
Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians

A REVIEW FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT
STAFF WORKING WITH SYRIANS AFFECTED BY ARMED CONFLICT

2015



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GLOSSARY

CBO	Community Based Organisation
IASC	Interagency Standing Committee
IDP	Internally displaced people
LGBTI	Lesbian, gay, bisexual, transgender or intersex
MHPSS	Mental health and psychosocial support
NGO	Non-governmental organisation
SGBV	Sexual and gender based violence
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UN	United Nations
WHO	World Health Organization

1. INTRODUCTION

WHY THIS DOCUMENT?

This report aims to provide information on the sociocultural background of the Syrian population as well as cultural aspects of mental health and psychosocial wellbeing relevant to care and support. It is based on an extensive review of the available literature on mental health and psychosocial support (MHPSS), within the context of the current armed conflict in Syria.

The document is primarily meant to inform mental health and psychosocial support (MHPSS) staff, such as: psychologists, psychosocial counsellors, social workers, psychiatrists, psychiatric nurses, and others who are involved providing individual or group counselling, psychotherapy and/or psychiatric treatment for Syrians. Other humanitarian professionals, such as general health providers working with Syrians or staff involved in public health, community-based protection, community mobilisation, child protection, sexual and gender based violence (SGBV), may find this document useful, although it is not primarily written for them. The specific information in this review complements more generic guidance, such as the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings^[1] and UNHCR's Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations.^[2] Together with these guidelines, this report can inform the design and delivery of interventions to promote mental health and psychosocial wellbeing of Syrians affected by armed conflict and displacement, both within Syria and in countries hosting refugees from Syria.

STRUCTURE OF THE DOCUMENT

The first chapters contain essential background information on the Syrian sociocultural context (chapter two), the situation of refugees from Syria and internally displaced persons (IDPs) in Syria (chapter three), and mental health and psychosocial problems of displaced Syrians (chapter

four). These chapters summarise the available literature to allow mental health and psychosocial practitioners working with displaced Syrians to put their work with individual clients and families within a broader perspective. The references in this section also provide practitioners, interested in more in-depth information, with key resources to further explore relevant issues.

The last chapters of this review focus specifically on culture and context. Chapter five provides detailed information on the role of social, cultural and contextual factors in the presentation and expression of mental and psychosocial distress and how this is interwoven with cultural and religious notions of personhood. Chapter six discusses how a cultural and contextual understanding of mental health and psychosocial problems and issues can inform the design and provision of MHPSS services. Chapters five and six are particularly relevant for those involved in the provision of mental health and psychosocial services to Syrian clients. The conclusion (chapter seven) provides a concise summary of the main issues discussed in this document.

SEARCH STRATEGY

The search strategy used to create this report was designed to capture relevant clinical and social science literature examining the sociocultural aspects of mental health in the Syrian population. The main medical, psychological and social sciences databases (PubMed, PsycInfo) were searched for relevant information, until July 2015. Additionally, manual searches of the reference lists of key papers and books or articles relevant to Syrian mental health were conducted, and included Arabic, English and French language sources. The database search was supplemented with web-based searches in Arabic, English and French media, as well as Google Scholar, to retrieve key books and non-academic literature relevant to the Syrian situation. Important information on displaced Syrians was

also found in assessment reports and evaluations, by non-governmental organisations (NGOs), intergovernmental organisations, and agencies of the United Nations. Many of these were retrieved through the Inter-agency Information Sharing Portal on the Syria crisis, hosted by UNHCR.¹ This search strategy provided many useful sources, but should not be taken as a comprehensive review of all issues related to mental health and psychosocial support of Syrians as many unpublished reports and evaluations were not reviewed.

Disclaimer: this review has been commissioned by UNHCR and a wide range of experts have been involved in its drafting. The views expressed in this document do not necessarily represent the views, policies, and decisions of their employers.

