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PERSPECTIVES ON MENTAL HEALTH PROBLEMS, MENTAL HEALTHCARE, AND QUALITY OF LIFE FOR PEOPLE LIVING IN AREAS OF CRISIS.

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ABSTRACT

This study aims to explore mental health (e.g. depression and PTSD) as well as the quality of life for people living in or coming from areas of crisis. The study also linked these mental health variables and quality of life (QoL) with access to mental healthcare; as well as QoL with receiving mental healthcare. The research also aims qualitatively to discover healthcare workers' perspective about access to mental healthcare, treatment methods, barriers to seeking therapy and number of beneficiaries in those countries. Studies have shown that individuals in Yemen, Sudan, and Syria have been facing recurrent exposure to stress, loss, and trauma, resulting in severe mental health difficulties and reduction in QoL. Common mental disorders prevalent among those exposed to war and conflict include PTSD and depression. Limited access to mental healthcare exacerbates the situation, affecting people's mental health and QoL. The study employed a mixed methods approach. PCL-5, PHQ-9, and WHOQOL-BREF questionnaires are used for PTSD, depression, and quality of life among 118 Syrian, Yemen, and Sudan adults. Semi structured interviews were conducted with 3 healthcare workers to explore access to mental healthcare, treatment methods, and number of beneficiaries. Over 52.5% exhibited high PTSD risk, and 55% showed moderate to severe depression symptoms. More than half lacked mental healthcare access, and most hadn't received prior care. There were significant differences in mental health disorders and QoL with the accessibility to mental healthcare. There was no significant difference in QoL between those who received mental healthcare and those who did not. Thematic analysis identified two master themes: access to mental healthcare and barriers to seeking therapy.

1.INTRODUCTION

1.1 Background

Several Arab countries such as Yemen, Sudan, and Syria have been witnessing unfortunate situations with political unrest for several years. The people of those countries have been facing severe psychological difficulties such as frequent exposure to stress, loss, and trauma. This happens repeatedly with the different difficult experiences they face, which has a direct effect on their mental health. Mental health is recognized as the most significant public health issue for people living in areas of crisis (Mohammad, ALBashtawy, Nasser , & Nasir, 2014). It is also considered a key requirement for individuals to live a normal life, cope with different stressors of life, and work productively in their community. The common mental disorders among people who are exposed to war and conflict are post-traumatic stress (PTSD) and depression disorders (Birhan, Deressa, Shegaw, Asnakew , & Mekonen, 2023). Research has shown that the prevalence of PTSD and depression disorders among populations affected by war and crises is high (Fazel, wheeler, & Danesh, 2005). According to Mayo Clinic, PTSD is a mental health condition resulting from experiencing a terrifying situation. This condition comes with several symptoms such as flashbacks, nightmares, or severe anxiety (Allen, et al., 2022).On the other hand, depression can be considered as a medical illness that affects how people feel, the way they think, and how they react. It causes emotional and physical problems that can decrease the ability to function at work and home (Torres, 2020).

Due to the civil wars, a large number of people have fled their countries and sought asylum in other stable countries. Despite their escape to find peace and safety, the mental health impact could continue for a long time regardless of the change and their new situation as refugees. Although the majority of those refugees found a relatively safe environment after overcoming significant risks to get to their destination, many suffered psychologically because they were separated from their home country, family, friends, and regular job environment while also dealing with poor living conditions.

The exposure to mental disorders or unrest situations in their home countries or abroad as refugees may lead to a reduction in their quality of life for many years. The term quality of life (QoL) refers to the well-being, of people in terms of both positive and negative elements within the entirety of their existence at a specific point in time which includes one's health, employment situation, relationships, education level, sense of security and safety etc. (Teoli & Bhardwaj, 2023). It would be one of the most critical elements in assessing the current situation of a population. Those studies and assessments would be very useful for health service providers to evaluate the needed support from different support agencies to improve a better quality of life for those people.

1.2 Literature Review

Many studies have been conducted to explore mental health impact as well as the quality of life for people living in areas of crisis such as Syria, Sudan, and Yemen. One of the studies was conducted in Syria on 1951 participants between the age of 19 and 25 using online surveys (Kakaje, et al., 2021). The objective of the study was to evaluate the post-traumatic stress disorder (PTSD), and the severity of the mental distress of those inside Syria or the Syrian refugees which

is caused by war and became worse by other factors such as the lack of social support. It was found that war resulted in significant mental disorder and full PTSD symptoms in most of those that lacked social support in these regions. The study revealed that there are various prominent factors that lead to severe PTSD and mental distress such as the number of times changing places of living due to war, educational level, and being distressed by war relevant loud sounds and noises. There were no differences in PTSD and mental disorder occurrence for people living in different regions or for those having different types of jobs. On the other hand, a few of the people in the same sample group had neither positive PTSD nor mental disorder symptoms.

