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ORIGINAL ARTICLE

Working with Arab women with PTSD: what do we know?

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ABSTRACT

Objective: Post-traumatic stress disorder (PTSD) is characterised by a range of symptoms including acute stress, flashbacks and avoidance of situations that trigger trauma. Women from Arabic-speaking backgrounds have been shown to have a higher likelihood of developing PTSD due to life stressors experienced.

Method: This paper aimed to provide an overview of the experiences and social circumstances of Arab women experiencing PTSD in Australia.

Results: Family, gender roles, religion, mental health stigma, trauma, re-settlement challenges, acculturation and discrimination were some of the factors explored in this review. The paper also aimed to review evidence-based treatment for PTSD such as cognitive behavioural therapy, narrative exposure and eye movement desensitisation therapy and whether these westernised approaches can extend to women from Arab backgrounds. Directions for culturally appropriate interventions and how to adapt treatments to suit the needs of individuals from the Arab community experiencing PTSD are discussed as well as considerations for specifically supporting women from Arab backgrounds who need treatment.

Conclusions: Future avenues for research are canvassed and discussed within.

KEY POINTS

What is already known about this topic:

(1) Women from Arabic speaking backgrounds in Western countries have been shown to have a higher likelihood of developing PTSD due to the life stressors that they have experienced.
(2) Particular life stressors include migration and acculturation stressors, marginalisation, financial concerns, family responsibilities and for some, family violence which can exacerbate distress and contribute to the expression of PTSD symptoms.
(3) No effective PTSD treatments for Arab populations in general, let alone Arab women have been identified in research.

What this topic adds:

(1) Effective mental health treatment for Arab women must take into consideration certain cultural values such as family, women's role/status and stigmas around mental health.
(2) Some of the main factors to consider include beliefs and values, communication and language, shame, strict gender roles and religious healing.
(3) There is a significant need for immediate future research to be conducted for this community.

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Post-traumatic stress disorder (PTSD) is a disorder defined as a difficulty to adjust after experiencing or being exposed to significant life stressors, such as crime, natural disaster, combat or accident (American Psychiatric Association, 2013). Individuals who have PTSD can experience a range of symptoms including flashbacks of the traumatic event, nightmares, reliving the event through intrusive memories, avoidance of situations in daily life that remind them of the traumatic event and severe anxiety (American Psychiatric Association, 2013). Clients who suffer from PTSD may be impaired in their daily life roles and experience poor sleep, irritability, poor concentration and depressive symptoms (Kinzie, 2013; Nahvi et al., 2019).

According to the World Health Organization (World Health Organization, 2020), individuals who experience emergencies (i.e., war or other conflict) will most likely experience psychological distress. Around 1 in 5 people living in conflict affected areas will have depression, anxiety, PTSD, bipolar or schizophrenia (World Health Organization, 2020). In Australia, prevalence rates for PTSD following a traumatic event are 4.4% after 12 months and 7.2% lifetime (McEvoy et al., 2011). Studies have shown that the lifetime prevalence

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of PTSD is around 5–6% for men, whereas it ranges from 10 to 12% for women (Olff, 2017). Higher rates are found with specific interpersonal traumas such as rape and torture with rates as high as 50% (Breslau et al., 2004). PTSD may be experienced differently by individuals from different cultures. For instance, women from Arabic-speaking backgrounds have been shown to have a higher likelihood of developing PTSD due to the life stressors that they have experienced (Hakim-Larson et al., 2007).

Additional stressors that women from Arab backgrounds living in Western countries experience include family violence, cultural stigmas, financial concerns, possible migration and acculturation issues and family responsibilities which can exacerbate distress and contribute to the expression of PTSD symptoms (Kakoti, 2012). Moreover, different cultural groups have differing experiences and beliefs concerning mental health. The Arabic-speaking community in particular possesses unique cultural experiences, beliefs and norms that may impact their mental health.

Arab culture in Australia

The Arabic-speaking community living in Western communities is largely made up of first- and second-generation migrants from various backgrounds. Some left their country of origin by choice, motivated by economic advancement, marriage, education and employment opportunities, whereas many were forced to leave their home country due to war, violence and persecution (Hanania, 2018).

