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A Systematic Review of Culturally Specific Idioms of Anxiety and Depression Among Refugee Women Across Displacement Contexts

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Abstract

Mental health research with refugees is largely driven by Western diagnostic frameworks, such as categories of anxiety and depression. But recent research has suggested that psychological distress is expressed and also comprehended in distinct ways across cultural contexts. This review aims to examine how refugee women use culturally specific idioms to express experiences of anxiety and depression across displacement contexts. A comprehensive search across databases like JSTOR, Google Scholar, Elsevier, PubMed and APA PsycINFO resulted in the identification of 89 unique records, out of which five studies met the rigorous inclusion criteria requiring either qualitative or mixed- methods research designs, adult refugee women, and documented anxiety and/or depression, and explicit mention of culturally specific expressions of distress. The findings indicated that refugee women consistently articulate distress through idioms that function across embodied, emotional, relational and spiritual/ moral dimensions, they describe anxiety and depression through expressions such as “deep sadness,” “stress, too many thoughts,” “fear,” somatic complaints, and metaphors of a “tired” or “crying” heart or soul. These idioms situate suffering within gendered experiences of intimate partner violence, displacement, poverty, and social isolation, and they strongly shape stigma, help-seeking patterns, and engagement with formal mental health services. They also overlap with clinical symptoms but women frame their distress mostly within social, relational and contextual realities rather than individual pathology. Across diverse populations and displacement contexts, distress is articulated as a meaningful response to loss, insecurity and hardship. This review amplifies the importance of recognising refugee women’s own explanatory models and calls for culturally grounded mental health assessment and intervention.

Keywords: refugee women, culturally specific idioms of distress, anxiety, depression, displacement

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Background and Rationale

The mental health system worldwide is reliant on Western psychiatric frameworks such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) to classify and determine anxiety and depression (Greene et al., 2022; Choe, 2024) and they, unseemly, suppose that all mental illnesses are encompassed in universal categories, and the symptoms are consistent. However, studies in other areas such as anthropology and transcultural psychiatry have disputed this apocryphal saying that psychological distress is not necessarily felt uniformly in all cultures and imply that most populations depend on the application of culturally specific idioms to convey distress, which capture their belief systems, moral values and social realities (Kaiser & Weaver, 2019; Hansen, 2019).

This matter, needless to say, is acute among the population of refugees. By April 2025, over 122.1 million individuals in the world had been displaced, with about 42.7 million individuals being refugees (UNHCR, 2025). Although women and girls make up nearly half of this group, studies on refugee mental health have predominantly used mixed-gender samples or not investigated distinct experiences of womanhood in conflict with the identity of a refugee (Brooks et al., 2022; Nagisetty and Thotaju, 2025). Sexual violence, domestic violence, the need to provide care, forced separation with children, and interrupted socially recognised roles in families and communal frameworks are only a handful of the vulnerabilities that refugee women are subjected to (Hossain et al., 2020; Maruf et al., 2025; Tanomand, 2025). Social isolation may also be supplemented by restriction of the mobility, cultural assumptions about gender separation, or family control over social contacts in the case of the Afghan women, in particular (Hosseini et al., 2025). Afghan women who are living in cities as refugees are usually exposed to what has been termed as social dislocation, in which they lack any significant social affiliations as well as group identity. According to Kalra et al. (2024), gendered experiences determine the level of distress and even the words used to describe distress.

It is essential to document prevalence rates of mental disorders, but the modern scholarship on qualitative research emphasizes the need to have an insight into the refugee experience in their own words and not using Western or colonial diagnostic typologies. Paudyal et al., (2021) emphasized that psychological distress in displaced individuals is not only diagnosed as per the criteria of DSM diagnostic definition but manifested as an embodied culturally specific symptom or a pattern of distress not within the limited definition of DSM. The Afghans express

their psychological torment by using culturally based idioms such as thinking too much that embodies continuous rumination of a lost homeland, lost family and unsure of the future (Sulaiman-Hill & Thompson, 2012). A person applying this idiom can make Western psychology think that this is a state of anxiety or depression, but it is something more organic, based on lived situations and culture (Dieste et al., 2025). Moreover, Lavdas et al. (2023) demonstrated that such meaning- making is inscribed in cultural reasoning and that the Afghan model of explaining distress tends to define pain as thinking too much, spiritual stress, physical tension or moral burden instead of stating that depression or anxiety is the reason.