In another study conducted in Syria on 1215 Syrian refugees to evaluate health-related quality of life (HRQoL) among Syrian refugees resettled in Sweden and how it is related to sex, age, education, area of residence, cohabitation, and social support (Gottvall, Sjölund, Arwidson, & Saboonchi, 2020). They reported that 59% of the refugees reported low social support. In addition, a low HRQoL index score has been reported which implies that there exists a positive correlation between higher index score of HRQoL and presence of social support. Another study was conducted in Syria on 133 Syrian refugees to determine healthcare services utilization (HCSU), healthcare costs and health-related quality of life (HrQoL) of Syrian refugees with mild to moderate Post-Traumatic Stress Symptoms (PTSS) using EQ-5D-5L a self-assessed, health related, quality of life questionnaire (Grochtdreis, et al., 2021). They found that the EQ-5D-5L index score was lower in those with probable PTSD than it was in those without probable PTSD. Finally, a study was conducted to assess quality of life in multi-traumatized refugees using the World Health Organization Quality-of-Life Scale (WHOQOL-BREF) (Teodorescu, et al., 2012).

They found that quality of life in physical health, psychological health, social relationships, and environmental health were low, well below the threshold for 'life satisfaction'.

A different study that took place in Jordan with a group sample of 155 Syrian refugees living in Jordan to examine PTSD symptoms (Jarrah, 2015). The study reported that more PTS symptoms were noticed for refugees who experienced traumatic events. Significant differences in the level of post-traumatic disorders among Syrian refugees was observed which could be attributed to certain factors such as gender, marital status, and education. For example, women suffered from PTSD more than men. This could be due to their sensitivity and increased sense of family commitment.

Another study was carried out among 494 married Syrian refugees couple residing in the Kurdistan region to examine the psychological consequences (i.e., PTSD and depression symptoms) of the crisis among the refugee population who fled to Iraq (Mahmood, Ibrahim, Goessmann, Ismail, & Neuner , 2019). It was found that more than half of the sample in a refugee camp in Iraq suffer from PTSD and depression. Among the different reasons, being female, older, and living at camp for an extended period of time, in addition to the many traumatic events experienced were all strongly associated with PTSD and depression.

Access to mental healthcare providers in areas of conflict is a challenge that prevents the treatment for those who need it. A study was conducted in Juba, Southern Sudan on 1242 adults aged over 18 years to measure PTSD and depression in the population (Roberts, Damundu, Lomoro , & Sondorp, 2009). This research highlighted the prevalence of PTSD and depression

among Sudanese people which over one third of respondents have symptoms of PTSD and half of respondents have symptom of depression. Unfortunately, they had limited resources for mental healthcare despite the great demand among those who have recently experienced conflict. Similarity, one study done in Yemen presented that individuals in low-income nations have been seen to experience mental health problems like depression, anxiety, and post-traumatic illnesses with a minimal lobbying activity to improve circumstances and mental health services (Tomada & Getty, 2017). Furthermore, only four mental facilities exist in all of Yemen. The nation's health system is in a bad shape and become worse because of the war, making it incapable of addressing many psychological health issues (Alhariri, Mcnally, & Knuckey, 2021).In addition, there is a shortage of psychologists where there is only one psychologist for every half a million people. This ratio is way below the average of other countries where the average number of specialists is one for every 10,000 individuals globally and one per 100,000 people in the Middle East (Samara, Hammuda, Vostanis, El-Khodary, & Al-Dewik, 2020). According to the Sana'a Center for Strategic Studies there is a serious lack of funding for mental health issues from both local and international community (Tomada & Getty, 2017). This gets even more challenging with the perception of the local people around patients with mental illness.

1.3 Gap in The Knowledge

Although many studies have explored mental health impact on people living in areas of crisis, there is a lack of research on the extent of the impact of crisis on the quality of life. This research gap limits our understanding of the well-being, happiness, and satisfaction in life of those suffering from mental health disorders. Therefore, this study aims to explore the quality of life

among Arab population who are living in areas of crisis considering the various effects of demographics, mental disorders, and accessibility to mental healthcare.

Another important aspect is that there are no articles discussing the accessibility to mental -healthcare facilities in Syria, Sudan, and Yemen. This study will take a deeper look from healthcare workers' perspective about access to mental healthcare and barriers to seeking therapy by using a semi structure interview.

Moreover, other investigations that look on PTSD and depression among specific groups of society usually do not collect the important information needed to understand the mental health impact. This work will take in consideration important variables such as the mental health background of the participants, the country of residence, current employment, and marital status. Collecting this information from people living in this unfortunate situation will assist with the analysis and understanding the mental health impact on the various types of people living in these conditions. Expanding the research sample to cover a larger group of people will help conduct a more comprehensive analysis and reach a more reliable outcome, which is going to be sought after if possible.