¹ <http://data.unhcr.org/syrianrefugees/regional.php>

2. BRIEF SOCIOCULTURAL BACKGROUND

There is wide diversity of social, socioeconomic, ethnic, and religious backgrounds among the Syrian population, which along with age and gender, influence family and community relations and dynamics, explanatory models of illness, coping mechanisms, and help-seeking behaviour. It is important that MHPSS practitioners are aware of this diversity in order to provide appropriate support to refugees and other persons of concern.^[3]

Religion, ethnicity and tribal identity are important for individual identities and group loyalties of many Syrians. These identities may contribute to creating group boundaries and accentuating differences that pose challenges to mental health.^[4] Practitioners should be aware of shifting identities and loyalties as they impact on displaced persons experience and understanding of the conflict and displacement, and their social networks and relationships.

ETHNIC DIVERSITY AND LANGUAGE

Over the centuries, the region that is now Syria was populated with people from a wide diversity of ethnic and religious backgrounds, and has served as a haven for a variety of groups fleeing persecution and conflict elsewhere, including, for example, Armenians, Assyrians, and Circassians.^[5] Given the lack of accurate census data, it is only possible to estimate the ethnic and religious composition of the current Syrian population. While the majority of Syrians are considered Arabs, this is a term based on spoken language (Arabic), not ethnicity.

Around nine to ten percent of Syria's population is Kurdish (close to two million people), followed by Turkmen, Assyrians, Circassians and Armenians. In addition, there are also small communities of Dom, Greeks, Persians, Albanians, Bosniacs, Russians, Chechens and Ossetians.^[5-7] Many of these have become 'Arabicised' and, as a result, may not necessarily maintain a specific ethnic affiliation.

Additionally, the Arabic speaking Bedouin tribal groups are also seen by some as a separate ethnic group.^[8]

In recent years, tribal affiliation has gained importance as a way for Syrians to identify and organise themselves, as well as to realise a sense of belonging in a country where state structures have been weakened. Tribal identity and the authority attached to traditional leaders (who, in the past, have often been co-opted by the Syrian government) continue to exist, not only among Bedouin groups, but also among other Syrians.^[8-10]

The Syrian Constitution refers to Arabic as the official language, with no mention of linguistic rights of other groups. The second most common language is Kurdish. A 1958 decree outlawed the publication of materials in the Kurdish language, and both public and private schools were barred from teaching in Kurdish. Consequently, some Kurdish Syrians are not fluent in Kurdish.^[11, 12] Developments in Kurdish areas since mid-2012 have provided the Syrian Kurds with opportunities to reassert long suppressed cultural rights. Kurdish language publications, radio and TV stations have sprung up, villages and towns have had their former Kurdish names restored and children can study the Kurdish language at school.^[13-15] Smaller numbers of Syrians have Armenian and Syriac/Aramaic as their mother tongue.^[16, 17]

RELIGION

Syrians are often categorised according to their religious affiliation (Sunni, Alawite, Christian, etc), but this does not necessarily mean an individual is devout, 'religious', or even an active practitioner. Prior to the current conflict, Sunnis accounted for the religious affiliation of approximately three-quarters of the population. Other Muslim groups, including Alawites, Ismailis, and Twelver Shi'a, constituted approximately 13 percent of the population; various Christian denominations, about

10 percent; and Druze accounted for three percent of the population. There is also a small Yezidi population of approximately 80,000 persons, who are ethnically and linguistically Kurdish, and follow a distinct religion.^[3, 18-20] The Christian population in Syria can be Arab or non-Arab, with the latter group including Syriac/Aramaic and Armenians. Most Syrian Christians belong to Orthodox Churches (Syriac Orthodox, Greek Orthodox, Armenian Orthodox and Nestorian) or to Catholic Churches (Melkite, Chaldean, Maronite, and Syriac), who are in communion with the global Roman Catholic Church, but follow distinct, eastern rites of worship. There are also small groups of Protestants.

