Religion, Refugees, and Mental Health in South Asia: A Systematic Review

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Abstract

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In recent years, increased emphasis has been placed on the relevance of social determinants of health in mitigating health inequities. As a social determinant of health, religion has the potential to impact a variety of health outcomes. Given that religious minorities face widespread discrimination in South Asia, and that religious dogma can promote stigma around mental health issues, there are clear risk factors for mental health problems associated with religious identity. However, religion can confer protective factors as well, which is evidenced by the emotional and social support commonly found in religious communities. The advocacy efforts of religious and faith-based organizations can also provide protection against mental illness. This study aims to clarify the relationship between religion and mental health among South Asian refugee populations through a systematic review of original research conducted over the last decade.

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Background

Displacement in South Asia

Migration has been an ongoing phenomenon in South Asia throughout modern history (1). In 1947, the partition of the Indian subcontinent into the separate states of India and Pakistan resulted in the displacement of approximately 14 million people (2). The tumultuous years following partition were marked with violence and political unrest, culminating in the Bangladesh Liberation War. This period sparked an exodus of refugees into India, as those occupying the former East Pakistan fled military oppression. By the end of 1971, the government of India had reported an influx of 10 million refugees (2).

Religious identity played a prominent role in the social and political tensions that ensued after partition, and in the ultimate decision to migrate. After Bangladesh declared independence, the United Nations High Commissioner for Refugees coordinated a widespread repatriation effort to relocate displaced individuals and their families. The lasting effects of colonial power can be seen in the intertwining of religion, ethic identity, and political affiliation throughout South Asia. Religion continues to contribute to controversy over citizenship status, as evidenced by India's National Register of Citizens (NRC) and Citizenship Amendment Act (CAA) of 2019—which grants a clear pathway to citizenship for refugees from Afghanistan, Pakistan, and Bangladesh who identify as Hindu, Sikh, Jain, Buddhist, Parsi, or Christian (3). The CAA has garnered substantial criticism for neglecting to provide this same pathway to citizenship for Muslim immigrants, putting them at a significant disadvantage by restricting their chances of acquiring citizenship status. Additionally, the NRC and CAA have been applied not only to immigrants, but to Muslims born in India who cannot document their citizenship because of a paucity of

documentation in rural and poor areas. Thus, despite their legitimate claims to citizenship, many Muslim Indians have been divested of the rights and protections they are entitled to as citizens.

While considerable attention has been given to the migration of Bengali, Pakistani, and Indian nationals over the last century, South Asia's refugee population also includes a number of ethnic minorities, many of whom are currently stateless. The Chinese occupation of Tibet initiated an exodus of Tibetan refugees into India, Nepal, and Bhutan beginning in 1959, and a large number of Tibetans remain displaced throughout South Asia. Additionally, since the escalated persecution of the Rohingya in 2017, Bangladesh has seen a rapid increase in the number of Rohingya refugees migrating from Myanmar. Nearly 75 years after the partition of India, the legacy of forced displacement in South Asia is still acutely felt.

Specific Aims

In recent years, increased emphasis has been placed on the relevance of social determinants of health in mitigating health inequities. As a social determinant of health, religion has the potential to impact a variety of health outcomes (4). Given that religious minorities face widespread discrimination in South Asia, and that religious dogma can promote stigma around mental health issues, there are clear risk factors for mental health problems associated with religious identity. However, religion can confer protective factors as well, which is evidenced by the emotional and social support commonly found in religious communities. The advocacy efforts of religious and faith-based organizations can also provide protection against mental illness.

This study aims to clarify the relationship between religion and mental health among South Asian refugee populations through a systematic review of original research conducted over the last decade. We seek to address the following aims:

1. Identify and describe the ways in which religion functions as a risk factor for mental health disorders among South Asian refugees.
2. Identify and describe the ways in which religion functions as a protective factor for mental health disorders among South Asian refugees.

Methods

We conducted this systematic review in accordance with the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (5). The review includes studies that examine the role of religion as a social determinant of mental health among displaced persons (refugees, asylees, and IDPs) in South Asian countries. To avoid confusion about the geographical boundaries of South Asia, we chose to only include members of the South Asian Association for Regional Cooperation (SAARC): Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka (6).

