Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review
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Mental health of refugees and displaced persons in Syria and surrounding countries: a systematic review

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Over the past two years, Syria went from being the third largest refugee hosting country in the world to the largest refugee producing country. This article provides the findings of a systematic literature review on the mental health and psychosocial support context, and the mental health profile of refugees (primarily Iraqi) and civilians in Syria. This review covers two periods: the complex refugee emergency that started in 2006 as a result of war in Iraq, and the current internal displacement and acute complex emergency starting in 2011. The systematic review of the published and grey literature on the mental health profiles of Iraqi and Syrian refugees and those Syrians who have been internally displaced includes complementing analyses of the needs and resources of different affected populations, using assessment results from Syria and surrounding refugee hosting countries. The problematic lack of recent literature is noted, and the need for more rigorous assessments, applied research and accessible grey literature identified.

Keywords: internally displaced, Iraq, Jordan, Lebanon, mental health and psychosocial support programming, refugee, Syria, systematic review, Turkey

Introduction

Syria is currently in the midst of a crisis level complex emergency, which started in 2011. This situation is further compounded by an ongoing refugee crisis that began in 2006, as a consequence of the Iraqi war. The war triggered complex emergencies in countries throughout the region as a massive influx of refugees spilled across its borders. Prior to the eruption of the armed conflict in Syria, the government had implemented a generous policy towards the stay of refugees. However, the escalating arrival of Iraqi refugees in 2006 put an immense strain on the already under resourced mental health sector (Quosh, 2011). With a population of fewer than 22 million (World Factbook, 2010), according to government estimates in 2010, the Syrian Arab Republic hosted 750,000 Iraqi refugees, nearly half a million Palestinians and several thousand refugees from Somalia, Sudan and Afghanistan.

Over a short period of time, Syria went from the third largest refugee hosting country, primarily for Iraqi refugees (United Nations High Commissioner for Refugees (UNHCR), 2012a), to the largest refugee producing country, with more than 1.9 million Syrians escaping its borders in less than two years. It is further estimated that in 2013, more than 4.25 million Syrians were internally displaced (Office for the Coordination of Humanitarian Affairs (OCHA), 2013d, Map 1 and 2). A United Nations (UN) and Government of Syria joint assessment

mission, in March 2012, highlighted mental health and psychosocial support (MHPSS) as one of the most urgent concerns resulting from the crisis. Foundations for MHPSS programming include understanding the mental health profile of concerned populations, mental health systems and contexts. This article describes the mental health profile of Iraqi refugees and Syrians during both of the above mentioned periods, within the context of a coordinated response initiative for MHPSS programming in Syria. It is complemented by an analysis of the shifting MHPSS resources and infrastructure available to affected populations in Syria (Qoush, this issue), and inter-agency collaboration in Eloul et al. (this issue).

There is general evidence that exposure to continuous, distressing and potentially traumatic events, depletion of resources, forced displacement and lack of security can all negatively impact mental health and increase risk of maladaptation. There is, however, a lack of research regarding the impact of prolonged uncertainty and the instability of protracted displacement settings, as well as of renewed violence and insecurity, on the mental health and resilience of refugees and internally displaced persons (IDPs) in Syria. That said, increasingly regular assessments, supplemented by research conducted in the region, have given indications of mental health outcomes and directions for programming. A systematic review of available published and grey literature (see below for full discussion) was conducted to provide an overview to inform MHPSS programming and coordination in Syria, and neighbouring, refugee hosting countries. Both populations are of focus due to the shift of MHPSS programming in the region, from protracted humanitarian and development aid to complex emergency efforts.

Background

Refugees in Syria: first crisis

Refugees in Syria have experienced quickly diminishing resources and the deterioration of economic and living conditions. This is largely due to the fact that refugees do not have the right to work legally in Syria, compounded by the recent general breakdown of the economy and security. The overwhelming majority of the recent refugees arriving in Syria (91%) were from Iraq, 62.2% of those sought refuge in Syria six or more years ago, primarily in urban settings. Most refugees expected to stay temporarily, but only 34,323 individuals were resettled to a third country between 2007 and mid-2013 (UNHCR, 2013a). This has led to a general lack of prospects and loss of hope among those remaining, who are also increasingly at risk. Furthermore, 37.7% in 2012, and 43.1% in 2013, have been identified as highly vulnerable with specific needs[1]. Out of 95,000 registered refugees in 2012, 35.1% of the families were female-headed households. In addition, more than 20,000 individuals were identified with a critical medical condition; more than 9,000 are survivors of torture or extreme violence, and more than 6,000 are women at risk (UNHCR, 2012a, 2013a).

The frequency and severity of protection incidents affecting refugees in Syria has risen sharply since 2012, including harassment, kidnappings and killings (UNHCR, 2013a). Although by 2012, the number of refugees registered with the UN Refugee Agency (UNHCR) was also declining, as many have fled the rising conflict. At the beginning of 2013, there were still more than 71,000 registered refugees in Syria (51% female, 49% male), which has since declined to 50,000 by July 2013 (Figure 1).