Culturally specific idioms of distress are words or phrases that demonstrate psychological distress and are meaningful locally, culturally and demonstrate common symbolic, linguistic, and explanatory systems (Kaiser and Weaver, 2019). Anxiety and depression reflect clinically important distress that can be identified by either formal diagnostic criteria (DSM-5 ICD-11), validated screening scales (Patient Health Questionnaire- 9 (PHQ-9), Generalised Anxiety Disorder-7 (GAD-7), Hopkins Symptom Checklist) or description of the participants (persistent fear/worry, persistent sadness/hopelessness, anhedonia, sleep/appetite disturbance, concentration issues, somatic symptoms). Notably, the emphasis is mostly put on the language and interpretation of women themselves. Distress also has a somatic and relational manifestation, which is reported on the lived experiences of refugees, and results in chronic fatigue and sleep disorders, bodily pains and emotional withdrawal (Schlaudt et al., 2020). Since forced migration removes the family connections, the ties of the community and social roles, it becomes a core of this distress. Also, post- migration stressors have been described as social isolation and discrimination as the most powerful (Jannesari et al., 2020). In addition, Warsi (2025) presents the concept of dual grief, which forced migrants tend to live with: the grief of the homeland and the grief of the social status, sense of self and career paths. The term displacement context used is to refer to the different ecological contexts where refugees are forced to migrate.

The necessity of this review is emphasized in various theoretical and empirical discussions, the disagreement between diagnostic universalism and cultural specificity being one of them. Mental disorders may be identified with the help of standardised tools, yet transcultural studies indicate that there is a significant difference in the significance of symptoms, their salience, and manifestation (Greene et al., 2022). Second, the understanding of gender is inadequately reflected in the literature of research on refugee mental health, despite the

established vulnerability of women; the lack of synthesis of knowledge on cross-gender impacts on cultural expression of distress is insufficient (Brooks et al., 2022; Kalra et al., 2024).

Method

This review followed a transparent search strategy, clearly defined inclusion and exclusion criteria, and a structured screening and extraction process. The goal was to ensure that the study selection was systematic, reproducible and directly answered the research question, i.e., *how do refugee women use culturally specific idioms to express experiences of anxiety and depression across displacement contexts?*

The first search brought 89 unique papers after eliminating duplicate records that was done manually. All 89 titles and abstracts were evaluated in line with the inclusion criteria. In this step, the researchers identified the studies that used refugee women, dealt with psychological distress, and incorporated culturally-specific types of expression. Following this 47 papers were retained for a full-text review to determine if each study met all the inclusion criteria. Finally, five studies met all the requirements and were included in the final synthesis.

Inclusion Criteria

First, the research design was required to be qualitative or mixed-methods with extractable qualitative results because the review specifically targets the processes of language and meaning-making by participants themselves. The researchers had to give first hand qualitative information which could be in the form of interviews, focus group discussions, narrative descriptions or thematic results. The participants needed to be refugee adult women of 18 and older age. Only studies with a mixed-gender sample were included in case of a clear disaggregation of the findings on the basis of gender and the ability of women narratives to be independently analysed.

The study also ought to record or measure anxiety and/or depression and that could be done by way of a formal diagnosis, validated screening measures or elaborate descriptions of the symptoms in line with anxiety and/or depression. And the paper had to clearly address cultural peculiarities of psychological distress. This encompassed the embodied or somatic presentation, emotional presentation by the use of culturally meaningful terms, relational presentation in terms of family or community or symbolic/spiritual presentation. Only peer-reviewed journal articles in the English language were included.