1.4 Aim of the Study

This research aims to explore mental health (e.g. depression and PTSD) as well as the quality of life for people living in or coming from areas of crisis. The study also linked these mental health variables and quality of life with access to mental healthcare; as well as quality of life with receiving mental healthcare. The research also aims qualitatively to discover healthcare workers' perspective about access to mental healthcare, treatment methods, barriers to seeking therapy and number of beneficiaries in those countries.

2. METHODOLOGY

The methodology in this study adopted a quantitative as well as qualitative design approach. Quantitative methods were found to be appropriate tools for investigating and evaluating PTSD, depression, and quality of life among certain populations. The survey included three assessments tools which were PTSD Checklist for DSM-5 (PCL-5) for PTSD, Patient Health Questionnaire-9 (PHQ-9) for depression, the World Health Organization Quality of Life – BREF (WHOQOL-BREF) for quality of life, and participants' demographic information.

The qualitative approach utilized semi-structured interviews with healthcare workers, psychologists, and psychiatrists to explore the accessibility to mental healthcare, treatment methods, barriers to seeking therapy and number of beneficiaries.

2.1 Participants

The quantitative method was employed to support this study by gathering data from 118 participants living in various areas of crisis. The targeted population in this study are male and female adults originating from Syria, Sudan, and Yemen who are living in their home country. A critical factor for the study is the relevant experience of the participants such as the exposure to the horror of wars or being misplaced by the war to other countries.

A total of 118 participants with 93 female (78.8%) and 25 male (21.2%) took the questionnaire. The participants indicated that 60.2% were Sudanese (n=71), 21.2% were Yemeni (n=25), and 18.6% were Syrian (n=22). The study sample were adults ranging from 18 to 45+. Out of the total sample, 77.1% (n = 91) were Single, and 22.9% (n= 27) were married. Over 44.1% (n= 52) of the sample were students, 30.5% (n= 36) of the sample were unemployed, and 25.4% of the

sample were employed. As for the level of education, more than half of the sample had study university 66.9% (n=79) 30.5% of the sample high school (n=36), 1.7% of the sample secondary school (n=2), and 0.8% of the sample high primary school (n=1). As for the city of residence, slightly more than half of the respondents are living in their countries during the crisis, and less than the half are living in other countries such as Saudi Arabia , Sudan , Egypt , UAE, Malaysia , Yemen, Syria , Turkey , Libya, Oman, Lebanon. The characteristics of the sample (n = 118) are shown in Table 1.

As for the qualitative part of the research, interviews were conducted with three participants to explore the accessibility to mental healthcare, treatment methods, barriers to seeking therapy and number of beneficiaries. Table 2 shows the participants' demographic information.

Table 1: Participants' demographic information showing the characteristics of the sample using the quantitative method.

Characteristics		Frequency [n]	Percentage [%]
Age	18 – 25	72	61.0%
	25 – 35	34	28.8%
	35- 45	8	6.8%
	45+	4	3.4%
Gender	Female	93	78.8%
	Male	25	21.2%
Nationality	Sudanese	71	60.2%
	Yemeni	25	21.2%
	Syrian	22	18.6%
City of residence	Saudi Arabia	21	17.8%
	Sudan	35	29.7%

	Egypt	20	16.9%
	UAE	5	4.2%
	Malaysia	1	0.8%
	Yemen	21	17.8%
	Syria	9	7.6%
	Turkey	3	2.5%
	Libya	1	0.8%
	Oman	1	0.8%
	Lebanon	1	0.8%
Level of Education	University	79	66.9%
	High school	36	30.5%
	Secondary school	2	1.7%
	Primary school	1	0.8%
Marital status	Married	27	22.9%
	Single	91	77.1%
Employment status	Unemployed	36	30.5%
	Employed	30	25.4%
	Student	52	44.1%
Accessible of mental healthcare	Yes	49	41.5%
	No	69	58.5%
Receiving mental healthcare before	Yes	6	5.1%
	No	112	94.9%
Are you currently ill or do you have a medical condition?	Yes	11	9.3%
	No	107	90.7%

Table 2: Demographic Information of Interview Participants.