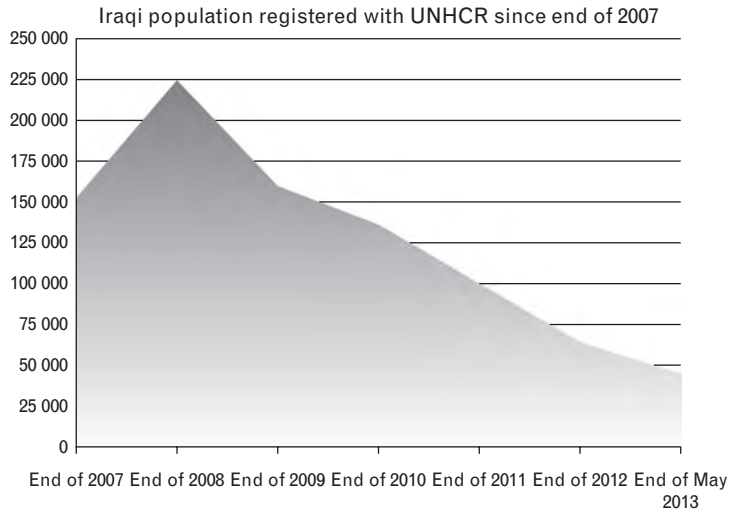


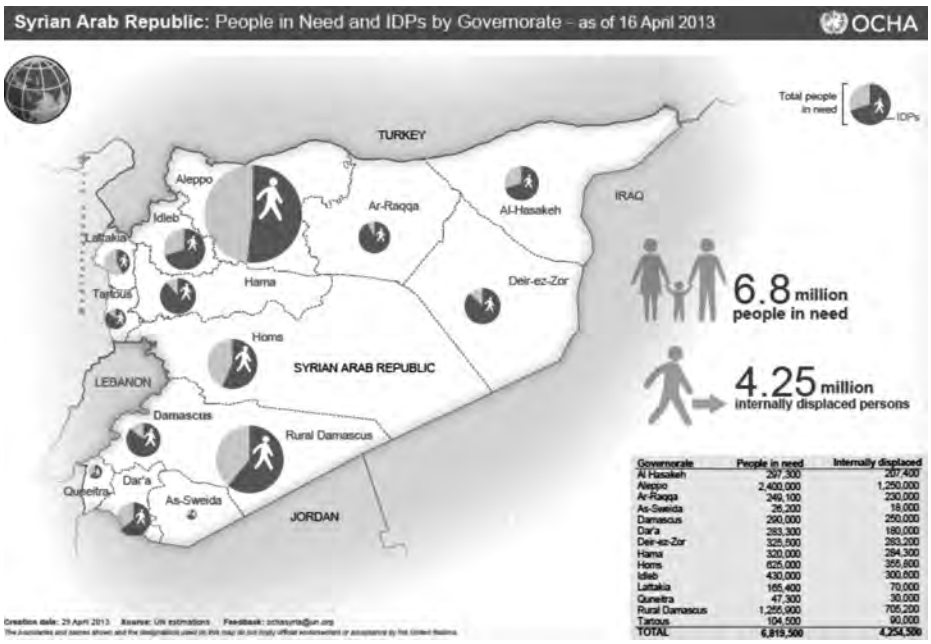
Figure 1: UNHCR Syria registered refugees (source: UNHCR, 2013b).

Internally displaced Syrians, Syrian refugees and affected populations due to the current conflict: second crisis

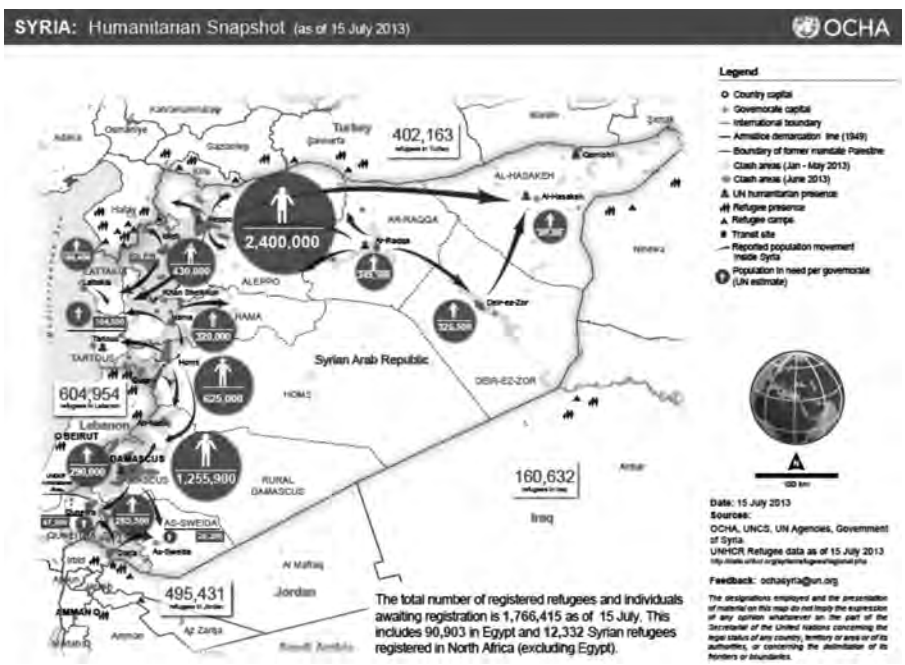
By mid-2013, the UN estimated that nearly one in three Syrians required assistance. More than 4.25 million Syrians are internally displaced. Delivering aid is difficult in some areas due to limited access, and an underfunded humanitarian operation. Many thousands have been killed and injured since the fighting erupted in March 2011.

