioeconomic variables such as the low social integration in the host country, stressors experienced after migration, lack of language dominance, unemployment, temporary residence permits, lack of social support, and not feeling accepted in the host country (Bogic *et al.*, 2012, 2015; Schick *et al.*, 2016). The interception phase alludes to refugee camps, places of detention of temporary residence, where there are situations of overcrowding, deprivation, and unsanitary conditions and often an effect of deterioration in the mental health of the refugees as well as possible violations of human rights. These situations pose an added stress, a clear association between the time that the refugees undergo these conditions and the severity of subsequent mental disorders, especially in those refugees who have previously been exposed to traumatic events (Keller *et al.*, 2003; Steel *et al.*, 2006). Finally, some refugees go through a phase of forcible return or repatriation, where in addition to the consequences of the cumulative effect of successive stressors experienced during migration, the refugees have to face once again the conflicts that motivated displacement.

War-scarred experiences can cause long-term psychological disorders (Priebe *et al.*, 2012). In this line, two decades after the settlement of Cambodian refugees, 62% of the population assessed was diagnosed with PTSD, and also high rates of post-traumatic symptomatology were found for both the Bosnian refugee population in Yugoslavia and displaced civilians (Schmidt, *et al.*, 2008).

In short, refugee status seems to lead to implicit mental health problems located in the area of depression, anxiety, and PTSD. Thus, in the systematic review of Robjant, Hassan and Katon (2009), with an asylum-seeking population, anxiety, depression and PTSD were observed in all studies, and high data on suicidal ideation.

1.2. Limited access to public health

Life in refugee conditions requires great doses of self-sufficiency and ability to overcome. The basic necessities are minimally covered, mental health care tends to be a relegated issue and unavoidable external dependence contributes to

feelings of uncertainty, instability, and little capacity for control, which add to the damage caused by war and displacement, and can make chronic the existing pathologies.

The first partial recognition that trauma had a psychological origin was not made until the First World War (Hunt, 2010). Today, making visible the psychological needs of war-affected populations is a growing phenomenon mainly because of the migratory events of recent years that mark high numbers of refugees. Thus, there is a long road ahead to fully cover the mental health needs of these types of populations, while taking into consideration the limitations that emerge within these contexts for access to public health.

First of all, mental health receives little attention from policymakers and funding agencies. It is rare that countries that have gone through a conflict situation subsequently emerge with an agenda that includes a robust attention to mental health services (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013). Thus, it is also common for health investments to be directed mainly to physical health issues in shelter conditions. However, in order to prevent the long-term psychic consequences and to prevent dysfunctions from persisting, victims should be provided with programs of support, counseling and psycho-social treatment (Niaz, 2014).

Secondly, the origin of the health care usually differs from that of the refugees and to consider the interference of cultural and religious phenomena will have relevance both for the evaluation and for the design of psychological treatments. It has been seen that culture impacts the mental health disorders of refugee populations implying limitations to consider on the part of healthcare professionals (Buckley, 2013). In this line, the stigma and traditional beliefs around how to care for ones health are some impediments to accessing health care for certain refugee people (Bettmann, Penney, Clarkson, & Lecy, 2015; Drummond, Mizan, Brocx, & Wright, 2011; Kira, Ramaswamy, Lewandowski, Mohanesh, & Abdul-Khalek, 2015).

In Arab culture, mental illness is highly stigmatized, and the internalization of social and family prejudices around the search for help carries feelings of shame and family misfortune, which can contribute to low self-esteem, self-efficacy and functioning (Kira *et al.*, 2015).

Moreover, the lack of knowledge about psychotherapy, stigma and non-recognition of symptoms are factors that explain the resistance to express psychological distress, fear and worries by refugee women (Niaz, 2014). To solve these limitations, the combination of psychiatric treatments with traditional medicine is posed as a tool (Buckley, 2013; Shore, Richardson, Bair, & Manson, 2015).

In addition, there are other factors that would hinder the effectiveness of psychological treatments and adherence to the health systems of the host country, such as linguistic difficulties (Buckley, 2013; Bettmann *et al.*, 2015) and access to health centers (Drummond *et al.*, 2011).