Syria have very limited flight options as they are barred from entering neighbouring Jordan and Lebanon, while Egypt requires visa and security clearance in advance.^[22-25]

REFUGEES IN SYRIA

Prior to the current conflict, Syria hosted significant numbers of refugees and asylum-seekers. The large majority originated from Iraq and Palestine, but there were also smaller groups from Afghanistan, Sudan, Somalia and other countries.^[21] Traditionally, most non-Palestinian refugees resided in Damascus and its surrounding countryside, and, to a lesser extent, in Homs, Deir Ez-Zour and Dera'a. Many refugees and asylum-seekers have left Syria since the beginning of the conflict. Others have been displaced within Syria or to other countries. At the end of 2014, close to 30,000 refugees and asylum-seekers were still registered with UNHCR in Syria. Also, prior to the conflict, Syria hosted Palestinian refugees, who had arrived in successive waves since 1948.²

As a result of the current conflict, approximately more than half a million Palestine refugees registered with UNRWA in Syria have been displaced within Syria, while another 70,000 Palestinian refugees from Syria have been scattered across the region and elsewhere. Palestinian refugees from

2 For more information on Palestinian refugees in or from Syria, see the website of UNRWA, the United Nations Relief and Works Agency for Palestine Refugees: www.unrwa.org/syria-crisis

3. REFUGEES FROM SYRIA AND INTERNALLY DISPLACED PEOPLE IN SYRIA

The current conflict in Syria has caused the largest refugee displacement crisis of our time. Since March 2011, nearly half of the population has been displaced, comprising almost eight million people inside Syria and more than four million registered refugees who have fled to neighbouring countries.^[26, 27]³ More than half of those displaced are children. Repeated displacements have been a striking feature of the Syria conflict, as frontlines keep shifting and formerly safer areas become embroiled in conflict.

VIOLENCE AND DISPLACEMENT IN THE SYRIAN CONFLICT

Both refugees from Syria and internally displaced people within Syria have faced war-related violence, although their current situation in terms of security, human rights, access to protection and humanitarian assistance differs. It is estimated that over 210,000 people have been killed and 840,000 injured, often resulting in long-term disabilities – with the concomitant average life expectancy being reduced from 75.9 years in 2010 to an estimated 55.7 years at the end of 2014.^[28] War crimes and crimes against humanity have been committed on a massive scale throughout the conflict. Many Syrians have suffered multiple rights violations and abuses from different actors, including massacres, murder, execution without due process, torture, hostage-taking, enforced disappearance, rape and sexual violence, as well as recruiting and using children in hostile situations. Indiscriminate bombardment and shelling have created mass civilian casualties and spread terror among civilians. Furthermore, parties have enforced sieges on towns, villages and neighbourhoods, trapping civilians and depriving them of food, medical care and other necessities. Parties to the conflict also have disregarded the special protection accorded to hospitals, and medical and humanitarian personnel.

³ For the latest data on Syrian refugees consult the Inter-agency Information Sharing Portal, hosted by UNHCR at <http://data.unhcr.org/syrianrefugees/regional.php>. The latest data on IDPs within Syria is available at <http://www.unocha.org/syria>.

Increased levels of poverty,⁴ loss of livelihood, soaring unemployment,⁵ and limited access to food, water, sanitation, housing, health care and education, have all had a devastating impact on the population.^[29] The situation is particularly dire for people in hard-to-reach areas (currently estimated to be 4.8 million people), and those who are trapped in besieged areas (approximately 440,000 people), cut off from basic supplies and largely inaccessible for humanitarian actors.^[29] Many Syrians are also concerned about the fate of relatives, especially those who are missing, and worry about the situation in the country including looting and/or destruction of properties left behind.^[30]

REFUGEES FROM SYRIA

Countries in the region have demonstrated great generosity in receiving refugees with over 4.1 million Syrian refugees registered in August 2015. However, there are growing concerns about the ability of persons in Syria to reach the borders, and to be admitted by, and remain in, host countries in the region and beyond.^[31] Given the scale and protracted nature of the crisis, countries of asylum, with the support of the international community, face mounting difficulties in attempting to adequately respond to the needs of refugees from Syria.