Different phases and varying displacement patterns can be observed associated with intensity and locality of conflict. Many people were displaced several times before deciding to leave the country. By July 2013, more than 1.9 million Syrians had crossed borders into neighbouring countries. The situation is compounded by an economic crisis, rises in criminality and vulnerability, as well as limited access to clean water, food and health care. Additionally, there is a breakdown of basic infrastructure (especially health care infrastructure, including the lack of essential medications and supplies). Also, compounding this emergency, '*the conflict has deepened social, political and sectarian fault lines, affecting the delicate fabric of Syrian society*' (OCHA, 2013b, 4). Importantly, OCHA has reported that '*the affected populations have exhausted their resources and coping mechanisms [. . .]. Traditional community support mechanisms are failing due to displacement and distrust. This has had a significant impact on the psychological wellbeing of the population and may lead to increased protection risks*' (OCHA, 2013b, 13).

Iraqi refugees from the first crisis settled mainly in urban settings and Syrians affected by the current conflict are overwhelmingly displaced, and re-displaced, into urban centres (such as Aleppo, Homs and Damascus). As a result, both crises have an urban displacement population profile, which has implications for service delivery.



Map 1: Map of Syrian governorates with IDPs and people in need (source: OCHA, 2013a)



Map 2: Map of Syrian governorates and people in need, movements and refugees (source: OCHA, 2013d)

Methodology

Systematic literature review

A systematic review of published and grey literature was undertaken by the UNHCR MHPSS programme in Syria during its initiation phase and in preparation of the first Consolidated Appeal Process for Iraqi refugees[2], launched in December 2008. Literature was reviewed for articles and reports annually, during the preparation periods of inter-agency appeals and regional response plans, between 2010 and 2012.

With the changing situation, and the Syrian Humanitarian Assistance Response Plan (SHARP) launched by the government of Syria in collaboration with UN agencies in 2012, a recent systematic literature review was undertaken that also included Syrian IDPs and refugees in the region.

The *aim* of a continued systematic review of literature was to ensure that UNHCR and inter-agency programming, assessments and coordination are evidence and good practice informed, particularly in terms of the mental health status and profile of the concerned population.

The theoretical foundation for this review is framed by the bio-psycho-social-spiritual approach and the psychosocial framework reflected in the *Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergencies* (Inter-Agency Standing Committee, 2007).

For published literature, standard bibliographic sources were systematically searched, including PsycINFO, PubMed and Medline, using different combinations of search terms synonymous to mental health, Iraqi and Syrian refugees and geographic locations, such as Syria and neighbouring countries. The search terminology used to identify studies, as well as the inclusion criteria, for the respective reviews are summarised in Appendixes 1 and 2 to this article, which may be found at the website, http://links.lww.com/INT/A4.

As the number of identified published studies was very low for Iraqi refugees in Syria, the scope was expanded to Iraqi refugees in the region. The overall number of published studies in the region was low as well; therefore the review also included grey literature. Grey literature comprises a diversity of document types produced by agencies, academics, and governments, *'where publishing is not the primary activity of the producing body'* (Schöpfel, 2010). Figures 2 and 3 detail the different stages and the selection processes of the studies. Literature, in both English and Arabic languages, was included.

These searches identified a total number of 5203 and 2112 articles for the Iraqi refugee and the Syrian refugee populations, respectively. Without duplicates, this comprised a published literature of 4725 and 1992 articles. The first author reviewed all abstracts with regard to relevance; 30 articles on Iraqi refugees were identified for full text review, however, no article fulfilled inclusion criteria for the Syrian populations. The detailed full text review of these articles led to 16 on Iraqis confirmed as meeting the inclusion criteria. Due to the lack of published studies on the mental health of Syrian IDPs and refugees, additional studies were identified that provide information on the mental health status of the population before the crisis. Out of the 15 that were included from the database search for full text review, seven were selected.

Grey literature was identified by contacting humanitarian networks and MHPSS coordination groups in the region, and through searching the internet platform