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Data Extraction and Analysis.

A systematic methodology was used to carry out the data extraction process; the features of the studies such as the year of publication (2016- 2022), geographical location and population of refugees of the study were extracted. The other information which was considered was the mixed- method study design and methodological approach, the demographics of the participants i.e female adult refugees , and culturally specific idioms of distress identified in the study, types of cultural expression recorded, which were embodied, emotional, relational and symbolic or spiritual expression, relationship between identified idioms and anxiety, and expression, indicators of methodological rigor, including sampling technique and analytic procedures and key findings related to meaning- making, explanatory models and coping strategies. After this, the results of each study were analysed by adopting a narrative synthesis approach. The review explored trends in terms of articulating distress which were practiced by the refugee women, how this articulation was placed in cultural and relational ways as well as how it was noncongruent or congruent with the Western diagnostic standards.

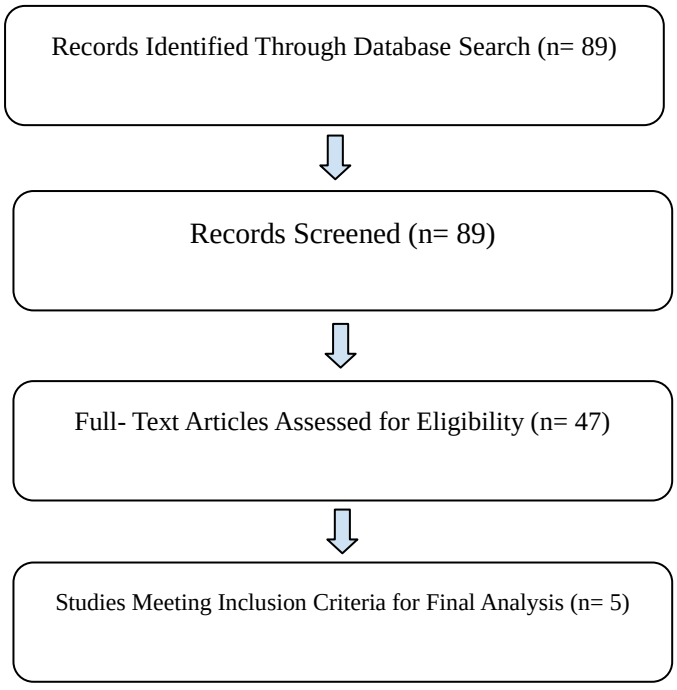

Fig. 1.

PRISMA Flowchart

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Results

The records were recognized by conducting a thorough search across PubMed, PsycINFO, Web of science, Google scholar and checking references and important journals pertaining to refugee mental health and transcultural psychiatry and global health. After the strict evaluation of all the criteria, five articles were selected and fulfilled the criteria necessary and were incorporated into the final review, 42 articles were eliminated at the full-text level; 18 of them employed only quantitative survey tools, like PHQ-9 or GAD- 7 questionnaires, but did not focus on own words and definitions of distress in women. They provided some useful information such as prevalence rates, but they have not provided any qualitative data that was essential in comprehending how women explain and conceptualize their suffering. Eight of the studies covered mental health but failed to specifically measure anxiety or depression. Ten studies involved women but did not distinguish the findings to the gender and thus it was hard to determine their manifestations of distress. And six articles included refugees with other migrants or mixed gender males and females without data disaggregation.

The five studies incorporated were carried out in Asia, Africa, Europe and North America and they evaluated the refugees in camps, transit and the host countries. They were Congolese, Afghan, Iraqi, Great Lakes Africans, Rohingya, Somali, Ukrainian, Syrians and Australian resettled refugee women. The collected data were undertaken in the period of 2014-2023 and all studies in general represent over 850 participants.