Researcher Positionality

As a non-South Asian researcher in the US, I understand that my perspective on mental health may differ quite considerably from South Asian perspectives. Although I have completed coursework in South Asian history, religion, and culture, I am aware that the majority of my knowledge has been acquired indirectly through secondary sources. Thus, my lived experiences may not resemble those of the populations I am studying.

Additionally, I am immersed in a culture that recognizes a variety of mental health disorders, and for the most part, encourages openness and transparency around mental health issues. While a number of mental illnesses do carry stigma, my personal experience with mental health stigma has been minimal. My education around mental health has primarily focused on biological and

psychosocial causes and treatment modalities, rather than spiritual or supernatural. Although I consider myself to be somewhat religious, I do not adhere strictly to a single religion or belief system. I have noticed that my immediate reaction to studies that privilege supernatural causes of mental illness is slightly dismissive. In continuing my research, I will try to remain conscious of this bias and consider how it impacts my analysis.

Search terms

We input search terms into four electronic database sources: PubMed, Embase, PsycInfo, and Web of Science. We looked for papers containing the terms “South Asia” (or one of the eight countries included in the SAARC), “religion,” “refugee” (or “asylee” or “displaced person”) and “mental health.” We then expanded the search to optionally include specific names of religions and common mental health disorders such as “depression” and “PTSD.” We used the Covidence database to extract and organize information from the articles. Since our focus is on mental health, we have used primarily health-focused databases in the search.

Inclusion criteria

We used the following eligibility criteria for inclusion: (1) peer-reviewed, (2) contained original research, (3) published after December 31st, 2011 and before the initiation of the search on January 5th, 2021, and (4) examined religion as a determinant of mental health.

Exclusion criteria

We excluded studies published in languages other than English, abstracts without full texts available, non peer-reviewed articles, and studies on refugees, asylees, and IDPs outside of South Asia. We also excluded other systematic reviews, editorials, theses, presentations, and scale validation studies. Lastly, we excluded articles published more than 10 years ago (before 2011), as well as those that focused predominantly on physical illness.