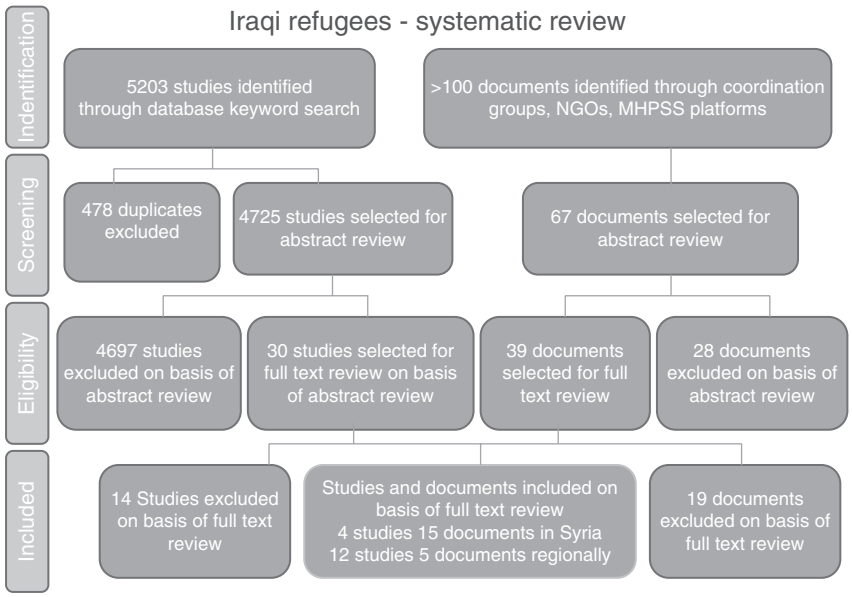


Figure 2: Iraqi refugees: overview systematic review process – selected studies and papers.

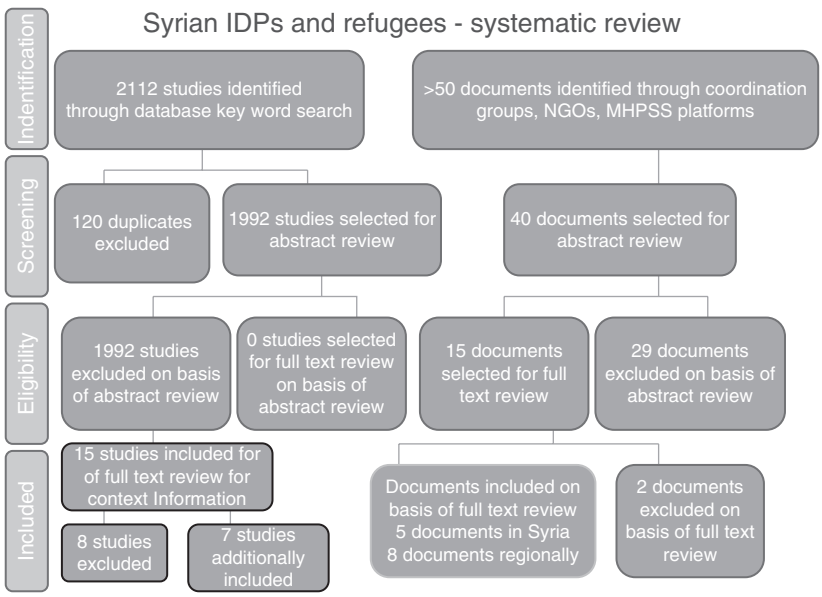


Figure 3: Syrian IDPs and refugees: overview systematic review process – selected studies and papers.

MHPSS.net. More than 100 documents were identified and reviewed for Iraqi studies, and more than 50 for Syrian studies, according to the criteria.

Twenty assessments on Iraqis and 13 on Syrians were confirmed for inclusion in the review. In addition to this, all PhD and master theses from the Faculty of Psychology and Education at the University of Damascus were reviewed for the specified time period. Out of 284 studies, one was related to Iraqi refugees in Syria (Al Ammar, 2009/2010). Due to the lack of grey literature on the mental health of Syrian IDPs, additional grey literature was identified that provides information on the mental health status of the population before the crisis. Out of 10, from the full text review, only one was selected (summaries can be found in Table 2 of the Appendix, published online, http://links.lww.com/INT/A4).

Ultimately, 16 articles (and seven additional articles) were identified through formal bibliographic searches and 33 (and one additional assessment) through grey literature identification, which provided a total of 49 (and 8 additional) articles and assessments of published and grey literature included in this review. The lack of available literature on Syrians can be attributed to the recent nature of the crisis, however there is a lack of mental health studies in Syria, in general.

Findings: systematic review

Iraqi refugees

Geographic location and population of studies

The research on mental health and Iraqi refugees is very limited. Of the published articles identified, only four studied Iraqi refugees in Syria, and 12 in the region, with the majority of the research with Iraqi refugees in the region undertaken in Jordan (seven out of 16 published studies). In contrast, among the 20 identified grey literature assessments, 15 were conducted in Syria and five in the region. Comparatively, many health assessments were conducted, however, most did not include an assessment of mental health, or if mental health was included, it was not appropriately defined and measured.

Research design

The majority of the published studies were based on quantitative research, while the majority of the grey literature used qualitative methods. Many refer to the difficulties in accessing communities in an urban displacement setting. The quality and diversity of the research does not warrant further quantitative analysis.

Results: mental health of Iraqi refugees

The findings are summarised in relation to what is of interest to MHPSS programming for the populations of concern. The full summary of all studies can be found in Table 1 of the Appendix, online, http://links.lww.com/INT/A4.

Across different assessments, the majority of refugee and host communities were indicated to be very resourceful, with comparatively high levels of education and diverse professional backgrounds. There was a willingness to support each other, but this was often contained within the family environment as lack of trust and a restrictive external environment prevented social organisation. The majority perceived religious beliefs and practices (Jayawickrama & Gilbert, 2008), as well as caring for younger family members, to be their main sources of support and meaning.