The mixed-methods study by Greene et al. (2022) involved 366 female victims of intimate partner violence in Nyarugusu refugee camp, located in Tanzania.. 55 in-depth interviews involving the 366 women were conducted, using free-listing and open-ended questions and using the interview questions, which did not impose any Western diagnostic criteria and explicitly asked the women, "*How do these problems affect you?*" and "*How do you know when someone is suffering?*". This also allowed them to communicate distress in their own cultural terms and constructs. The following phase was the quantitative one that examined 311 individuals with the Common Mental Disorder screening instruments and documented anxiety, depression and PTSD.

The qualitative data and quantitative data were analysed using thematic analysis and exploratory factor analysis, respectively. This resulted in three culturally specific concepts, i.e, *huzuni* (deep sadness), *msongo wa mawazo* (stress/ too many thoughts) and *hofu* (fear). The convergence of local concepts with symptoms was analytically displayed with factor structures

from local idiom- based constructs. This helped in moving from women's own language to structured quantitative measurement, but keeping cultural validity in mind.

Choe et al. (2019) also opted for this methodology but extended it with 298 recently resettled Afghan, Iraqi and Great Lakes African refugees in the United States. This study employed 18 semi- structured interviews conducted inductively and deliberately attending to the multiple settings where participants lived and worked, the impact of traumatic events of pre and post migration and experiences of resettlement stressors. And this contextual awareness acknowledged that idioms of distress emerge not in abstract but in specific contexts of lived experience.

Here, the researchers identified idioms: *"thinking too much"* and *"too many thoughts"* referring to mental preoccupation and worry, *"pressure in the head"* referring to somatic-cognitive stress. Additionally, women linked these idioms to post- migration stressors like family separation, financial strain, discrimination, loss of professional roles and difficulties in parenting. This study found that women's own language indicated symptom clusters comparable to common mental disorder constructs while also embedding stress in social, relational and contextual meaning.

Tay et al. (2019) conducted a comprehensive systematic review of the mental health literature of the Rohingya community. The findings indicated that women from this community expressed distress through emotional language, such as fear and sadness and also through bodily complaints, like headaches, gastrointestinal symptoms and chest pain. Additionally, these embodied expressions were particularly common where social norms limited open emotional expression. Women also linked distress to relational and spiritual concerns like sexual and gender-based violence, injustice and moral suffering.

Markova and Sandal (2016) analysed lay explanatory models of depression among the Somali refugees in Norway using mixed-methods vignette methodology combined with separate focus group discussions with men and women. Women attributed depression to social isolation, trauma, spiritual and relational causes rather than biological reasons. They preferred religious, family- based coping, ethnic/ religious community engagement and interaction with religious leaders over professional treatment and also described depression using phrases related to *"thinking too much"*, linking distress to circumstances rather than individual pathology. The study also found that cultural authorities like fathers, elders and religious leaders served as

"gatekeepers" to mental health support and determined whether women could access services. This illustrated how comprehending culturally specific idioms cannot be separated from understanding social structures and power dynamics.

Vromans et al. (2020) conducted a longitudinal mixed-methods study on 83 Australian resettled refugee women at risk (mean age 33.41 years, SD=11.93) at one year post migration. The researchers assessed trauma events and symptoms, loss distress, post- migation issues, anxiety, depression and somatic symptoms using formal screening instruments and qualitative interviews that captured their own language of distress. Despite one year of resettlement, 39% women reported depression above clinical cut-offs, 32% reported anxiety and 20% reported PTSD. Many showed no improvement in symptoms from the first assessment. Qualitative analysis found that women articulated distress through "*loss distress*", which is profound grief for lost family, homeland and life pre- war as well as social status. They expressed a lack of trust in community members, linked to hypervigilance, threat perception, and difficulty forming relationships. Longitudinal design aided the unveiling of chronicity and persistence of distressing, indicating that psychological suffering in refugee women is not an acute adjustment difficulty but an enduring complex trauma- loss disruption mix. The most frequently used idiom was *"thinking too much"* or similar phrases, *"too many thoughts"* or *"pressure in the head"*. These were seen across various cultural groups, but the meaning they carried was subjective. For some women, it referred to worry about family safety and to financial insecurity and for some it related to trauma or social isolation. Although the phrases are similar, the content and emotional meaning are dependent on the context.