Figure 1

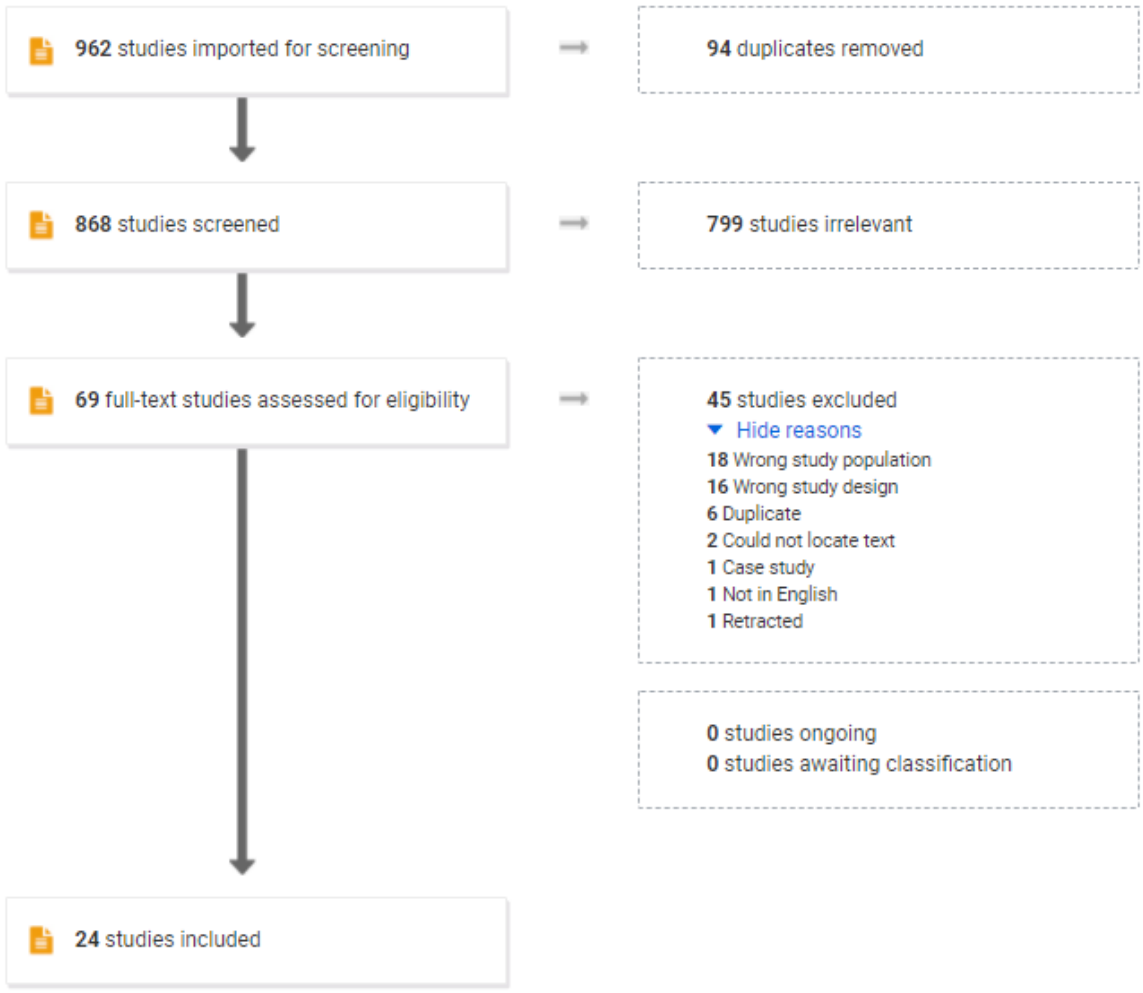
Boolean Search Term (Inclusion Criteria)	***Exclusion Criteria***
("South Asia" OR "India" OR "Nepal" OR "Pakistan" OR "Bangladesh" OR "Bhutan" OR "Sri Lanka" OR "Maldives" OR "Afghanistan") *AND ("Religion" OR "Religious" OR "Muslim" OR "Islam" OR "Jain" OR "Jainism" OR "Hinduism" OR "Hindu" OR "Christian" OR "Christianity" OR "Sikh" OR "Sikhism")* *AND ("Minority" OR "Refugee" OR "Asylum Seeker" OR "Asylee" OR "Displaced Person" OR "Forced Migration" OR "Conflict" OR "Unrest" OR "War")* *AND ("Mental Health" OR "Depression" OR "Anxiety" OR "Stress" OR "PTSD" OR "Trauma" OR "Suicide")*	• *Reviews (flagging reviews with helpful terms/definitions)** • *Editorials, theses, and presentations* • *Case studies, theory only* • *Primary focus on caste* • *Non-English Language publications* • *Non-South Asian population* • *Data collected outside of South Asia* • *Focus on physical illness, political issues (e.g. terrorism, radicalization)* • *Exclusive focus on healthcare workers (including caregivers)* • *Focus on non-South Asian military personnel deployed to the SAARC region* • *Scale validation studies* • *Published before the 2011 (last 10 years)* • *Article retracted* • *Could not locate full text*

Data extraction

After generating a list of articles using the search criteria above, we removed duplicate studies and screened the remaining titles and abstracts for eligibility. After eliminating duplicates, we screened a total of 868 articles. Titles and abstracts were screened by the primary and secondary student researchers (JE and MB), with approximately 60 discrepancies resolved by a third investigator (DR). The entire research team convened to discuss these discrepancies in detail, and this discussion led to clarification and refinement of our inclusion and exclusion criteria for the full-text review. Notably, we decided to expand our exclusion criteria at this stage to eliminate studies that focused primarily on caste. As a team, we agreed that the relationship between caste and mental health warranted its own study, as the scope of our review was too broad to capture the nuances of caste relations in South Asia. Upon completion of the title and abstract screening process, we conducted a full-text review to identify all articles meeting our inclusion criteria. Once again, both the primary and secondary student researchers (JE and MB)

screened the full-text articles for eligibility, and approximately 12 discrepancies were resolved by the third investigator (DR). We screened 69 articles in our full-text review, and 45 articles were excluded for a variety of reasons (see Figure 2). Of the 45 excluded articles, 6 were duplicates that were not recognized as such by the Covidence software (most likely due to slight variations in formatting). One article was originally published in German (although the abstract had been translated into English), one study was retracted after publication, and two texts could not be located. After discrepancies were resolved, we included a total of 24 articles in our final review.