Participants	Country	Specialization	Years of Experience
Participant 1	Syria	Psychiatrist	18 years
Participant 2	Yemen	- Majority: Bachelor of Medicine and Surgery (MB.ChB.) - Diploma Of neonatology	7 years
Participant 3	Sudan	Senior Psychotherapist	22 years

2.2 Procedures

This study deployed a quantitative as well as qualitative design method. The participants of the quantitative method received an online electronic survey by Google form application and distributed through social media platforms. It is designed to obtain data on parents' QoL, PTSD, and depression. In the survey, the first component of the survey contained a detailed consent form, a brief description of the study, the study's purpose, and the estimated 15 to 20 minutes required to complete the survey. The questionnaire had four sections translated into Arabic and English : (1) participants demographic information, (2) Organization Quality of Life Brief Version (WHOQOL -BREF) questionnaire, (3) PTSD Checklist for DSM-5 (PCL-5), and (4) Patient Health Questionnaire-9 (PHQ-9).

The semi-structured interviews were conducted online through phone with an identified healthcare worker psychologist, and psychiatrist. The interviewed individuals were asked a total of four open-ended questions related to access to mental healthcare, treatment methods, and number of beneficiaries. The duration of each interview was 20–48 minutes, and it was conducted in English.

2.3 Ethical consideration

Participants received a consent form for Participation in Research that contained information about the nature and the purpose of the study, as well as the estimated time required to complete the survey, and the interview. They were also informed that all data collected was confidential and anonymous. After the responses were collected, they were securely stored in a password-protected file on the researcher's laptop, ensuring that only the researcher had access to the information. The study was approved by Effat University with Decision (No. RCI_REC/7.Sep.2023/7.1.Exp.6.).

2.4 Measures

2.4.1 Quality of Life

The widely used WHOQOL-BREF survey instrument, created by the World Health Organization (WHO), gathers data required to evaluate a variety of subjective factors associated with a respondent's quality of life (Vahedi, 2010). The 26-item test covers four QoL domains: environmental health (eight items), social relationships (three items), psychological health (six items), and physical health (seven items). Furthermore, there are two items that assess general

health and overall quality of life. Participants use a 5-point Likert scale ranging from “very dissatisfied” (1) to “very satisfied” (5); from “very poor”(1) to ”very good” (5) ; from “not at all” (1) to “extremely” (5); from “not at all" (1) to "completely” (5)); or from “never” (1) to “always” to show how much they had experienced the things over the preceding two weeks. The reliability of the questionnaire was satisfactory, with a Cronbach's alpha (α) of 0.881.

2.4.2 Post Traumatic Stress Disorder

PCL-5 is an instrument created in the 1990s by Frank Weathers and colleagues at the National Center (Hamblen, J, & Barnett, 2018). The PCL-5 is a 20 item self-report assessing the 20 DSM-5 symptoms of PTSD. On a 5-point Likert scale from 0 to 4, respondents are asked to rank how bothered they have been by each of the 20 items in the previous month. The scales ranges from “not at all” (0); or from “extremely” (4). Moreover, to get a total severity score ranges from 0-80. The PCL-5 has translated into different languages, including Arabic. Regarding the scale’s reliability, it was determined to be good with a Cronbach-Alpha (α) of 0.876.

2.4.3 Depression

PHQ-9 is an instrument developed by Drs. Robert L. Spitzer and colleagues in 1999 for screening, diagnosis, monitoring, and measuring the severity of depression (Marvin & PT, 2011). It contains 9 items from the DSM-IV used in the diagnosis of depression. Each item is rated on a severity scale from 0 to 3, with respondents indicating the frequency of each symptom over the past 2 weeks. The scale ranges from “ not at all” (0); “ several days” (1); “more than half of the

days" (2); or "nearly every day" (3). The total score, reflecting the cumulative severity across all items, ranges from 0 to 27. The PHQ-9 has been translated into various languages, including Arabic. The reliability of the questionnaire was determined to be excellent, with a Cronbach's alpha (α) of 0.921.

2.5 Statistical analysis

By using the Statistical package for the Social Sciences (SPSS) program, all of the quantitative data were gathered and analyzed. The utilized methods of analysis were descriptive statistics for summarizing data frequency. Another way of analysis is independent sample t-test. It was employed to determine statistically significant differences between two groups Taguette online software for the qualitative data was used for a thematic analysis of the transcripts of the interviews.

3. Preliminary analysis

The results on the Post traumatic event scale are given in Figure 1. Results showed that more than half of the sample (52.5%) were classified as high risk of PTSD, and (47.5%) of respondents were classified as low risk of PTSD. The results of the depression scale are given in Figure 2. Results showed that 17.8% of the sample reported Minimal level (n= 21), 27.1% had reported mild level (n= 32), 25.4% had reported moderate level (n=30), 22.0% had reported moderately severe (n=26), and 7.6% had reported sever level (n=9). As shown in Table 3, the mean score for QoL scale was M=76.51, SD = 14.98. Table 3 below shows the means and standard deviations of the study variables.