The Arab culture emerges from 22 countries across the Middle East and African regions (i.e., Lebanon, Syria, Iraq and Egypt) all of which share some common values and traditions. The 2016 Australian census noted that the three largest Arab groups in Australia were from Lebanon (78,653), Iraq (67,352) and Egypt (39,779) (Ryzk, 2017). There are key cultural dynamics and challenges experienced by many members of the Arab diaspora in Australia which will be briefly outlined below. It is important to note that these experiences may also be present for women from other culturally and linguistically diverse (CALD) backgrounds.

Family

Individuals from Arabic-speaking communities may identify themselves in relation to their family more than individuals from Western cultures (Dwairy et al., 2006). This phenomenon is often referred to as collectivism, which refers to cultures that emphasise interdependence, extended family and communalism above the individuals needs/desires. In contrast, individualist cultures tend to prioritise personal agency, self-interest, achievement and decision-making (Gelfand et al., 1996). For Arabic-speaking communities, families often take the primary role of support and influence important life decisions in regards to health, marriage and career choices (Cho, 2018). The honour and needs of the family are placed above the individual needs, and the family may be reserved in their disclosures with those outside of the extended family (Al-Krenawi & Graham, 2000). Individuals sometimes have limited freedom from their extended family – there may be multi-generational structures and traditions which impose explicit limits on particular social relations and activities.

Gender roles

Across the Arab culture, defined gender roles are common. Generally, men assume the role of "head of the household" and often take a leading role in financial matters, while a woman's role is traditionally focused on domestic duties, raising children and maintaining religious traditions (Cho, 2018). In some Arabic-speaking families, it is not uncommon for males to accompany females to appointments and act as a chaperone for them (Gearing et al., 2012). Observations of gender inequality for women/girls from Arabic-speaking backgrounds have been noted in prior literature (Kira & Tummala-Narra, 2015).

Religion

Arab countries predominantly adhere to two broader religious groups, Christianity and Islam, with each religion split into several sub denominations (i.e., Maronite and Orthodox for Christians; Shia and Sunni for Islam). Religion plays an integral role in the life of many individuals from Arab backgrounds (Cho, 2018). This can influence social practices such as marriage, family dynamics, behavioural expectations and education (Cho, 2018). For example, many individuals from the community may seek guidance and support from their religious leaders in many areas of their lives including mental health concerns (Ali, Mistein & Marzuk, 2005; Weatherhead & Daiches, 2010).

Mental health stigma

Stigmas pertaining to mental health and treatments to manage mental health are common within the Arab community. For instance, social shame may be

experienced by individuals who seek help from a mental health professional (Gearing et al., 2012; Kira et al., 2015). Many Arab communities believe that mental health symptoms reflect God's will and should be accepted as such, and as a result, many may not understand mental health diagnosis (Bemak & Chung, 2017). As a result, Arab communities possess lower levels of help-seeking behaviour for mental health problems in comparison to English-speaking communities (Youssef & Deane, 2006).

Acculturation

Many refugees and migrants in Australia have experienced loss and acculturation issues. Although many individuals from Arab backgrounds have integrated successfully into Western communities, some may struggle to incorporate the values and norms from their culture of origin to new Western cultures (Hakim-Larson et al., 2007).

Arab communities often believe that family unity, closeness and solidarity are more important than personal friendships and work life. Establishing social networks, language barriers, maintaining individual cultural identity and changes in family dynamics are also common barriers that many Arab communities experience during acculturation (Bemak & Chung, 2017).

Discrimination and impact on psychological health

Many Arabic-speaking individuals living in Australia experience discrimination which has been linked to lower levels of acculturation and subsequent susceptibility to mental health disorders such as depression, anxiety and PTSD (Aprahamian et al., 2011; Kira, Lewandowski et al., 2014; Baird et al., 2017). Data from representative population surveys have found a considerable minority (~20–25%) of respondents harbouring negative views to Australians from Middle Eastern backgrounds and Muslims (Markus, 2018).

Arab women living in Australia

Mental health and trauma

Women from refugee backgrounds in Australia are a vulnerable group for several reasons. Many experience PTSD from gender-based violence, loss of family members, sexual violence during civil unrest, destruction of community in their country of origin and witnessing death (Baird et al., 2017; Norris & Aroian, 2008). Moreover, studies have shown that women are twice as likely to develop PTSD in comparison to men when exposed to traumatic events and their symptoms last longer (Jina & Thomas, 2013; Roberts et al., 2009).