1.3. Mental health in refugee women

In environments of military conflict, gender differences give different roles for men and women depending on the structure and social functioning of the culture. It is more common for men to perform tasks related to fighting and other military aspects, while women deal with the domestic environment and caring for the family. In this context, women are more susceptible to psychological problems as a result of war, with greater exposure to situations of violence outside their environment, and with greater concern for family needs that can lead to carelessness of their own. In some armed conflicts women are often used as a weapon of war and may suffer violence subjected to persecution, discrimination, oppression, sexual violence and slavery (Niaz, 2014); in addition to being victims of military attacks. Such was the case in April of 2014, when 276 students at the women's School in Chibok (Nigeria) were kidnaped by the terrorist organization Boko Haram, and were sexually abused and assaulted, constituting a crime against humanity.

Gender differences also affect migratory processes and those that stay stagnant in refugee camps, with men having more individual mobility and women more collectively. In shelter situations, family structures can be altered and the assumption of responsibility on the part of women will also determine changes in relational dynamics with their children and family members. Thus, it has been found that mother's mental health is a strong predictor of the mental health problems experienced by their children. Similarly, in a study on mental health in Palestinian population (Thabet, Abu-Khusah, & Vostanis, 2014), PTSD found in Palestinian children was the best predictor of the psychopathology of the mothers.

Psycho-social afflictions in women are commonly expressed through somatic complaints. One of the reasons that explain the somatization of anxiety and depression is the common perception that considers psychological treatment as unnecessary and unfounded. Therefore, women's health is characterized by both a traumatic past and daily stressors. However, the role of caregiver can have a protective role for women in their identity and social function (Niaz, 2014).

Also, resilience has been observed as a protection factor against the development of psychological disorders (Arnetz, Rofa, Arnetz, Ventimiglia, &

Jamil, 2013). Of the modulating variables of resilience, the coping capacity has been one of the most studied, with existing divergences with respect to other relevant factors such as emotional expression, religious resources, social support, personality characteristics or situational factors, among others (Hooberman, Rosenfeld, Rasmussen, & Keller, 2010).

1.4. Situation of prolonged refuge: the Sahrawi camps

After Morocco invaded Western Sahara, and the ensuing war (1975-1991) between Morocco, Mauritania and the Polisario Front, an exodus occurred consisting largely of the Sahrawi population, especially women and children. The first displacements took place within the territory, mainly to Um Draiga, Tifariti and Guelta Zemmur and after the bombardment of these towns with napalm and white phosphorus bombs, the refugees were sheltered in the camp of Tindouf, where they remain to date (Fiddian-Qasmiyeh, 2011). The refugee camp of Tindouf is structured in five wilayas or municipalities, where part of the Sahrawi refugees reside since 1975. The population density in the camps is imprecise, thus Algeria and the Sahrawi sources estimate 165,000 exiles, and UNHCR estimates 94,144 (Spanish Agency of International Cooperation for the Development, 2015).

During the period of war, the matriarchal character of the construction of the camps and in the organization of life in exile, attributed the Sahrawi woman a status of distinction maintained to this date. In 1997, the staff of the daycares was 100% female, that of the administration was 85% and of education was 70% (Dukic & Thierry, 1998).

The prolonged stay in Tindouf has resulted in the creation of departments to manage life in the camps. In 2010 a division for Mental Health was created in the Ministry of Health and with it officially introduced psychological care in the wilayas.

Mohamed Fadel, a psychologist in Tindouf, says, "cases of depression, of anxiety, and psychosomatic problems abound and, in the majority of cases, the cause must be found in the waiting, in the uncertainty, in the lack of a clear future. All of this is provisional. We try to survive" (Sober, 2010).

Thus, the Sahrawi population faces the difficulties of exile and the violation of human rights in both the Western Sahara and the camps (Martín-Beristain & González-Hidalgo, 2012). This situation of prolonged refuge, with no resolution in the near future, gives the Sahrawi crisis the maximum score in the list of forgotten crises, being the only one with this score (Spanish Agency of International Cooperation for the Development, 2015).

The present study is exploratory in nature and its main objective is to evaluate the presence of psychological disorders that in turn would be reflected in the global indicators of discomfort in women in situations of prolonged refuge in the Sahrawi camps. Consequently, it is intended to contribute to the knowledge of the mental health of this population, considering the recent implementation of the psychological services, and of the factors that interfere the access to them.