Table 3: Descriptives of the study variable:

	Mean	Std. Deviation
PTSD	30.4	16.6
Depression	11.0	6.2
QoL	76.5	15.0

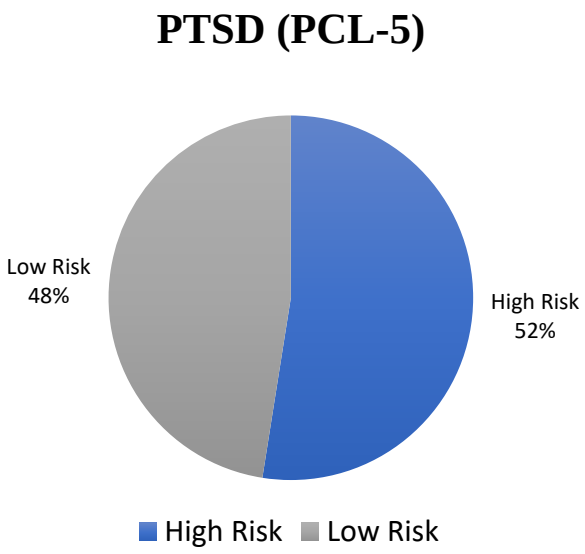

Figure 1: Statistical analysis for PTSD questionnaire.

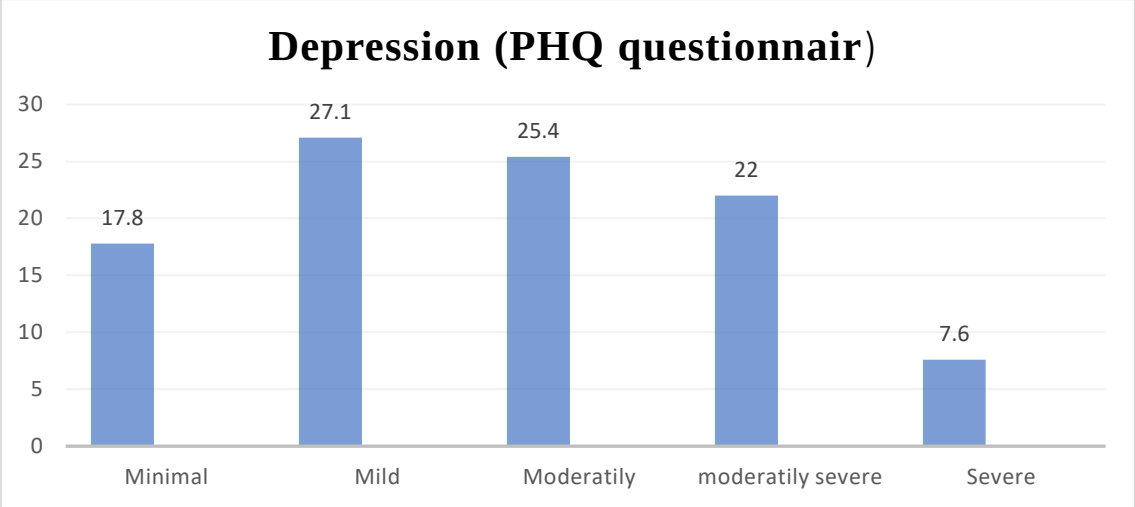

Figure 2: Statistical analysis for depression questionnaire.

4. RESULTS

Accessing and receiving mental healthcare

As shown in Figure 3(a) more than half of the participants (58.5%) do not have access to mental healthcare, and slightly less than half (41.5%) reported that they do have access to mental healthcare. However, even though they have access to mental healthcare the majority, (94.9%) didn't receive mental healthcare before as shown in Figure 3(b).