Many of these stressors are endured by first-generation Arab women (especially those who are refugees) such as loss of home, poor living conditions and family separation (Rowe et al., 2017). They may also experience cultural bereavement, described by Isfahani (2008) as the loss of identity, culture, home, familiar surroundings and loss of family and friends. Furthermore, due to the ongoing stressors that some Arab women may experience because of migration and acculturation, some may not begin to experience PTSD symptoms until later in the re-settlement phase (Gagin et al., 2011).

Early and forced marriage

Some women from Arabic-speaking backgrounds living in Australia may have been forced into marriage at an early age in their lives (Australian Muslim Women's Centre for Human Rights [AMWCHR], 2020). Although Australian law does not allow for minors to marry, some women may have been taken to their country of origin and married in the hopes of protecting them and providing a secure future for them (Ouyang, 2013). The AMWCHR has explored the reasons why parents and families force their daughters to get married. These include the deprioritisation of women/girls' voices, the fear of sexual relationships, the concept of "family knows best", financial and religious/cultural traditions to name a few (AMWCHR, 2020). This may cause a significant level of distress for the girls involved, including the interruption of their education, impacts on health, feelings of abandonment and loss of support from parents (Hassan et al., 2016). With early marriage, the sexual relationship may also be physically and mentally traumatic for women (Jina & Thomas, 2013).

Women married at a young age are at a higher risk of being exposed to domestic violence especially sexual abuse (AMWCHR, 2020). Women who have experienced sexual abuse at a young age may also experience challenges with attachment which can also impact their psychological well-being (Elklit, 2009). Often, there are psychological and social impacts of sexual or gender-based violence experienced by women, for instance, fear of social repercussion (divorce and rejection; Hassan et al., 2016).

Family and domestic violence

Women from Arabic-speaking backgrounds as well as other CALD women are at a higher risk of experiencing family violence, especially those who have migrated or

come as refugees to Australia than women from Westernised countries (Ghafournia, 2011). Data from the Australian Institute of health and Welfare (Australian Institute of Health and Welfare, 2018) found that in the general Australian population 1 in 6 women and 1 in 16 men have experienced physical and/or sexual violence by current or previous partners (Australian Institute of Health and Welfare, 2018). Moreover, 1 in 5 women and 1 in 20 men had been sexually assaulted and/or threatened (Australian Institute of Health and Welfare, 2018). Studies have shown that CALD women including Arab women may be at higher risk of experiencing family violence (Fageeh, 2014). For example, they may have limited knowledge of services and rights, and their main source of information may be their partners whom they often rely on for guidance and support (Ghafournia, 2011). Many migrant women from CALD backgrounds rely on their partners for financial support due to lower levels of education, lower English-language ability, unfamiliarity with local services and having young children in their care.

Some Arab women are also often isolated and some live in fear of being deported which may be weaponised by partners within abusive relationships (Ghafournia, 2011; Satyen et al., 2018). Some may be unemployed and financially dependent on their husbands. Financial abuse is considered intimate partner violence in Australia (Women's Information and Referral Exchange (WIRE), n.d.).

Many women who leave their abusive relationships may continue to experience the impacts including financial burdens, the responsibility of providing for their children and maintaining daily living expenses (Goodman et al., 2017). Some women may rely on shelters to protect them from their significant partner which can increase levels of PTSD for those women (Johnson & Zlotnick, 2006).

Women experiencing family and domestic violence may also develop negative health reactions including feelings of shock, fear, phobia, guilt, sleep, eating disorders and anxiety sensitivity (Jina & Thomas, 2013; Jungersen et al., 2019; Lang et al., 2002). They are also more prone to experiencing sexual abuse within their relationships which can impact their sense of security, safety and their levels of vulnerability (De Wilde et al., 2007).