Figure 2



Data analysis

We used thematic analysis to deductively code the articles in our final data set. The primary student researcher (JE) used a subset of 6 articles to generate a list of codes categorized into three code families: protective factors, risk factors, and associations/experiences with mental health (see Appendix 1 for the complete list of codes). We modified our code list after reading all 24 articles, combining and collapsing codes as needed. We also added the codes *self-efficacy/ self-compassion* under the code family of protective factors, and *internally attributed blame for traumatic events* and *stigma/ discrimination* under the code family of risk factors.

Timeline

Data collection began in January 2021. In February 2021, a second investigator (MB) was introduced to the specific aims of the review and trained in the screening process. The title and abstract screening began in late February 2021, and was completed in late March 2021. The full-text screening began in early April 2021, and was completed by May 1, 2021. The primary student researcher created the initial coding matrix in early May 2021. The coding matrix was reviewed and modified during the month of May, and blind coding was completed by the primary and secondary student researchers in early June 2021.

Results

Study Characteristics

The table below includes a breakdown of relevant characteristics of the 24 studies we coded in our final data set. Overall, two-thirds of these studies were conducted in either India or Sri Lanka. About a quarter of the studies recruited participants from multiple countries or countries that were not specified; however, when the country of origin was explicitly stated, we found that a notable percentage of participants had also migrated from India and Sri Lanka, with smaller percentages from other countries throughout South Asia and Southeast Asia. Nearly half of the

participants identified as Hindu. I have also included several other demographic characteristics that frequently appeared in the studies we coded.

Coding

The final version of our coding matrix consisted of 19 codes organized into 3 code families. Each of the 24 articles in our final data set was reviewed by the primary and secondary student researcher, and codes that applied to the articles were marked in the coding matrix. Of a possible 456 code applications (19 codes multiplied by 24 articles), both researchers agreed on the applications of 385 codes, producing an 84% agreement rate.

Overall, we found that codes for protective factors occurred with the greatest frequency, as the vast majority of studies we analyzed focused on the increased resiliency of displaced people who belonged to religious groups or faith communities. We also found that the majority of the articles in our final data set mentioned participants experiencing trauma, anxiety or depression. A low agreement rate (<80%) was exhibited for the codes *environmental factors*, *stigma/ discrimination*, and *trauma*, suggesting that further clarification of these codes and their applications may be necessary.

It should be stated that environmental factors are associated with both protection and risk, in that natural disasters have caused mass displacement in South Asia. We did not code for environmental factors as risk factors because in most cases, natural disasters did not have a direct association with religion. In contrast, religious beliefs and practices concerning physical environments frequently appeared as protective factors in our review.

Themes

Some salient themes we identified are interactions between religious identity, socioeconomic, and environmental factors that influence susceptibility to mental illness, as well as protective factors that may be either extrinsic or intrinsic to minority groups. For example, extrinsic factors include the availability and accessibility of psychological support services from aid organizations, whereas intrinsic factors include unique spiritual beliefs or practices within religious communities that contribute to resilience and safeguard against mental illness. Interventions that leveraged both extrinsic and intrinsic protective factors were particularly successful at improving mental health in refugee populations.

Our findings also indicate that many protective factors not only mitigate the effects of past trauma, but also help refugees cope with ongoing stressors. In many of the study populations of the articles we reviewed, festivals and ritual celebrations played an important role in promoting post-migration continuity and enhancing mental and emotional well-being. Festivals and ritual celebrations are also closely tied to intracommunal bonding and access to psychosocial support. Interventions that incorporated both new and familiar rituals, such as the testimonial ceremony (based on testimonial or narrative therapy) were effective at strengthening psychological resilience (7).