Very similar data were reported in studies with Iraqi doctors in Jordan (Doocy, Malik

According to a survey based on the Harvard Trauma Questionnaire (HTQ) conducted in Syria in 2007 (Centers for Disease Control and Prevention/UNHCR 2007):

- 80% of Iraqi refugees participating said they had witnessed a shooting
- 77% stated being affected by air bombardments and shelling, or rocket attacks
- 75% reported that someone close to them had been killed or murdered
- 72% reported being witnesses to a car bombing
- 68% reported interrogation or harassment (with threats to life)
- 22% said they had been beaten by armed groups

Other reports indicate a high incidence of kidnapping and gender based violence.

& Burnham, 2010) and Iraqi refugees in Egypt (Al Obaida, 2009).

Difficulties in adjusting to the forced displacement situation are often linked to unmet basic needs, and the lack of livelihood opportunities. Doocy et al. (2011) assessed food security and living conditions of Iraq refugees in Jordan and Syria, and demonstrated dire financial needs and limited availability of assistance.

In quantitative surveys, symptoms of heightened anxiety and depressed mood were often found, ranging from 42% among samples of Iraqi refugees in Jordan to above 80% in Syria (Center for Disease Control / UNHCR, 2007). In a secondary analysis of two assessments in Syria and Jordan, 44% of the adult respondents in Syria reported depressed mood, compared to 17% in Jordan (Cope, 2011). Respondents to a WHO survey conducted in 2010 in Syria reported sadness (60%), desperation, loneliness and anxiety (50%), sleeping difficulties (50%), a sense that everything requires more effort than usual (50%) (WHO, 2010). While some studies did not identify gender nor age differences, others reported that Iraqi women have higher rates of affective disorders than men (Community Development Center/UNHCR, 2007; Doocy et al., 2013), while middle-aged and older men trend towards higher rates of anxiety disorders and posttraumatic stress disorder (PTSD). In addition, exacerbation of epileptic and non-epileptic seizures, substance abuse, increased body pains and somatisation were reported.

Reports on Iraqi refugees in the region confirmed a high sense of isolation, lack of social support, loss of networks and safe spaces, family conflicts, and lack of future opportunities, as well as their effect on mental health (Le Roch et al., 2010; El-Shaarawi, 2012; Community Development Centre / UNHCR, 2007; Al Obaidi & Atallah, 2009).

Studies have also documented de-professionalisation and the feeling of being '*not useful in society*', particularly among men and adolescents (International Organization for Migration (IOM), 2008). In some extreme cases, desperation in adults led to self-harm or harming others, notably in the form of suicide attempts, survival sex and child abuse. Importantly, fundamental role shifts due to the inaccessibility of work and socio-economic difficulties often resulted in domestic and sexual violence (Jayawickrama & Gilbert, 2008; Le Roch, et al., 2010; CDC/UNHCR 2007; SARC/DRC, 2007; Refugee International, 2009; Chynoweth, 2008). Moreover, psychological stress and desperation intensified as the length of stay increased (Bader et al., 2009;

LeRoch et al., 2010). This oppressive and unstable climate often also made it impossible for many displaced Iraqis to address and process traumatic experiences that occurred prior to, during and after their flight, potentially exacerbating symptoms.

Parents were concerned about education for their children (some studies reported high school drop-out rates, e.g. Centers for Disease Control / UNHCR, 2007), peer relationships and aggression among children, unstable family situations, stunted development, and child abuse. Parents also reported increased attachment, aggressiveness (among boys), withdrawal (among girls), developmental problems, learning difficulties, and enuresis among children (Le Roch, et al., 2010; Tsovili, Coutts & Quosh, 2010).

Refugees attributed their psychological problems to past (potentially traumatic) experiences, as well as present distress and adjustment difficulties (Salem-Pickartz, 2009).*'Current perceived needs was found to mediate the association between past traumatic exposure and distress in Jordan'* (Jordans et al., 2012).

The current situation appeared to be exacerbating pre-existing mental health problems. According to the preliminary analysis of a UNHCR assessment on psychosocial wellbeing, distress and functioning, the overall psychosocial wellbeing of the refugee population has been consistently low, and the overall concept for psychosocial wellbeing is understood as a multi-faceted idea of fatigue (Quosh, 2013).

Since mid-2011, the dynamics of the context have changed significantly, which has had dramatic effects on the wellbeing of refugees, as well as the host community. Refugees have been especially susceptible to the deteriorating situation in Syria. Essential needs have become more acute. Many refugees have been displaced from their Syrian neighbourhoods, thus limiting their access to already fragile social networks, mental health care services and other assistance. According to mental health professionals in Syria, many refugees have presented renewed, multiple and complex vulnerabilities with increased existing high levels of anxiety, fear, hopelessness and depression, increased relapse among clients, and regression to maladaptive coping mechanisms (e.g., increased suicide attempts, domestic violence). Many have considered the difficult option of returning to an unstable and insecure Iraq. In a UNHCR study conducted in February 2012, an overwhelming 75% of respondents stated that the current deteriorating situation has had a negative impact on their psychosocial and physical wellbeing (UNHCR, 2012b). Unfortunately, no further studies or assessments are available on Iraqi refugees in Syria since the beginning of the recent crisis, which prompted a shift of focus.