Huzuni (deep sadness) was specific to the Congolese women and reflected symptoms similar to clinical depression, like hopelessness and withdrawal. *Msongo wa mawazo* meant ruminative thinking and distress that combined anxiety and trauma symptoms and *hofu* described ongoing fear and hypervigilance, especially in unsafe environments. Somatic or embodied expressions like headaches, chest pain, sleep problems and weakness were seen in all studies. They are not random physical complaints but a way of expressing distress when it is not socially accepted. Relational expression also appeared in all five studies, where women framed psychological suffering in terms of relationships and roles. Loss of family through death or permanent separation, inability to fulfil mothering or household responsibilities because of poverty, displacement or health constraints, relationship conflict like domestic violence, social isolation and inability to form new relations in host countries.

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Table 1.

Specific Idioms by Type of Expression

Study Population	Emotional Idioms	Embodied Expression	Relational Framing	Spiritual/Moral Meanings
Congolese women	Huzuni (deep sadness), too many thoughts	Headaches, chest tightness, body weakness	Inability to care for children, family conflict	Moral failure as good wife/mother
Afghan/Iraqi/African women	Sadness, worry, cognitive overload	Pressure in head, somatic arousal	Separation from family, role loss	Grief for lost status
Rohingya women	Fear, sadness, mental burden	Head/chest/ GI complaints, pain	Family conflict, gender-based violence, and constrained mobility	Spiritual suffering, injustice
Somali women	Sadness, grief, fear	Unspecified physical manifestations	Social isolation, family separation	Spiritual possession, past trauma
Australian refugee women-at-risk	Sadness, anxiety, numbness	Persistent pain, sleep disturbance	Solo parenting burden, family separation, distrust	Inner emptiness

Discussion

This review of five qualitative and mixed-methods studies represents over 700 refugees across different displacement contexts and found consistent evidence that women express anxiety and depression through culturally specific idioms such as *huzuni*, *msongo wa mawazo*, *hofu* and

thinking too much. Standardised instruments recognise symptoms, since these idioms overlap with DSM-5 and ICD- 11 categories of anxiety and depression (Greene et al., 2022; Choe et al., 2024; Vromans et al., 2020). But these women interpret their suffering as rooted in family separation, violence, social loss, discrimination and structural uncertainty rather than intrinsic problems.

This review demonstrates that the anxiety and depression experienced by refugee women are expressed through culturally specific idioms, which are embodied, emotional, relational, and spiritual. Women in studies did not merely state that they were depressed or anxious. Rather, Congolese women talked about *huzuni* (deep sadness) and too many thoughts, usually combined with headaches, chest tightness, and body weakness (Greene et al., 2022). Afghan, Iraqi, and Great Lakes African women reported about head pressure, sadness, and cognitive overload, and related them to separation and loss of social roles (Choe et al., 2024). The most common complaints of Rohingya women were head, chest, and gastrointestinal pain, as well as fear and a heavy mental burden, particularly amidst family conflict, gender-based violence, and limited mobility (Tay et al., 2019). Somali females explained sadness, grief, and fear, with the inclusion of spiritual possession or previous trauma, and emphasized social isolation and family separation (Markova and Sandal, 2016). The Australian women-at-risk refugees claimed that they experienced chronic pain, sleep disturbance, anxiety, numbness, and inner emptiness, which were usually associated with single parenting burden, distrust, and family loss (Vromans et al., 2020).

These idioms match with DSM-5 and ICD-11 at the symptom level. Depression and anxiety manifestations that can be identified are sadness, worry, rumination, sleep disturbance, and somatic tension. The sense attached to these experiences is, however, different, women always explained their predicament in terms of relational disconnection, failure to take care of children, mourning over lost status, family struggle, and moral accountability. As an illustration, when Congolese women talked about distress, they referred to the inability to be a good wife or a good mother, whereas Afghan and Iraqi women mentioned excessive thinking, as something that leaves them uncertain about people they love remaining behind (Greene et al., 2022; Choe et al., 2024). Rohingya and Somali women also said that they felt a spiritual burden or injustice instead of illness (Tay et al., 2019; Markova and Sandal, 2016).