Additionally, these refugees face numerous other challenges.^[32] Increasingly they have exhausted their assets and resources and face difficulties accessing: employment, adequate housing, health services,

⁴ In 2014, four out of every five Syrians lived in poverty. Governorates with intensive conflict, and that had higher historical rates of poverty, suffered most. Almost two-thirds of the population (64.7 per cent) lived in extreme poverty: being unable to secure basic food and non-food items necessary for the survival of the household. This was particularly acute in the conflict zones. Thirty per cent of the population fell into abject poverty: being unable to meet the basic food needs of their households. See Syrian Centre for Policy Research (SCPR), *Syria – Alienation and Violence: Impact of Syria Crisis Report 2014*

⁵ Syria's unemployment rate increased from 14.9 per cent in 2011 to 57.7 percent by the end of 2014. Almost three million people have lost their jobs during the conflict. See Syrian Centre for Policy Research (SCPR), *Syria – Alienation and Violence: Impact of Syria Crisis Report 2014*

documentation and education, putting them at risk of exploitation.^{[32-34]a} Community and family protection networks have been undermined and increased social tensions between refugees and host communities have limited refugees' integration into local communities, along with access to basic services.^[32, 35-43] Refugees from Syria bring substantial positive human and social capital that could benefit host communities, and contribute to economic growth, but this may be overlooked or under-utilised under the current circumstances in which host governments and communities often feel overwhelmed by the pressures on their economies, public infrastructure and resources.^[44, 45] Some displaced Syrians are particularly at risk, such as women in female-headed households, adolescents, the elderly, those lacking documentation, persons with disabilities or pre-existing health or mental health issues, survivors of various forms of violence, and those in extreme poverty.

4. MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF SYRIANS AFFECTED BY THE CRISIS: A BRIEF OVERVIEW FOR MENTAL HEALTH AND PSYCHOSOCIAL PROFESSIONALS

PERVASIVE PSYCHOSOCIAL EFFECTS OF CONFLICT AND DISPLACEMENT

The effects of conflict on Syrian mental health and psychosocial wellbeing are profound. Experiences of conflict-related violence and concerns about the situation in Syria are compounded by the daily stressors of displacement, including poverty, lack of basic needs and services, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future.

A central issue in armed conflict settings is loss and grief, whether for deceased family members or for other emotional, relational and material losses.^[46] Ongoing concerns about the safety of family members are reported to be a significant source of stress.^[37] Displaced persons often search for news about loved ones, but get contradictory or misleading information, leading to more insecurity and confusion.^[37] For relatives of people who have been forcibly disappeared, the uncertainty of their fate and the inability to adequately mourn family members who have disappeared adds further distress and complicates grief.^[47] In displacement settings, the social fabric of society is often severely disrupted by conflict, and many Syrian families become isolated from larger support structures.^[48] Feelings of estrangement, yearning for the loss of homeland, and loss of identity, run high as displaced Syrians struggle to adapt to life as refugees within a foreign community, or in camps.^[49, 50] In some countries, discrimination against refugees and social tensions also contribute to additional stress and isolation. Many refugee women and girls feel particularly isolated and rarely leave their homes, often due to concerns over safety or lack of opportunities.^[51, 52] A similar sense of isolation can affect boys, with some refugee boys rarely leaving their homes.^[53]

Daily challenges in meeting basic needs and increased poverty are reported as key sources of stress, and are a source of increasing family tension and violence.^[37, 52]

As more and more Syrians exhaust their own financial means they must turn increasingly to survival strategies that undermine their wellbeing. They may resort to illegal or informal housing, informal employment and/or enter in debt, which in turn increases risks of exploitation and abuse. Women and children may be particularly vulnerable to forced or child marriage, survival sex and child labour.^[54] Moreover, when people do not have access to safe and supportive environments, they may react with rigid behaviour that attempts to re-establish prior roles affected by displacement.^[55] In the current protracted crisis, with no end in sight, a pervasive sense of hopelessness is setting in for many Syrians.^[51, 52]