Treatments for PTSD

Evidence-based treatments such as trauma-focused cognitive behavioural therapy, narrative exposure therapy and eye movement desensitisation reprocessing have shown reductions in symptoms associated to simple PTSD (Beck et al., 2018). However, evidence-based approaches have not been effectively researched for treating Arab women with complex trauma and childhood trauma (Bosch et al., 2020). No extant research has explored the utility of these approaches with Arab populations in Western environments. Kira, Amer et al. (2014), explored the resilience and recovery of individuals from Arabic-speaking background experiencing PTSD. In their literature review, they based their study on refugees and migrants from Arab backgrounds resettling in America. They highlight that Arabic individuals from Arab background are more susceptible to experience intergroup identity trauma due to experienced oppression (Kira,Amer et al., 2014). As a result, individuals may experience day-to-day challenges with resettlement in Western communities that can associate to original traumas experienced such as war and torture-related trauma events (Kira,Amer et al., 2014). As such, Kira,Amer et al. 2014) noted in their research that often Western approaches to treatment may not take into consideration such unique experiences faced by Arab populations living in the West and as such treatments may be less effective for that population (Kira, Amer et al., 2014). This was believed to be because the experience of trauma is often more collective for Arab populations which is different from single personal identity trauma which most PTSD treatments are based upon (Kira,Amer et al., 2014).

Culturally informed practice with Arab populations

Individuals with PTSD often present with complex personal and interpersonal symptoms. The addition of cultural needs can add another layer of complexity (Fortuna et al., 2009; Hassan et al., 2016). Adapting therapeutic techniques and evidence-based approaches from one culture to the next without taking into consideration cultural differences, and obstacles to treatment implementation, could lead to misdiagnosis (Gearing et al., 2012). Practitioners may overlook the migration experiences and impact on symptoms of PTSD for Arab clients (Fortuna et al., 2009). Responding effectively to the specific cultural needs and working towards developing a strong, trusting therapeutic alliance with the client is an important part of culturally responsive care (Edge & Lemetyinen, 2019).

Cognitive behavioural therapy has been shown to be effective in treating individuals from the Arab community (El-Jamil & Ahmed, 2016). While CBT is deemed highly effective, by challenging core beliefs, some Arab clients may perceive the response of the practitioner as

judgemental and lacking understanding and therefore it is important to develop a strong understanding of the cultural beliefs and work on incorporating those beliefs into the treatment plan (Kira & Tummala-Narra, 2015). For instance, Slewa-Younan et al. (2014) investigated the mental health literacy of 225 (98 male, 127 female) resettled Iraqi refugees residing in Western Sydney. They explored their understanding of PTSD and identified that religion impacted the acceptability of CBT approaches (Slewa-Younan et al., 2014).

In Western communities, mental health disorders are often assessed through the employment of tools that have been normed and tested in Western populations. Kakoti (2012) notes, "Unfortunately, Western therapies may not include traditional healing support or religion in their treatment plans" (Kakoti, 2012, p. 63). There is a wide perception among the Arabic-speaking community that mental health issues are caused by external or supernatural origins such as the will of God and evil spirits (Gearing et al., 2012). Therefore, understandings are important within culturally based therapeutic interventions.

Moreover, practitioners may employ psychological jargon when treating clients and this may generate stigma and be challenging for the client to understand, leading to issues with the therapeutic alliance (Hassan et al., 2016; Slewa-Younan et al., 2014). This may lead to individuals preferring traditional healing support rather than accessing professional services due to the fear of having one's values ignored (Al-Krenawi et al., 2009). The client may also lack the understanding of what the diagnosis means and treatment goals due to low mental health literacy (Gearing et al., 2012). As such, Arab clients may show a preference for a medical model or directive approach (Gearing et al., 2012).

Bemak and Chung (2017) recommend the use of a multiphase model (MPM) to treat refugees diagnosed with trauma. The guidelines include (i) providing psychoeducation on mental health due to the lack of knowledge around counselling; (ii) incorporating individual or group/family therapy-based approach; (iii) providing cultural empowerment which enables the client to connect with their own culture and then incorporate it into their new culture, leading to overcoming cultural barriers; and (iv) incorporating indigenous healing methodologies as well as being mindful of the clients' experience with injustice and experiencing human rights violations (Bemak & Chung, 2017).

Treatment implications for Arab women

The impact of premigration and displacement for Arab women may need to be considered and incorporated into treatment (Bemak & Chung, 2017). Some women may cope with displacement by becoming numb and unresponsive which could minimise the feelings associated to the traumatic memories of violence (Bemak & Chung, 2017). Similarly, clinicians should avoid stereotypical views of Arab clients, for example, that Arab women are oppressed, or all Arabs are Muslim, or that Arabs and Muslims are prone to violence (Bahdi, 2019; Mende, 2019). Effective mental health treatment for Arab women must take into consideration certain cultural values such as family, women's role/status and stigmas around mental health (Gearing et al., 2012). Some of the main factors to consider include beliefs and values, communication and language, shame, strict gender roles and religious healing. Growing evidence encourages the liaising with general practitioners to help with providing service information (Signorelli et al., 2017). Arab communities often have more trust and involvement with their general practitioner, and so the practitioner can play a strong role in providing clients with information beyond their medical needs that can help in addressing external stressors (Signorelli et al., 2017).