These results indicate convergence of the symptoms but divergence of the meaning on a symptom level. The standardized tools can capture the symptoms showing distress, however, they do not adequately capture the way women make sense of why they are not doing well. Wessells &

Kostelny (2022) highlighted how distress is shaped through gendered structures of power. The feminist and postcolonial perspective iterate women's expressions of suffering are not solely cultural, they represent situated knowledge emerging from structural violence. Congolese women's sense of moral failure reflects internalised patriarchal expectations, where their identity is tied to caregiving roles that shift under conditions of displacement and poverty. This inevitably leads to a gap between expected roles and lived reality, producing a form of gendered suffering. This distress is not adequately documented by clinical depression categories because they largely pathologise the women rather than recognising the structural impossibility that generated their suffering. Afghan and Iraqi women also faced grief for lost status because of disruption of socially embedded identities, where their personhood is constituted through family and community roles rather than individuality. Feminist scholarship on refugee experiences has proven that women's displacement experiences differ fundamentally from men's because the former's identity is more tightly bound to domestic and community roles and displacements severs these identity anchors completely (Gatwiri & Kim, 2024)

Similarly, Rohingya women's experience of gender- based violence and constrained mobility cannot be separated from their expressions of distress, since physical immobility, that is, being confined, unable to move freely in public spaces due to gender norms, becomes encoded in somatic symptoms and emerges in emotional expressions of fear. According to Maruf et al., (2025), constrained mobility is both literal and metaphorical, since they prevent one from making autonomous decisions and controlling one's body through reproductive choices. This produces the embodied immobility syndrome, distress that manifests through the body because women's bodies have been rendered immobilised by gendered power structures. Somali women attributed depression to "spiritual possession" and through the feminist lens it can be recognised that spiritual frameworks often encode gendered power relations, where women's psychological distress is attributed to spiritual causes in order to avoid confronting structural, social and relational dimensions of their suffering that might implicate patriarchal systems (Markova & Sandal, 2016).These findings can also be understood through identity theory, specifically the relational models of selfhood. Tol el al., (2018) explains that in many non- Western contexts, identity is not individual but constituted through relationships and roles and displacement disrupts these relational anchors. This emotional distress eventually turns into fragmentation of self, like the inability to perform the role of a mother or a wife leads to ontological disruption rather than just psychological distress.

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The strength of these findings lies in the consistency across different methodologies, populations and displacement contexts. However, it is important to acknowledge a few limitations, including small sample sizes and limited population coverage. But despite these, the convergence of findings supports the view that refugee women use culturally grounded idioms that move beyond diagnostic categories. This suggests that refugee mental health practice should recognise women's knowledge systems as legitimate rather than subordinate to Western diagnostic frameworks.

Implications

This review underscores the importance of future research moving away from Western classifications for mental disorders and instead emphasizing culturally-specific idioms of distress as legitimate and significant articulations of suffering. Future research must prioritize understanding the explanations of distress among women in their own terms and in their language and not reduce these articulations to analogues of anxiety and depression. In addition, there is an evident gap in longitudinal research concerning the development of these idioms at various stages of displacement and distressing events in their context, such as legal uncertainty, gender-based responsibilities, and poverty. The research methodology must focus on qualitative and participatory methods where refugee women are regarded as knowledge generators. Lastly, comparative and tool development studies are needed to explore commonalities and variations in distress among women refugees as well as create culturally-appropriate assessment measures.

Conclusion

The evidence provided in this review indicates that culturally specific idioms are not inaccurate translations of Western diagnoses but coherent knowledge systems in their own right. Research must move forward from superficial cultural adaptation toward genuine engagement with explanatory frameworks. Equitable and effective mental health care for refugee women is, hence, dependent on respecting their lived experiences and meanings of distress.

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