Findings: systematic review Syrian IDPs and refugees

Geographic location and population of studies

Out of the 13 grey literature assessments identified for Syrian IDPs and refugees, five studied Syrian IDPs and eight studied Syrian refugees in the region. A few additional articles, as well as grey literature pre-2011, were included in the mental health profile of Syrians in the Appendix online, in order to provide additional contextual information, http://links.lww.com/INT/A4.

Research design

Five of the assessments were based on quantitative methods and eight on qualitative methods. Many refer to the difficulties of conducting assessments inside Syria due to the prevailing insecurity. The quality and limited number of assessments do not warrant further quantitative analysis. There

has not been any comprehensive assessment of the mental health of Syrian IDPs and affected populations since the beginning of the crisis. Some small scale assessments provide snapshots of the current situation and indicate priority areas.

Results: mental health of Syrian IDPs

These findings are summarised in relation to what is of interest to MHPSS programming for the populations of concern. The full summary of all studies can be found in Table 2 of the Appendix online, http://links.lww.com/INT/A4.

Across the different assessments, it was reported that the majority of the displaced and affected host communities were mobilising resources, such as community networks and support. Many referred to religious beliefs and practices as a primary source of support (UNHCR/SARC, 2013).

According to a stakeholder assessment in 2012 (MHPSS Working Group, 2012), 60% of the respondents indicated a lack of basic needs impacting mental health and wellbeing. This lack of basic needs was confirmed during a second stakeholder assessment at the beginning of 2013 (UNHCR/SARC, 2013), with increased severity. The lack of security, sudden forced displacement, destroyed homes and lack of shelter, or overcrowding in collective shelters, lack of access to schools, health care and other services, high unemployment and poverty were all reported to be priority concerns. Stakeholders covered the areas of Damascus, rural Damascus, Homs and Aleppo, but could not provide information on other governorates.

Similar to the findings among Iraqi refugees in Syria between 2008 and 2011, focus groups in 2012 conducted by UNHCR with internally displaced Syrians in areas around Damascus, confirmed high levels of fatigue, fear and loss of control, as well as family separation due to displacement and shifts in gender roles. Across the different assessments, heightened levels of distress, anxiety, fear, frustration, grief, fatigue, and depressed mood were found as well. The review of available studies and assessments also highlighted isolation and lack of social support. None of the assessments specified or quantified *'high levels'*. An assessment in the northern governorates of Syria also reported that communal tensions were attributed to assistance being insufficient to meet the needs of all those affected (Assessment Working Group for Northern Syria, 2013, 70). Parents reported that their children are fearful and show *'signs of significant emotional distress, such as nightmares, bed-wetting, or becoming uncharacteristically aggressive or withdrawn; any loud noise reminds the children of the violence they fled from. Children with disabilities, chronic diseases or from single parent families are particularly vulnerable and do not have equal access to services. [...] Some children are exposed to maltreatment and neglect from parents who themselves are showing high levels of distress and are unable to cope with their own difficulties'* (Assessment Working Group for Northern Syria, 2013, 70).

Mothers were concerned about interruptions in education for their children and the effects of not having basic needs met. High school dropout rates were reported (UNICEF, 2013; Assessment Working Group for Northern Syria, 2013, 75). Serious child protection concerns for tens of thousands of children have been reported, including: killing and maiming; sexual violence; torture; arbitrary detention; recruitment and use of children by armed forces; and exposure to explosive remnants of war (Assessment Working Group for Northern Syria, 2013, 68; UNICEF, 2013, 9). An increased number of early marriages and

child labour was also reported (UNHCR/SARC, 2013). A remote assessment found that children's exposure to extreme violence is causing serious psychological distress and impacting school performance (UNICEF, 2013).

It is difficult to assess the scope of sexual violence in Syria, but reports point to alarmingly high rates, including in combination with physical violence and torture, and a significant portion of the reported incidences involving men and boys as targets. Although there remains a lack of sexual and gender based violence (SGBV) assessments, according to INGO reports stigmatisation of this subject, shame and distrust led to massive under reporting (Assistance Coordination Unit (ACU), 2013; International Rescue Committee (IRC), 2012; Assessment Working Group for Northern Syria, 2013).

Results: mental health of Syrian refugees regionally

As there is not sufficient literature yet covering the mental health of IDPs in Syria, assessments that have been conducted with Syrian refugees in the region are also analysed in this paper. It is noted that the experience of displaced people who leave their country of origin differs from that of those who remain, and that the length of time since displacement has an impact on adjustment and stressors. All of these factors will affect results in data collection, however, the parallel needs are significant and, given the lack of information on IDPs, worth evaluating.

Jordan

A rapid MHPSS assessment with Syrians in Jordanian host communities in February 2012 (International Medical Corps (IMC)/Jordan Health Aid Society (JHAS), 2012) and with Syrian refugees in Za'atari refugee camp in August 2012 (IMC/UNICEF, 2012) highlighted increased levels of fear, worry, grief, boredom and psychological distress (45% felt intense fear all or most of the time). The most frequently cited coping methods were praying, smoking and socialising with friends and family. Particularly, with lack of durable solutions and livelihoods, the level of frustration, anger and aggression is increasing (Rudoren, 2013).