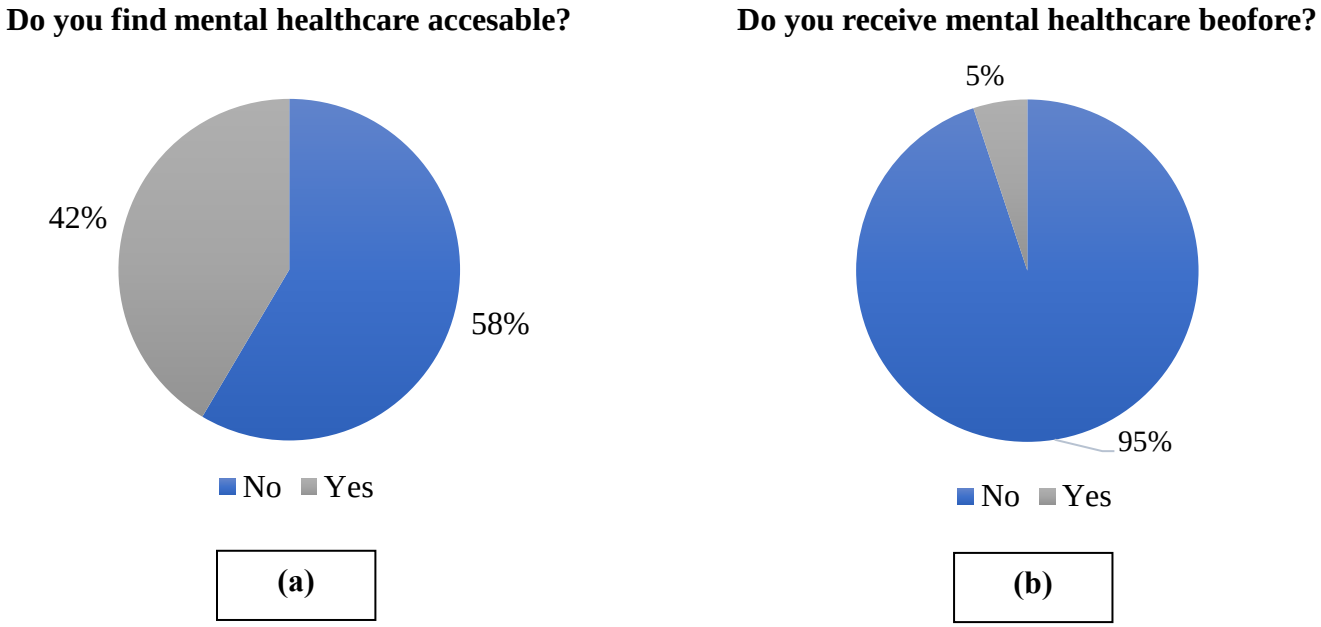

Figure 3: Sample results of the survey questions.

4.1 PTSD and access to mental healthcare

This study measures the differences between people's PTSD and access to mental healthcare. An independent sample t-test found that people who indicated that they had no access to mental healthcare had significantly higher PTSD (M=12.07, SD= 5.94) than people who had access to mental healthcare (M=9.43, SD=6.91), with a T-value of (2.012) and a p-value of (.046).

4.2 Depression and access to mental healthcare

Regarding the findings of depression and access to mental healthcare, an independent sample t-test revealed that people who indicated that they had no access to mental healthcare exhibited significantly higher levels of depression (M= 33.01, SD=15.23) compared to those with access to mental healthcare (M=26.67, SD=17.86), with a T-value of (2.32) and a p-value of (.022).

4.3 QoL and access to mental healthcare

An independent sample t-test found that the people who reported they had access to mental healthcare had significantly higher QOL (M=83.40, SD= 13.57) than people who had no access to mental healthcare (M=71.61, SD=14.06). Furthermore, the t-test is -4.585. This means that there is a significant difference between the two groups ($p < .001$).

4.4 QoL and receiving mental healthcare

The results found that there is no statistically significant difference in QoL for those who received mental healthcare (M=77.12, SD= 19.01), and those who did not received mental healthcare (M=76.47, SD= 14.84), with a T-value of (-.088) and a p-value of .(933).

4.5 Semi structured interview

The transcripts from the interviews underwent thematic analysis through Tagutte, resulting in the identification of master themes and emergent themes, which are presented in Table 4.

Table 4: Emergent themes generated from semi-structured interviews

Master themes	Emergent themes	Participants' comments
Access to mental healthcare	Lack of Facilities	***Participant*** *1mentioned,"It is really hard situation to the mentally ill civilians in this period because of unavailability of psychiatric facilities".*
	Number of beneficiaries	***Participant*** *1 stated, "The number of beneficiaries is increasing".* ***Participant*** *2 also stated," A huge number of people demanded psychiatric help and attention and counsel because of large damage caused to country in this period".*
	Few seeking help	***Participant*** *1 stated," few people seek the help of a psychologist, unfortunately, after the development of their condition and its doubling for the worse".* ***Participant 2*** *reported, "due to the lack of good opportunities in this regard, no good training, good methods for dealing with such conditions, the individual feels that he is not benefiting from seeking help".*
	Low number of healthcare worker	***Participant*** *1 reported," The number of health workers is not enough".* ***Participant*** *2 mentioned, "There are only a few health workers working in mental health field, and while wars are increasing and the psychological effects on the health of the community are increasing, the number of workers in the field is decreasing".*

Barriers to seeking therapy	Only critical condition	***Participant** 1stated, "our population see those who resort to psychiatrists are only those who have lost their minds, society's culture plays the biggest role in not seeking help".*
	Only medication	***Participant** 1 stated," Yes, some of these medications are available in the region, but they require prescriptions".* ***Participant** 2 reported, "Yes, there are drug treatment methods in the critical case that needs medical intervention."* ***Participant** 3 also reported, "Yes treatment options are available for mentally ill civilians by psychiatric drug"*

5. DISCUSSION

5.1 Questionnaire

The aim of the study was to explore mental health (e.g. depression and PTSD) as well as the quality of life for people living in or coming from areas of crisis. The study also linked these mental health variables and quality of life with access to mental healthcare; as well as quality of life with receiving mental healthcare. The research also aims qualitatively to discover psychologist and healthcare worker perspective about access to mental healthcare, treatment methods, barriers to seeking therapy and number of beneficiaries in those countries.