MENTAL HEALTH DISORDERS AND PSYCHOSOCIAL DISTRESS AMONG CONFLICT-AFFECTED SYRIANS

Psychological and social distress among refugees from Syria and IDPs in Syria manifests in a wide range of emotional, cognitive, physical, and behavioural and social problems.^[37, 54-63] Emotional problems include: sadness, grief, fear, frustration, anxiety, anger, and despair. Cognitive problems, such as: loss of control, helplessness, worry, ruminations, boredom, and hopelessness are all widely reported, as are physical symptoms such as: fatigue, problems sleeping, loss of appetite and medically unexplained physical complaints. Social and behavioural problems, such as: withdrawal, aggression and interpersonal difficulties are also common. Most of these phenomena among Syrian refugees, and for most people, are the result of ongoing violence, displacement and the difficult circumstances in which they currently live and do not necessarily indicate mental disorders. Difficult life circumstances often lead to demoralisation and hopelessness, and may be related to profound and persistent existential concerns of safety, trust, coherence of identity, social role and society. Symptoms related to past experiences have also been widely documented, such as nightmares, intrusive memories, flashbacks, avoidance behaviour and hyper arousal.^[60, 64]

All these phenomena may occur in people who feel distressed, but do not have a mental disorder. However, when distress significantly impacts daily functioning, or includes specific constellations of characteristic symptoms, the person may have a mental disorder. The rates of mental disorders among Syrians have likely gone up significantly, but there are no reliable estimates of prevalence. For planning purposes, many agencies use the projections estimated by the World Health Organization (See Box 1).

It is important to realise conflict affected Syrians may experience a wide range of mental disorders, and that these could be 1) manifestations or exacerbations of pre-existing mental disorders, 2) prompted by the conflict related violence and displacement, and 3) related to the post-emergency context, for example related to the living conditions in the countries of refuge. This document is not meant to provide an exhaustive overview of the mental disorders among Syrians, but will briefly discuss some salient aspects.

Emotional disorders

Generally, as within other populations affected by collective violence and displacement, the most prevalent and most significant clinical problems among Syrians are emotional disorders, such as: depression, prolonged grief disorder, posttraumatic stress disorder and various forms of anxiety disorders.^[61-63] Some of these would amount to a severe mental disorder if they include high levels of suffering and functional loss, but most emotional disorders fall into the category of mild-moderate mental disorders. It is important to realise that the presence of symptoms does not necessarily imply that the person has a mental disorder.^[66, 67] Evidence of impairment of social functioning and/or a high level of suffering from specific symptoms is essential for the diagnosis of a mental disorder. Mental health professionals should thus be careful not to over-diagnose clinical mental disorders among displaced Syrians, especially among those facing insecurity with many ongoing daily stressors. Difficult life circumstances may result in mental disorders or exacerbate

BOX 1: WHO PROJECTIONS OF MENTAL DISORDERS IN ADULT POPULATIONS AFFECTED BY EMERGENCIES [65]		
	Before the emergency 12-month prevalence ^a	After the emergency 12-month prevalence ^b
Severe disorder (e.g. psychosis, severe depression, severely disabling form of anxiety disorder)	2% to 3%	3% to 4% ^c
Mild or moderate mental disorder (e.g. mild and moderate forms of depression and anxiety disorders, including mild and moderate posttraumatic stress disorder)	10%	15% to 20% ^d
Normal distress / other psychological reactions (no disorder)	No estimate	Large percentage