Discussion

The studies we coded in our final data set were primarily conducted in India and Sri Lanka, and the majority of study participants identified as Hindu. Many articles highlighted mental health challenges in specific ethnic minority groups such as the Tamil and Rohingya populations in Sri Lanka and Bangladesh, respectively. We also found that internally displaced persons from Kashmir and refugees from Tibet constituted a large portion of study participants. While most of the articles included in our analysis focused on populations displaced as a result of protracted

conflict, we also included several that examined the mental health of climate refugees. Finally, a number of studies were conducted across multiple countries, focusing on particular demographic groups such as women head-of-households, widows, and children and adolescents. Factors that protect against mental illness, such as spirituality, self-efficacy/ self-compassion, and mental health and psychosocial support were discussed most frequently and in the greatest detail, indicating that religion is associated with a multitude of characteristics that can be leveraged to improve the mental health of refugee populations. Although risk factors for mental illness are also prevalent in refugee populations, they can be targeted through advocacy efforts to promote legal protections, increase access to educational opportunities, and reduce stigma.

Limitations

Because our review excluded non-English language publications, there is a possibility that linguistic or translation biases could have influenced our results. For example, evidence from other systematic reviews has demonstrated that the vocabulary used to express emotions in South Asian languages does not always align with Western expressions, and this can lead to the misinterpretation of important mental health symptoms (8). Future studies would benefit from recruiting multilingual researchers to conduct smaller analyses with individual populations.

In addition to narrowing our review to include only publications in English, the scope of this study was quite large. We analyzed data collected throughout an entire region and looked at studies on populations with a diverse range of unique identities and characteristics. As such, we have drawn general conclusions that may not be uniformly applicable across all displaced populations in the SAARC region.

We also used research databases primarily focused on the health sciences and included studies that used a mix of quantitative and qualitative methods. Because many displaced populations are highly vulnerable, data collection can be challenging and time-consuming, which has led to a shortage of data in this area. We only had access to data that has been published, so publication bias constitutes another limitation of our analysis. The emergence of the COVID-19 pandemic in early 2020 constricted global health research and made data collection especially difficult. At the same time, the impacts of the pandemic have clearly exacerbated many of the mental health challenges that refugees face and created enduring obstacles to treatment and recovery. Future research should examine these effects in greater detail.

Lastly, this systematic review did not look at interactions between gender, caste, and social status. A substantial body of research has shown that these aspects of identity are strongly correlated with mental health in South Asia. We chose not to examine these complex interactions due to time constraints, and we opted instead to keep our analysis broad. However, this should not be construed as an attempt to minimize their significance, and future research would be strengthened by exploring these areas.

Conclusions

In conclusion, our data suggest that culturally relevant interventions informed by religious beliefs and practices can promote resilience in displaced populations, consistent with the findings of other systematic reviews. Our findings also show that having opportunities to bond with community members of the same faith and participate in rituals and festivals is an important factor in recovering from trauma, as well as managing symptoms stemming from the ongoing stress associated with migration and protracted conflict. Reducing stigma and discrimination on the basis of religion and increasing access to legal services and education can mitigate some of the risk for mental illness in these populations.

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Appendices

Appendix 1

Protective factors	***Risk factors***	***Associations/ experiences with MH***
Intracommunal bonding/ connectedness	*Pressure to conform to cultural norms*	*Psychosis*
Faith in rituals/ festivals	*Limited access to education*	*Trauma*
Spirituality	*Lack of legal/ social protections*	*Post-traumatic growth (PTG)*
Environmental factors	*Migration*	*Anxiety/ depression*
Openness to treatment options	*Ambiguous loss*	
Self-efficacy/ Self-compassion	*Internally attributed blame for traumatic events*	
MH/ Psychosocial support	*Stigma/ discrimination*	
	Protracted conflict	

Appendix 2

Country where study conducted	*Participants' country of origin*	*Participants' religious affiliation*	*Specific populations*
India: 33%	*Multiple or unspecified: 25%*	*Hindu: 42%*	*Tamil*
Sri Lanka: 33%	*India: 21%*	*Multiple or unspecified: 21%*	*Rohingya*
Pakistan: 13%	*Sri Lanka: 17%*	*Muslim: 21%*	*Tibetan refugees*
Bangladesh: 8%	*Tibet: 8%*	*Buddhist: 17%*	*Climate refugees*
Nepal: 8%	*Pakistan: 8%*		*Kashmiri IDPs*
Afghanistan: 4%	*Myanmar: 8%*		*Women head-of-households; widowed women*
	Afghanistan: 4%		*Children and adolescents*
	Nepal: 4%		
	Bhutan: 4%		

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