Regarding the impact of crisis on people's mental health, the results presented in this study showed that slightly more than half of the sample (52.5%) met the PTSD high risk criteria. This result corresponds with other study conducted among Syrian population (Mahmood, Ibrahim, Goessmann, Ismail, & Neuner , 2019). They found that the prevalence of probable PTSD was about 60% among people exposed to traumatic events during the crisis. Furthermore, the study showed that around 55% of the sample had moderate to severe depression. Similarly, a study conducted in Southern Sudan (Roberts, Damundu, Lomoro , & Sondorp, 2009). They recorded a high rate of depression in which 50% of respondents had symptoms of depression. Another study conducted in Iraq where they found that about 60% of Syrian refugees who experienced traumatic events are likely suffering from depression (Kakaje, et al., 2021).

Another finding of the study was that more than half of the participants (58.5%) do not have access to mental healthcare, and the majority of the participants (94.9%) haven't received mental healthcare before. The minority who had previously received mental healthcare had diagnosis of depression, social phobia, and ADHD disorders. The accessibility to mental healthcare for people living in countries with war and crises for very long periods is important because of the high probability of developing mental disorders during this period. A study in Ukraine estimated that approximately 10 million people are currently at risk of developing a variety of mental health issues, including severe anxiety, stress, post-traumatic stress disorder, and suicide thoughts (WHO, 2022).

This study reported significant differences between mental health (e.g. PTSD, depression) and QoL with access to mental healthcare. Overall, the study results showed that people who had no access to mental healthcare had a significantly high probability of developing PTSD and depression. Based on the study findings, their PTSD and depression could be higher due to the lack of availability in crisis areas of mental health services, and due to the scarcity of healthcare workers in the field of mental health. The impact is magnified when individuals cannot reach the healthcare provider, not being aware of their existence, or due to poverty when families cannot afford the cost of treatment. Moreover, war affects the economic situation, which may lead to difficulty in covering the cost of psychological care when the money is needed for higher priorities during the financial crises they are experiencing. Another reason is the lack of sufficient support from the government in times of crises, which led to an increase in the rate of mental disorders and worsening it over time.

Furthermore, people who saw that they have access to mental healthcare in their region had significantly higher QOL than those who had not. The study results showed that people who had access to mental healthcare had a higher QOL in these three domains: “psychological”, “social relationships”, and “environment”, however there are no significant differences in one domain “physical health”. Based on the study findings, it was concluded that people had higher quality of life could be because of the availability of the treatment in the mental health facilities in their region, and the presence of support from specialists and mental health workers. In addition, because quality of life is linked to several areas in our lives, including psychological wellbeing,

the availability of mental health services makes the QoL rate high. Other results of this study showed that people who have a high quality of life often have a very good standard of living, so they can access psychological care more easily than people who live a simple life with earning a low salary, so they see psychological care as something secondary and not essential in their lives. Finally, the analysis of received mental healthcare and its impact on the quality of life (QoL) revealed that there is no statistically significant difference in QoL between individuals who have received mental healthcare and those who have not. This finding is attributed to the limited number of participants, with only a small sample (N=6) having received treatment previously.

5.2 Interview

Although we found out that people had high rates of mental health problems , they had poor access to mental health care, Therefore, we conducted interviews to identify the underlying problems.

Theme 1: Access to mental healthcare

The first major theme represents the participants' perspectives on the access to mental healthcare during the crisis. According to the responses of participants, we found four emergent themes by using Taguette: (1) Lack of Facilities, (2) increased number of beneficiaries, (3) Few seeking help, and (4) Low number of healthcare workers.

The first emergent theme for access to mental healthcare was lack of facilities. In general, the participants agreed that mental health facilities are often in short supply in countries suffering from war and crisis. For instance, Participant 1 stated, “It is really hard situation to the mentally ill civilians in this period because of unavailability of psychiatric facilities”.

Another emergent theme was the increased number of beneficiaries. War has contributed significantly to a rise in mental health problems in areas of crisis which lead to an increase in the number of people receiving mental healthcare. Participant 1 reported, “The number of beneficiaries is increasing”. ” Participant 2 stated, adding, “A huge number of people demanded psychiatric help and attention and counsel because of large damage caused to country in this period”.