WHO, in collaboration with the Jordanian Ministry of Health, IMC and Eastern Mediterranean Public Health Network (EMPHNET) is planning to conduct a mental health needs assessment in Amman, Irbid, Ramtha, Mafraq and the Zaatari camp (Inter-Agency Standing Committee Mental Health And Psychosocial Support Reference Group (IASC MHPSS RG), 2013). Results were not available at the time of this literature review.

Lebanon

A similar assessment by IMC, at the northern Syrian/Lebanese border showed comparable results to the one in Jordan (IMC, 2011). The participants reported anxiety, feeling depressed, lethargy, eating and sleeping problems, anger and fatigue. In particular anger, fear, anxiety, feeling depressed and stress affected relationships within families, daily functioning and health. Mothers described changes in the behaviours of their children, and expressed difficulties in handling them, as well as an inability to show affection. Positive coping mechanisms included going out, exercising, and playing with one's children. Negative coping mechanisms were primarily smoking, watching TV and doing nothing.

An assessment in the Bekaa Valley (Pérez-Sales, 2013), showed similar overwhelming emotional responses for most respondents, and reported that wellbeing is greatly

attributed to fulfilling basic needs such as sufficient income, shelter and food. Similar priority concerns were reported in different locations (Médecins Sans Frontières (MSF), 2012). According to Pérez-Sales (2013), feelings of humiliation, linked to the frustration with dependency on aid, were prevalent. While other studies indirectly present links between unmet needs, dignity, humiliation and also sexual violence (Doocy et al., 2011; Chynoweth, 2008), the Pérez-Sales assessment (2013) is the only identified assessment that clearly links unmet basic needs with feelings of humiliation and impacting dignity.

Negative emotions seemed to increase over time. Among the refugee community a lack of unity, community organisation, support, trust and confidence was reported, as well as increased frustration and anger. SGBV, as well as experiencing torture, were reported among both men and women. Praying was described as the main coping strategy (Pérez-Sales, 2013).

According to a study by Mobayad in camps (referred to in Abou-Saleh & Mobayad, 2013) prevalence rates of PTSD were identified, from 36% to 62%, among adult refugees. The main predictors for PTSD among adults were exposure to fighting and hostility, as well as a history of trauma before the conflict. Prevalence rates of PTSD were reported, from 41% to 76%, among children. The main predictors for children were the number of traumatic experiences related to the conflict. An increasing number of arranged early marriages and survival sex is reported in Jordan, as well as Lebanon (McLeod, 2013; IRC, 2012).

Turkey

According to the Bahcesehir Study (2013), Syrian children in Islahiye camp in southern Turkey display different levels of functioning and adaptation. Three out of four Syrian children have lost a loved one in the fighting, more than 60% experienced events where they felt their lives were in danger, and 50% had been exposed to six or more traumatic events. However, 71% of the girls and 61% of the boys also had strong close relationships to trusted persons for help and support. At the same time, 30% reported that they had been separated from their families. Also, around 60% of the children reported symptoms of depression (significantly higher among girls), 45% reported symptoms of PTSD, 22% aggression and 65% psychosomatic symptoms to a degree that seriously reduced the children's level of functioning (Özer et al., 2013, 36). Similar prevalence rates: 61% PTSD; 53% anxiety; and 54% depression, were reported from a study with Syrian refugees in four camps at the southern Turkish border (Marwa, 2012, 2013). The nongovernmental organisation (NGO) Malteser International, planned to conduct a mental health assessment in Turkey during the second half of 2013 (IASC MHPSS RG, 2013).

Limitations

Major weaknesses in the design and robustness of studies constrain the analysis of the review. Some of the main weaknesses are:

- Most research focuses on global categories of mental health problems, disorder symptoms (particularly of mood and anxiety disorders), and psychosocial distress from a vulnerability perspective.
- There is less attention to resources, resilience and coping perspectives that are an important part of understanding the mental health profile of the community.

- There is very little culture-grounded research that focuses on positive factors of adaptation
- Only one study on resilience, as a protective factor against developing psychopathology, was identified; however it was conducted in a resettlement context (Arnetz et al., 2013), and indicates a multi-dimensional and partially interrelated idea of vulnerability and adaptation.
- Culturally relevant conceptualisation of dignity and humiliation, as well as their relation to unmet basic needs, are rarely addressed.
- Few studies used mixed-method approaches, sampling strategies often relied on convenience samples (not randomly selected) and sample sizes tended to be small and not representative.
- Many studies did not provide sufficient information on methodology, the measurement instruments used and the validity of those measures for the context, consent procedures and stigma, as well as ethical considerations or approval by ethics committees.
- Many health and disability assessments only provided results in the overall categories of physical and mental disabilities.
- Particularly assessments identified through the grey literature search have methodological shortcomings.
- Most studies pay limited attention to cultural concepts, as well as terminologies without validation in the native language of study participants. Measurements for psychosocial problems and mental disorders carry different degrees of stigmatisation, which may impact reporting. There is also limited attention accorded to potential cultural tendencies to express distress through somatic complaints.