^a The assumed baseline rates are median rates across countries as observed in World Mental Health Surveys.
^b The values are median rates across countries. Observed rates vary with assessment method (e.g. choice of assessment instrument) and setting (e.g. time since the emergency, sociocultural factors in coping and community social support, previous and current exposure to adversity).
^c This is a best guess based on the assumption that traumatic events and loss may contribute to a relapse in previously stable mental disorders, and may cause severely disabling forms of mood and anxiety disorders.
^d It is established that traumatic events and loss increase the risk of depression and anxiety disorders, including posttraumatic posttraumatic stress disorder

them, but also contribute to non-clinical phenomena, such as demoralisation and hopelessness, and may be related to profound and persistent existential concerns of safety, trust, coherence of identity, social role and society.^[54, 62, 67-69] Moreover, non-clinical interventions, relating to improvement of living conditions of refugees and IDPs, may contribute significantly to improving mental health, in many cases more so than any psychological or psychiatric intervention.

Psychosis and other severe mental disorders

There is little research data on Syrian people with psychosis and other severe mental disorders. Most likely, the number of Syrians with psychotic disorders will have gone up given the increase of risk factors for psychotic disorders, such as potentially traumatic events and forced migration. Moreover, people with existing vulnerabilities who, in normal circumstances, would not have developed a manifest psychosis, may become symptomatic due to the breakdown of social support. The largest psychiatric hospital in Lebanon has seen an increase in admissions of Syrians over the past few years, with more severe psychopathology and suicidality.^[68] The International Medical Corps (IMC), a medical humanitarian organisation providing outpatient care to Syrians in five countries in the region, has treated more than six thousand people in their centres, of whom almost 700 had psychotic disorders.^[69]

Alcohol and drugs

There is limited data on the use of alcohol and other psychoactive substance in displaced populations from Syria. Consumption of alcohol in Syria has been traditionally been low.^[70] Use of alcohol may have increased: a study among Syrian refugees to Iraq found that about half of the respondents had more than five alcoholic drinks per week.^[71] Figures on the use of illegal drugs are not available, but may have increased due to the increased production and trade of illegal drugs as a result of the crisis.^[72] A worrying trend is the use of synthetic stimulants such as fenethylamine ('Captagon'), a drug that is popular throughout the Middle East and that is produced in Syria and neighbouring countries.^[73] Use of fenethylamine is reportedly popular among combatants because of its stamina-enhancing effect.^[74]

Challenges with epidemiological studies

It should be noted that results of psychiatric epidemiological studies (patterns, causes and effects on health) among conflict affected Syrians need to be interpreted with caution. Usually, standard instruments do not assess local cultural symptoms or idioms of distress, and are rarely validated for use within the Syrian humanitarian emergency.^[75] Some validation research has been done with refugees in the Middle East region, for example with Iraqi refugees,^[76] Palestinian refugees,^[77] and with Syrians before the crisis.^[78] Furthermore, most screening tools tend to focus on symptoms of pathology, with little or no attention to resilience and/or coping. However, new instruments assessing positive coping and growth are being validated for use in conflict affected populations in the Middle East region.^[79] A narrow focus on the effects of past events in Syria, without taking current life circumstances into consideration, may lead to conflating symptoms of posttraumatic stress disorder (PTSD) or clinical depression with distress generated by stressors related to the current context.^[80-83] Studies of distress in populations affected by the crises in the Middle East region have found current living contexts impact strongly on mental health.^[84, 85]

COPING WITH PSYCHOSOCIAL DISTRESS

In general, when provided safety and some external support, many families are able to adapt and adjust to the changes required by a new situation.^[57-59] For most Syrians, the first source of support is the circle of family and friends. Displacement and the dynamics of the conflict challenge and may disrupt these social support structures. Refugees and IDPs, dealing with the effects of difficult living conditions and/or exposure to violence and adversities, consistently report high levels of distress. The efforts people make to minimise or overcome distress and to solve (inter)personal problems are often called *coping*. Displaced Syrians use various ways to cope with psychosocial distress. This may include individual strategies to reduce tension and stress such as praying, withdrawal, listening to music, watching TV or drawing, as well as social activities such as seeking the companionship of family and friends, engaging in social activities, attending a community activity or school, talking with a trusted person.