2. Method

2.1. Participants

The sample was composed of 31 women who reside in the camp of Tindouf (Algeria), with an average age of 43.32 years (*DT* =12.34). Of the participants, 25 (80.64%) had received psychological assistance at some point. Sociodemographic variables (see Table 1) show that 87% of the participants were born in Western Sahara and participated in the migratory process, and 12% were born in the camps.

The average time in refugee status until 2014, is established in 33.55 years (*DT* = 7.31), excluding a participant who does not answer and another that provides an incongruous answer. 64.52% were married and 19.35% were separated or divorced. With regard to education, they emphasize incomplete primary studies for the total of the sample (58.06%). In terms of labor occupation, unemployment prevails in both conditions, representing 80.64%.

Table 1. *Socio-demographic characteristics* of the sample.

	N	%
Place of birth		
Western Sahara	27	87.10
Refugee Camps	4	12.90
Time as a refugee		
Since 1975	12	38.70
After 1975	13	41.93
Since birth	4	12.90
No answer/disjointed data	2	6.45

Marital status		
Single	3	9.68
Married	20	64.52
Separated or divorced	6	19.35
Widow	2	6.45
Education		
Incomplete primary	18	58.06
Completed primary	2	6.45
Incomplete secondary	7	22.58
Completed secondary	3	9.68
University	1	3.22
Employment occupation		
Unemployed	25	80.64
Incapacitated	2	6.45
Paid word	4	12.90
Mental health services users	25	80.64

In addition to the participants evaluated in the study, a semi-structured interview was conducted with the psychologist of Auserd, El-Aaiún, Dajla, and Bojador (who is also the director of the Department of Mental Health), a general practitioner who is a member of the Polisario Front and a specialist at the Ministry of Health; to the doctor and Director of Health of the wilaya of Bojador and to the doctor of Auserd.

2.2. Procedure

Prior to the implementation of the evaluation instruments, training of the camp psychologists team was carried out. Explanatory sessions of questionnaires and simulated practices were developed for data collection. Thus, all materials were translated into Arabic to facilitate their application. The selection of the participants was carried out by random sampling and with the participation of the psychologists of the wilayas who allowed the access to the women users of the service.

All evaluations were conducted throughout April and May 2014. Data collection took place in hospitals and health clinics in each of the wilayas (in the presence of health psychologists) or in the domestic context of the participants. All the interviews were carried out individually, respecting con-

fidentiality, the voluntary nature and obtaining the informed consent for the use of the data for research purposes.

In December 2013 as well as in April and May 2014, the different testimonies of health personnel were collected and registered in audio recordings.

2.3. Instruments

- *Symptom Checklist-90-R (SCL-90-R)* is a questionnaire that values the presence of 90 items on a Likert-type scale ranging from total absence (0) to maximum intensity (4). It quantifies in clinical and normal population nine somatic dimensions, three global indexes of psychological discomfort and seven items that are not incorporated into the nine dimensions but have clinical relevance.

  The dimensions evaluated are: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. In addition, three global indexes are analyzed: Global Severity Index, Total Positive Symptoms (TSP) and Discomfort Index (Derogatis, 1996).

  The reliability indexes (Cronbach α) of the test oscillate between 0.80 for social anxiety and 0.95 for depression, except for the psychoticism dimension/anxiety where $\alpha = 0.66$; being the total reliability of the scale of 0.98 (Bados, Balaguer, & Coronas, 2005).

- The *clinical history* was designed to collect data on gender, place and date of birth, as well as issues related to the health of respondents: knowledge of their current illnesses, meaning of mental health and possibilities of access to mental health services in the camps. On the other hand, six open questions regarding refugee status were collected: time they have been staying in the Tindouf camps, perception of their situation and of the future, presence of fears for the situation of their relatives in the Western Sahara, feelings associated with the impossibility and uncertainty of returning to the Western Sahara and presence or absence of fears facing a possible cut of the external assistance. The practice of traditional medicine did not constitute one of the questions of the medical history, however, it was collected in some testimonies by the allusions made by them and by the health personnel.