Family systems therapy models (Hakim-Larson et al., 2007) and utilising religion as part of therapy (Zoellner et al., 2018) have been forwarded as potential useful approaches for Arab populations in the literature. Some of these are explored below and how they may be adapted to women from the Arabic-speaking background.

Family systems therapy

Family systems therapy may be an effective approach with Arab women due to the emphasis being on the family unit rather than the individual, a focus on concrete issues which allows members to be in the here and now rather than abstract issues and exploring the transgenerational domain of trauma which is an acceptable concept in the Arab community (Hakim-Larson et al., 2007). Being aware of the complexities of Arab families and, in some cases, meeting the needs of the full family may be necessary (Rossen et al., 2014). In some cases when interpersonal abuse may be present, it is more appropriate to have individual sessions with women as this would offer a safer therapeutic space.

Person centred

Utilising a person-centred approach may be helpful when initiating the therapeutic journey given the sense of loss and disempowerment experienced by Arab women. This approach may give them the opportunity to be more

involved in treatment and provide them with a sense of control (Hassan et al., 2016).

Group interventions

In Australia, women from Arabic-speaking backgrounds have been found to experience many challenges accessing mental health services. They may be more likely to participate in community group sessions due to the connectedness they feel and values shared (Bailey et al., 2019).

Group-based approaches can provide a safe space for women to receive support in their social environment; provide observational learning; help shed light on their own experiences and hear similar stories from their cohort (Clifford et al., 2018). Most group-based therapies adapt a psycho-educational or cognitive based approach which alone may sometimes not be sufficient to address the complex features of PTSD for some clients (Clifford et al., 2018). However, group settings can provide a safe and trusting environment for women who have experienced interpersonal trauma as a result of interpersonal violence by building connections and providing a safe space to share experiences which helps in normalising the experience and empowering women (Schlee et al., 1998). However, some individuals may oppose to group settings due to the risk of being exposed to other members of the similar community and being scrutinised or shamed within the community.

Further factors to consider

A focus on helping Arab women advance their coping skills can promote external safety and stabilisation of symptoms associated with severe PTSD, in particular those who are experiencing ongoing victimisation (Bailey et al., 2019). Incorporating emotional regulation strategies may be useful for treating chronically traumatised individuals (Nickerson et al., 2016; Van der Kolk, 2014). Providing advocacy and incorporating multi-agency (multiple specialised services working together to help reduce different stressors experienced by the individual) support may also be useful for women from Arab background (Bailey et al., 2019). However, practitioners should be aware of the quality and safety of external networks and level of support for the women because they can end up being burdensome which could impact the outcomes of the healing process (Bailey et al., 2019). Contributing to the establishment of social networks, language support and support in maintaining cultural identity leading to positive adjustment and can help in reducing symptoms associated with trauma for the women (Bemak & Chung, 2017; Whitsett & Sherman, 2017). Providing recreational therapy may support in decreasing the level of avoidance for women, and utilising behavioural activation techniques can improve quality of life through improving self-esteem and a sense of achievement (Bosch et al., 2020).

A potentially effective approach for working with women is to draw on treatment plans which empower the women in their family and community context and create independence (Kira,Amer et al., 2014). Interventions should aim to improve the family's settlement within the unfamiliar cultural environment and increase protective resources (Baird et al., 2017). Although some therapeutic work with Arab clients may be perceived by some counsellors as breaching professional or personal therapeutic boundaries, for instance, helping to liaise with other organizations, giving and receiving gifts or including self-disclosure and emotional expression in sessions with clients (Cowles & Griggs, 2019). Interventions that are aimed at supporting clients in managing their daily living environment and supporting in the feeling of normalcy may be initially more helpful for Arab women than general psychological and psychiatric interventions (Hassan et al., 2016).