Many of the common coping strategies among Syrian refugees appear to be positive such as talking to friends and family, praying, or thinking of (former) good times. However, negative coping approaches, such as withdrawal, are also extremely common. Increasingly, refugees lose hope and resort to coping strategies to deal with psychosocial stress that are less effective, or induce more stress, such as: smoking, obsessively watching the news, worrying about others still in Syria, and behavioural withdrawal or ‘doing nothing’, which may cause negative ruminating thoughts.^[37, 59, 61, 67, 68] Displaced Syrian adults may resort to such passive and individual coping methods because they have a sense there is little else they can do, feeling they have little control over their life circumstances.^[56, 86]

Syrian women also commonly use prayer and talking to family and friends as coping strategies. For Syrian women, social networks serve as an important means of coping, as well as organising charity and support groups, bazaars, and leaving the home to work together.^[56, 87] Distraction through keeping oneself busy (e.g. by cleaning the house) is often described as another way to cope. However, some Syrian women report they increasingly use passive coping strategies, such as: sleeping, crying, smoking cigarettes, and seeking time alone. Some women also try to isolate themselves, or deny that current stressors are actually happening. Such passive coping mechanisms particularly occur when the refugee situation, such as in camp settings, makes it difficult to maintain the pre-displacement regular daily routines, such as performing household chores, working, going out, or watching TV.^[88] Reinforcing women’s social networks and opportunities for active forms of coping is therefore of great importance to their wellbeing.

For displaced Syrian men living in refugee camps, praying and spending time alone are common ways of coping, both before becoming a refugee as well as while in the camps. Working, visiting family and friends, walking, and going out, used to be common forms of coping for Syrian men, but many men, particularly those living in camp settings, feel they have limited opportunities for these activities. As a result, men increasingly cope by sleeping, crying, smoking cigarettes, and “getting angry.”^[88] Many men may not feel comfortable to seek other ways of dealing with distress due to feeling helpless, or due to cultural norms

about masculinity and cultural expectations that men may not acknowledge weakness.^[50, 89] Syrian refugee men’s coping mechanisms, therefore, appear to be primarily individual and often have negative consequences. As a result, providing men with gender appropriate opportunities for collective activities would appear to be an important intervention.

Syrian adolescents in Jordan reported commonly using ‘withdrawal’ as a main coping mechanism in surveys in 2013 and 2014, although in 2014, talking to parents and friends was rated as the most common coping mechanism.^[37, 56] Other common methods of coping were thinking of (former) good times in Syria, reading the Quran, listening to music, crying, finding things to do, watching TV, joining school or community centres, sleeping, joining a support group, playing with friends, eating or drawing, and distracting themselves. A small number of Syrian adolescent youth say they use smoking, stealing and beating others as additional coping methods.^[90] The *family* can provide ways of coping, especially for youth who have experienced displacement and war-related violence. Caretakers and adults can provide a buffer from the potential negative emotional consequences of war. However, when caretakers are themselves struggling with how to cope with emotional distress, they may feel overwhelmed with the responsibility of caretaking, and youth must look for other means of support.^[37] Due to the extreme stress of social, financial and occupational turmoil accompanying the war, some Syrian parents report increasingly resorting to maladaptive coping strategies, such as beating their children or being overprotective.^[37, 91] Many Syrian adolescents, witnessing the stress and the suffering of their parents, do not want to disclose their emotional problems to their parents for fear of overburdening them.^[37]