- *Oral interviews with camp health personnel*. Through oral, open and unstructured questions, the testimonies of psychologists and doctors in the

camps were collected. The topics addressed were the implementation and functioning of mental health services in the camps, the stigma associated with mental illness and the use of traditional medicine to alleviate ailments of a psychic nature.

3. Results

As Table 2 shows, the results found in the SCL-90 (R) Questionnaire: 100% of the users of mental health services scored positively in the form of somatization, 90.3% in obsessive-compulsive disorders, 93.5% in interpersonal sensitivity, 60.1% in depression, 93.5% in anxiety, 48.1% in hostility,% in anxiety phobic, 90.3% in paranoid ideation and 90.3% in psychoticism. With the exception of one women who scored positive only in one of the disorders (somatization) and another that scored positive in four (somatization, paranoid ideation, depression and psychoticism), the rest of the women scored positively in the presence of 6 to 9 disorders, with an average of 8.12 disorders (*SD* = 1.78). *The total number of positive symptoms* reflects a tendency to exaggerate the pathology if it is greater than 60 and for the set of women participants it is of 61.84 (*SD* = 18.88). *The index of discomfort* yields a score of 2.13 (*SD* = 0.56), and it determines a slight tendency to exaggerate the discomfort, since the theoretical amplitude oscillates between 0 and 4. Finally, the *global index of severity* with theoretical amplitude of 0 to 4, represents in the participants a value of 1.19 (*SD* = 0.65), and thus reflects a low overall perception of discomfort.

Table 2. Descriptive data of the scores found in the SCL-90 (R).

	N	Range	Minimum	Maximum	*M*	*SD*	% Positive diagnostic
Somatization	31	2.0	1.0	3.0	1.77	0.76	100
Obsessive Compulsive	31	3.0	0.0	3.0	1.68	0.79	90.3
Interpersonal sensitivity	31	3.0	0.0	3.0	1.42	0.92	93.5
Depression	31	3.0	0.0	3.0	1.74	0.85	96.8
Anxiety	31	3.0	0.0	3.0	1.39	0.92	93.5
Hostility	31	3.0	0.0	3.0	0.97	0.87	77.4
Phobic anxiety	31	3.0	0.0	3.0	1.32	0.83	87.1
Paranoid ideation	31	4.0	0.0	4.0	1.39	0.95	90.3
Psychoticism	31	3.0	0.0	3.0	1.32	1.01	90.3

	N	Range	Minimum	Maximum	*M*	*SD*	% Positive diagnostic
Global Severity Index	31	2.0	0.0	2.0	1.19	0.65	
Total positive Symptoms	31	62	23	85	61.84	18.88	
Number of positive disorders per subject	31	8.0	1.0	9.0	8.19	1.78	
Discomfort Rate	31	2.0	1.0	3.0	2.13	0.56	

3.1. Medical History

Table 3 shows the results obtained through the clinical history, which was fully answered by 58% of women. Difficulties attributed to fatigue after completing the SCL-90 (R) caused many refugees not to answer all the questions. Regarding mental health issues, it is observed that 32% do not know the meaning of mental health. In relation to access to psychological care service, 61.29% of women recognize that they do not have access problems, compared to 9.68% who believe that access to this service is limited and a 29.03% that do not respond. More than half (60%) of women who are being treated or have requested assistance in these services (25 of the total) do not know their mental health diagnosis and/or confuse it with physical illnesses, while 16% do not answer the question. Finally, the practice of traditional medicine has been referred to by 35.48% of women.

Table 3. Mental health responses collected in the medical history.

	N	%
Do not know the meaning of mental health	10	32.26
Do not answer about the meaning of mental health	10	32.26
Recognize access to mental health systems	19	61.29
Express limited access to mental health systems	3	9.68
Do not answer regarding access to mental health systems	9	29.03
Do not know their mental health diagnosis	15	48.39
Do not answer regarding knowing their mental health diagnosis	4	12.90
Express having used traditional medicine	11	35.48

In relation to the perception of their situation (see Table 4), 45.16% defines it as positive (36% of the total were users of mental health services and 83.3% non-users), and 35.48% interpreted it as negative (40% were users while

16.6% were non-users). The loss of hope in the future represents 41.93% of the opinion of the women surveyed, compared to a 35.48% that perceives it as good or that does not answer (22.58%). 64.52% of women fear for the situation of their families in Western Sahara, 48.39% feel sadness, and a 48.39% hatred or anger for not being able to return to Western Sahara. Finally, 32.26% of women recognize that they are afraid external assistance will be cut.