Other helpful strategies include offering interpreting services for clients but informing the client about the name of the interpreter beforehand to help eliminate the risk of the client knowing the interpreter and feeling unsafe in sessions (Kakoti, 2012; Pope, 2012). The gender of the interpreter may be important as well to help in providing safety for the women. Offering to provide mental health support for clients in their home and, if possible, considering a therapist from the same gender may help Arab women to be more engaged (Kakoti, 2012). Additional information is available in the Australian Institute of interpreters and translators, code of ethics (Australian Institute of interpreters and translators, 2021). Some of the issues that clinicians should account for within sessions for clients with PTSD include identifying the external event itself, personal meaning of the event to the client, predisposition to risk range, quality and intensity of defences, quality of past and current relationships and second-generation traumatisation (Kinzie, 2013; Kira et al., 2012).

Utilising the cultural formulation interview in the *Diagnostic and statistical manual for mental health disorders* (5th ed) can help with the assessment phase and treatment approach for the client (American Psychiatric Association, 2013). During the cultural interview, practitioners may take into consideration the following approach as highlighted by Khawaja (2011). Khawaja notes the importance of allowing 90 min for the session, briefing the interpreter before and after the session (if utilised), a consent form to be prepared in the clients'

language if English proficiency is limited, obtaining client's demographic details (such as gender, age, education levels, language proficiency) and information about country of origin and the migration experience to help with identifying any psychosocial stressors. While gathering the client's biopsychosocial history, it is useful to explore current stressors such as family members being at risk in the country of origin, visa concerns, social connectedness, cultural explanation of the presenting problem, as well as identifying strengths and weaknesses, including cultural strengths. It is also recommended for clinicians to consider reviewing meeting times early and avoid the assumption of lateness as treatment resistance (Erickson & Al-Timimi, 2001). Paying close attention to the women's support networks is also important (Bailey et al., 2019). A list of organizations that provide information and/or mental health services for women from Arabic speaking backgrounds in Australia is detailed in Appendix 1.

Conclusion

Women from Arab backgrounds are susceptible to PTSD due to significant life stressors and experiences including gendered issues, family violence, cultural stigmas, financial concerns, migration, and acculturation issues and family responsibilities (Kakoti, 2012). Other factors impacting Arab communities at large include mental health stigma and discrimination. No effective PTSD treatments for Arab populations in general, let alone Arab women, have been identified in research. There is a significant need for immediate future research to be conducted for this community. Counsellors need to be mindful of cultural impacts on mental health and treatment expectations; be open to working with traditional healers in establishing the cause of the problem; be aware of errors when using mainstream tools and adapt treatment plans to incorporate cultural understanding and utilisation of strategies that correspond to the client's cultural worldview and beliefs. Treatment should also consider offering family systems therapy, person centred and group interventions with Arab women.

Seeking supervision support and culturally specific professional development can support clinicians in providing strong support for Arab women experiencing PTSD symptoms.

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No potential conflict of interest was reported by the author(s).

Data sharing

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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Appendix A: Culturally specific services in Australia by state

Below are a list of some services in each state that clinicians can seek guidance from when working with CALD clients. Clinicians can also seek advice from the Australian Psychological Society nationwide.

State	Services
Australian Capital Territory	Federation of ethnic communities' council of Australia https://fecca.org.au/
New South Wales	Transcultural mental health centre https://www.dhi.health.nsw.gov.au/transcultural-mental-health-centre Arab Council Australia https://www.arabcouncil.org.au/ The Australian Arabic Association of Western Sydney Inc. https://www.facebook.com/TAAAWSI/ Western Sydney MRC https://wsmrc.org.au/
Northern Territory	Multicultural Council of the Northern territory https://www.mcnt.org.au/
Queensland	Multicultural Australia https://www.multiculturalaustralia.org.au/ Ethnic communities' council of Queensland https://eccq.com.au/ Multicultural community centre https://mccbrisbane.org/
South Australia	Muslim women's association of South Australia http://mwasa.org.au/wp/
Tasmania	Multicultural Council of Tasmania https://mcot.org.au/
Victoria	Arabic Welfare Incorporated https://www.arabicwelfare.org.au/# Victorian Arabic social services https://www.vass.org.au/ Australian Muslim women's centre for human rights https://amwchr.org.au/
Western Australia	Australian Arab Association https://www.australianarab.org/ Multicultural Services Centre https://www.mscwa.com.au/