In terms of seeking help, all participants reported that during the crisis few of the populations who need psychological treatment are seeking help. According to participant 1, “few people seek the help of a psychologist, unfortunately, after the development of their condition and its doubling for the worse”. The weak scarce mental healthcare policies has led to limited and inadequate health services in the country. These services became rarer and worse due to the conflict. Participant 2 explained, “due to the lack of good opportunities in this regard, no good training, good methods for dealing with such conditions, the individual feels that he is not benefiting from seeking help”.

Regarding the number of healthcare workers, participants highlighted that there are only a few health workers working in the mental health field compared to people who need treatments. According to participant 1, "The number of health workers is not enough". Participant 2 also cited, "There are only a few health workers working in mental health field, and while wars are increasing and the psychological effects on the health of the community are increasing, the number of workers in the field is decreasing". As can be seen from the participants' responses, although population exposed to many economic and political crises and is involved in many wars that leave many psychological effects on the health of individuals, the accessibility to mental healthcare is not offered all the time.

Theme 2: Barriers to seeking therapy

The second major theme depicts the participant's perspective of barriers to seeking therapy in areas of crisis. Adults infrequently seek professional help, despite the significant frequency and burden of mental health problems among them. We found two emergent themes by using Taguette: (1) Only critical condition (2) Only medications.

The first emergent theme for barriers to seeking therapy was "only critical condition". Some participants reported that there are some barriers to seeking therapy created by stigmatization in mental healthcare. For instance, Participant 2 mentioned that "our population see those who resort to psychiatrists are only those who have lost their minds, society's culture plays the biggest role in not seeking help".

Another emergent theme was “only medication”. When asked about the available treatment options for disorders (e.g. depression and PTSD) that commonly affect people during time of crisis, all participants mentioned medications more than psychotherapy. For example, Participant 1 stated, “yes, some of these medications are available in the region, but they require prescriptions”. Participant 2 reported , “yes, there are drug treatment methods in critical cases that needs medical intervention”. Participant 3 also reported, “Yes treatment options are available for mentally ill civilians by psychiatric drug”. After the participants' responses, we can conclude from our perspective that the main reason for the availability of medicines more than psychological treatments is the shortage of psychologists. In addition, because of the financial crises they are experiencing during this time, medicines are considered a less expensive option and fastest way to get relief.

5.3 Limitation

The current study has a number of limitations that should be addressed in future studies. The first limitation is relevant to the sample size. Data was collected from a small sample size due to the poor living circumstances for the targeted population, their presence outside Saudi Arabia, and the unavailability of stable internet connection. Second, the majority of the participants are from Sudan, which could limit generalizability and fair metrics for direct comparison and benchmarking between the different group sectors. The interviews were conducted over the phone, which is less preferrable than face to face and could limit the depth of information that could be collected from direct interaction.

Fourth, the sample number between the different groups is not balanced. For example, the response rate from the male respondents in the questionnaire was lower than that of females. The last limitation was that very few people within the identified sample had received mental healthcare, so it was difficult to compare between people who received treatment and those who didn't.

5.4 Implication

The findings of this study imply that mental health disorders (e.g. depression and PTSD) as well as quality of life are highly prevalent in people living in or coming from areas of crisis. The strong link between mental health and quality of life with the accessibility to mental healthcare facilities was highlighted. This study also found that there is no link between QoL with receiving mental healthcare previously. Exploring the prevalence of mental health disorders, QoL, the accessibility to mental healthcare, and the treatment they received during the crisis may help in developing supportive programs and interventions for people living in areas of crisis to overcome their traumatic experiences and reduce the possibility of developing serious psychological disorders. Finally, there is a critical need for upcoming research to explore interventions aimed at mitigating the effects of mental disorders on individuals.

6. CONCLUSION

In conclusion, this study investigated the mental health (depression and PTSD) and quality of life of individuals from crisis-affected areas, examining their association with access to mental healthcare. Additionally, it explored the relationship between quality of life and receiving mental healthcare. The qualitative aspect involved gaining insights from healthcare workers on aspects

like access to mental healthcare, treatment methods, barriers to therapy, and the number of beneficiaries in these countries. The research found a high prevalence of PTSD and depression among Sudanese, Yemeni, and Syrian people, but there were limited accessibility and limited resources provided for mental health services. As this study showed, there is a strong link between mental health and quality of life with accessibility to mental healthcare. However, there was no significant difference in QoL with received mental healthcare previously. Finally, intensive psychological assistance and supportive measures are found to be essential to help individuals overcome the trauma and distress they have experienced and continue to endure. The relevant authorities and the World Health Organization (WHO) should enhance awareness initiatives in developing nations to promote understanding of the significance of psychotherapy and decrease the stigma surrounding mental health conditions.

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