Table 4. Answers collected in the medical history with regard to the perception of their situation and their future and of the fear that the external assistance may be cut off.

	N	%
Perception of their situation		
Positive	14	45.16
Negative	11	35.48
Does not answer	6	19.35
Perception of the Future		
Good	11	35.48
Hopeless	13	41.93
Does not know/Does not answer	7	22.58
Fear of the situation of their relatives in Western Sahara	20	64.52
Feelings of sadness, hatred or anger for not being able to return to the Western Sahara	15	48.39
Fear that external assistance will be cut		
Recognizes feeling afraid	10	32.26
Sees it as improbable	6	19.35

3.2. Interviews with healthcare professionals

In the interviews made to the healthcare professionals (see Table 5), there are condensed opinions in three areas, the psychological attention in the wilayas and the absence of psychiatrists, the rejection and social stigmatization of mental disorder in the Sahrawi culture and the use of traditional medicine. One of the most highlighted aspects of the interviews refers to the demand for psychological care in the camps, especially in the area of the somatization. The lack of psychiatrists and awareness-raising campaigns contribute to an increase in patient visits and greater acceptance of mental disorders among the population. However, the stigma surrounding the mental disorder within the Saharan culture contributes to the interpretation of it as a divine punishment or as an incurable disease. These aspects cause the patients and their families to avoid social judgment by going to consultations covered up and in fear of

being stigmatized permanently. In this way, the physicians explain that the psychological treatments are considered the last option when other interventions based on traditional medicine or readings from the Quran have already been contemplated. On the other hand, health professionals noted a greater willingness to receive psychological treatment in women than in men. This tendency would explain why the stigma of mental disorder is greater in men, causing them feelings of shame and fear of family dishonor and the risk that their social image and virility be questioned. In addition, a better therapeutic alliance between professionals and Sahrawi users of the same sex would be established, there being only a single male psychologist in Tindouf. However, one of the psychologists stated that the proportion of men and women cared for by her was very similar, although she pointed out that in men there were more disorders related to toxic consumption. Finally, there is one more aspect that can explain these gender differences; women reside more permanently in Tindouf than men, who tend to leave with more frequency from the camps.

Table 5. Responses gathered in interviews with Sahrawi health psychologists and staff.

Psychological care in the Wilayas	
Bojador psychologist and director of the Department of Mental Health	*"We have seven psychologists in the camps, one in each wilaya, another in the psychiatric hospital and one in the nursing school. Mental health in the camps has cost us a lot, we had to do awareness campaigns.* *Year after year there are more psychological disorders, in recent years. I have received a lot of somatic disorders in women."*
General Practitioner, member of the Polisario Front and technician of the Ministry of Health	*"We don't have psychiatrists, we take a clinical psychologist and we give him training. Together we assign treatment for the patient."*
Auserd Doctor	*"We have a psychiatric practice without a psychiatrist. The psychological side is booming, people identify with it and seek help."*
Auserd Psychologist	*"I've been working for 6 years and I have 68 patients. When I arrived there were not many patients, there were no psychologists in the wilayas and people were not accustomed to go to a psychologist."*
Dajla Psychologist	*"I work three days a week since 2004, taking care of 40 psychiatric and psychological patients."*
Aiún Psychologist	*"More patients with psychological problems rather than physical come to the clinic … Especially in women the psicosomatización is very abundant".*