The review likely identified most of the literature relevant to the review aim. One constraint of the structured review process relates to the comprehensiveness of the search process, the criteria, restricted time span and languages used to include articles and documents. Only the first author was engaged in the systematic review, which did not allow for a double blind selection of articles. Efforts were made to identify Arabic (grey) literature and a number of resources were identified and translated. Only a few fulfilled the inclusion criteria and it is possible that some resources were not identified.

The time span covered a longer period than the actual crisis periods in order to identify general studies on mental health of the population of concern for the purpose of better understanding context and baseline.

Discussion

This systematic review provides an overview of existing literature and a foundation to inform MHPSS programming. It indicates a clear need for more comprehensive and integrated mental health assessments with robust mixed-method research designs and urban assessment methodologies. The analysis further suggests that health assessments should integrate mental health aspects more consistently and rigorously.

During the systematic review, only a few studies could be identified for Iraqi refugees and displaced Syrians. The low number can be attributed to several different constraints; primarily limited physical access to the most affected areas (particularly due to the humanitarian and urban displacement context), and limited capacity and competing priorities severely impacting support and service provision. Given that this review covers mental health data for the two major displacement crises of this

decade, there is very little known about the mental health and resilience of the displaced populations.

Based on the identified studies, the majority of the assessed populations were able to adjust to extremely difficult situations. However, much of the research focused on global categories of mental health problems and mental disorder symptoms. Respective findings are consistent with the high prevalence rates documented in the refugee and forced migration literature, particularly of depression and PTSD among adults and children, as well as significant variations in those rates. While it was reported that mental health problems co-occur with health problems, there was no systematic assessment of psychosomatic conditions, pre-existing chronic or severe, and comorbid mental disorders, as well as cumulative exposure to potentially traumatic events. The focus on sets of symptoms fails to present the diversity of responses at different levels (including at the community level) and provides limited information for a comprehensive, context sensitive and integrated response.

No coherent patterns for age, gender, education, background, or for factors that would indicate higher risk or protection, were identified. However, decreased socioeconomic status, loss of meaningful social roles and support were indicated to result in worse mental health outcomes. Religious and spiritual coping, as well as social support, was identified as protective factors. It was shown that in addition to the risk of developing mental health problems, there is a high risk for developing social problems in both crises. Parents in both settings were very concerned about interrupted education for their children. There is a need to invest more in assessments of children's psychosocial wellbeing.

The ability to address basic needs and daily stressors, as well as past (potentially traumatic) experiences, is important in explaining mental health outcomes. However, few studies looked at the complex interrelationship between past and current stressors, as well as the link between different aspects of wellbeing and mental health, including what contributes to resiliency and adaptation. It is important to understand this complex relationship, including aspects such as dignity, humiliation and coping, as well as cultural concepts of mental health. Fatigue (*taaban*) was identified as an overarching concept to express psychosocial distress among Iraqi refugees, but there is neither research on idioms of distress and wellbeing, or on help-seeking behaviour in either forced displacement context.

Humanitarian aid delivery must include considerations that do not exacerbate mental health problems and psychosocial distress, nor negatively impact wellbeing. In order to close the research/practice gap, research needs to be oriented towards what is relevant to inform humanitarian aid delivery.

Given the importance of grey literature and assessments in informing MHPSS programming and coordination in these situations, the relatively low quality of their designs and result presentations is problematic. It is vital to increase investment in technical guidance, capacity building, and field/academic collaboration, as well as applied field relevant research.

Desk reviews of humanitarian assessments often rely on accessible grey literature (mostly in English). Due to limitations in accessing academic search databases, available studies are often not included in desk reviews, lowering the quality of the assessment. Facilitation of access to academic journals for humanitarian aid

providers, or collaborations with academic institutions (e.g., through regular external systematic reviews), could fill this gap.
Given the difficulty of tracking grey literature and respective assessments, it is suggested that data collection tools be developed that make these easily available to organisations and agencies interested, e.g., through dedicated groups on MHPSS.net, or other platforms.

Conclusion

The protection and basic needs of refugees and IDPs in Syria continue to intensify as a result of the displacement and pronounced economic and political insecurity generated by the past two years of armed conflict. More and more refugees and IDPs are entirely dependent on assistance provided by international agencies. The current literature review indicated rising levels of psychosocial distress, and an anticipated further increase in people identified with mental disorders requiring reinforced, culturally appropriate mental health care, psychosocial and community based support (UNHCR, 2013a). Although living in distinct environments, the mental health profiles of the displaced populations assessed indicate many similarities alongside context specific characteristics. As a result, there is increased demand for context sensitive, integrated, multi-level, and multi-disciplinary MHPSS programmes, with close links to protection, health, education and livelihood. Coverage of MHPSS among IDPs and refugees in difficult to access areas is minimal, while demand for services is expected to continue growing in light of the ongoing violence, requiring increased inter-agency capacity building efforts. These should be based on more comprehensive and systematic assessments and research studies.

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[1] Specific needs as categorised by UNHCR: categories include among others children at risk, women at risk, older persons at risk, SGBV, survivors of torture, serious medical conditions.

[2] Specific needs as categorised by UNHCR: categories include among others children at risk, women at risk, older persons at risk, SGBV, survivors of torture, serious medical conditions.

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