Rejection and social stigmatization of mental disorder in Sahrawi culture	
Doctor and director of health of the wilaya de Bojador	*"There is a saying that we have in our Saharan culture, the psychiatrist never cures you. You don't tell this to a psychiatric patient. When you tell him, you lose him."*
Dajla Psychologist	*"They come covered with turbans or sunglasses, without anyone knowing they've come to a consultation or they prefer you go to their home."*
General Practitioner, member of the Polisario Front and technician of the Ministry of Health	*"In Arabic being crazy and psychology is the same. When I see it is a psychological problem and I want to steer them in that direction, they do not want to go there."*
Psychologist of Bojador and director of the Department of Mental Health	*"They see madness as a taboo. They fear they will be put to the side, that they are crazy. I have many patients that not even their families know … The first thing they do is try to hide, so nobody sees them, and when they try everything and find no solution they come."*
Auserd Psychologist	*"People think that the mentally ill will stay that way all their lives, so they are afraid. There is lack of knowledge …".*
Use of traditional medicine	
Dajla psychologist	*"In the early stages of illness, the family gives them traditional treatments, with "witchcraft". They try many things before they come".*
Psychologist of Bojador and director of the Department of Mental health	*"They see everything as if it were the evil eye, witchcraft. They go to see the psychic, the healer and when they grow tired they go to the psychologist".*
Auserd Psychologist	*"Very religious people prefer to use religion as a treatment."*
Medical and health director of the Wilaya de Bojador	*"People can combine religion with treatment, there are combinations of traditional medicine with religion … I've seen agitated people read the Koran stay calm and heal."*
Psychologist of El Aaiun	*"There are many people who still go to the healers before coming to the specialists."*
Auserd Psychologist	*"Psychiatric cases are not detected early. The family starts with their traditional or religious beliefs, and when they see that failed they come to the center".*

4. Conclusions

This research takes a small sample of the women living in Tindouf, of which the results are far from being able to be generalized, due to the limitations of access to the women in the camps and the small sample size. In addition, the stigmatization of mental disorder in Sahrawi culture generates rejection in the population towards external investigations, although it received good reception from the practitioners and the Polisario Front. Thus, the results achieved can only be considered an approximation to the situation of the women in Tindouf, a more thorough work involving a larger number of participants, both men and women, is necessary in order to determine the influence that gender would have on the prevalence of disorders in the refugee population.

The results of this research support the contributions obtained by the psychologists of the wilayas that indicated the presence of somatization as the most outstanding psychopathological aspect. In this study, all Sahrawi women rated positively in this category. Thus, many American clinicians have observed that in the Arab population the shame and the stigma when confronting psychological difficulties leads to somatization (Hakim-Larson, Farrag, Kafaji, Duqum and Jamil, 2002).

Consequently, silence accompanies the refusal to express mental disorders in Tindouf avoiding early attention that palliate the symptomatology. Niaz (2014), stresses a strong social pressure for refugee women that implies the exhaustive fulfillment of traditional patterns. The collective identity in situations of prolonged refuge leads to the reaffirmation of the social values to preserve its idiosyncrasy as exiled people. In the Sahrawi society, the tendency to use traditional medicine and the lack of interest in knowledge of mental health aspects is reinforced by the belief system that attributes negative connotations to psychological disorders. However, since the introduction of psychological care in the wilayas and the sensitization campaigns, an increase in the demand for treatment has been observed. The ease of access to mental health systems is recognized by many of the women although resistance and anonymity to attend therapy is the common denominator. Depression and anxiety associated with exile mark a high prevalence in mental health studies with refugee populations (Robjant, *et al.*, 2009). Thus, the category depression was the second most rated, detected in almost all of the refugees. The lack of hope in the future and the persistence of negative feelings because of the inability to return to Western Sahara are identified as contributing elements to this ailment. Anxiety and personal suspicion constituted the third most prevalent dimensions among Sahrawi women. It was detected that more than half of the participants were afraid of the situation of their relatives in the Western Sahara and although only one third expressed fear of a possible cut to external assistance, both factors contri-

bute to the emotional instability and persistence of anxiety symptomatology. Personal suspicion is contextualized in the widespread political abandonment of the Sahrawi people, which since 1991 expect a peaceful international solution. The absence of armed conflict and the factors of coping and adaptation to the inability to manage their destiny, explain that almost half of women perceive their current situation as good despite the conditions of Tindouf, observing a reduced level of perceived discomfort. The hospitable character of this society, its strong rooted identity and the need for forced coexistence in exile concentrates the lowest scores in the hostility aspect, being positive for three out of four women. Thus, high scores are observed in all aspects and the global indexes indicate a slight tendency to exaggerate the discomfort, determined by the need to make visible the situation in which they are in or because of the lack of adequate instruments. Considering the contributions of this study, it is necessary to continue conducting awareness campaigns that bring psychology and its treatments closer to the Sahrawi people as well as to underline the psychological consequences that long-term exile has on refugees.

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