MENTAL HEALTH AND PSYCHOSOCIAL DISTRESS: DIVERSITY AND VULNERABILITY

As noted above, age, gender, language, religious and ethno-cultural diversity impact on refugees’ experience of displacement. Specific groups may be particularly vulnerable and at risk, such as women headed households, adolescents, the elderly, those lacking documentation,

persons with disabilities or pre-existing health or mental health issues, survivors of various forms of violence, and those in extreme poverty.^[92] These factors affect the MHPSS issues faced by refugees, influence their coping mechanisms and may increase the risk of psychosocial problems and mental disorder. This section provides an overview of the specific mental health and psychosocial issues faced by men and women, survivors of sexual or gender based violence (SGBV), children who have experienced violence, abuse and exploitation, torture survivors and Syrians who are lesbian, gay, bisexual, transgender or intersex (LGBTI). Each section provides a brief overview of the issues, followed by an explanation of the MHPSS consequences. Chapter six of this report contains essential information on ensuring that services for mental health and psychosocial support are made accessible and are culturally acceptable to all Syrian refugees, including the groups discussed in this section.

Gender roles and MHPSS issues

Violence and displacement can alter social networks and roles, which may undermine the ability to cope and lead to family tension, identity crises and psychological distress. Additionally, within a refugee context, family roles and gender roles may change dramatically. Many Syrian women have become providers for the household, as well caring for their families, as their husbands are absent, wounded or disabled, or have died.^[93, 94] These additional responsibilities, combined with feelings of lack of security, often create great stress for women.^[93] Traditional views on gender roles or stereotypes about refugees from Syria can also put great pressure on refugees of both sexes.

A study in Lebanon found that many refugee women felt uncomfortable that they had to undertake tasks not previously considered appropriate for women from their community, such as running errands and engaging in paid work, in addition to their roles as caregivers. However, other women reported that that this new situation gave them a sense of empowerment and had provided them with new opportunities that would otherwise not have been available to them.^[55]

Men, who often ground their identity in their role as the families' main provider of material and financial needs,

may experience psychological distress when their ability to provide food or money for their family is disrupted. Moreover, concerns for the safety and security of their families, unemployment, exploitation and working illegally may also lead to major worries among men. Urban refugee men in Jordan frequently mentioned feeling depressed and ashamed of their inability to continue their education, and being forced by circumstance to work in very low paying and/or harsh jobs to help support their families.^[50] Moreover, men, women and children report that these additional stressors exacerbate family tensions and have led to increased domestic violence.^[52, 95]

Survivors of sexual and gender based violence

Sexual and gender based violence (SGBV) has increased substantially due to the conflict.^[96] Many women and girls, and to a lesser extent boys and men, are exposed to SGBV resulting from conflict-related violence, the breakdown of law and order inside Syria, increased poverty, lack of basic needs and safe services, family separation and disruption of traditional social networks and protection mechanisms.^[52, 97-99] Refugees who have fled to other countries may be safe from conflict-related SGBV, but continue to face other forms of SGBV, including: domestic violence,^[25, 98, 100-103] sexual violence, early marriage, harassment and isolation, exploitation and survival sex.^[52, 102, 104-107] Refugees have repeatedly identified rape, and the fear of rape, as a driving motivation to flee the country.^[108, 109]

The psychological and social impacts of SGBV, in particular sexual violence including rape, can be devastating for the survivor,^[110, 111] and may have a ripple effect throughout the family and wider community.^[99] Fear of being subjected to abduction, rape and other sexual violence limits women and girls' freedom of movement. In addition to the actual ordeal of suffering sexual violence, women and girls often fear or actually face social ostracism and further repercussions, including: rejection, divorce, abuse and for a minority of cases "honour" crimes" at the hands of family members.^[112-114]

Women subjected to arrest or kidnapping are reportedly, frequently stigmatised on release because of presumed sexual abuse.^[96] Boys and men who have experienced sexual violence also face negative social consequences.

All of these factors increase the risk that sexual violence leads to psychological problems, such as depression and anxiety. Survivors of sexual abuse often experience a combination of feelings, including: injustice, a sense of guilt and self-condemnation.

Domestic violence is reported as among the most common form of SGBV. Forms of domestic violence against women and children are reported to have become more aggressive and common as a result of the conflict. Stress among men is reported to be a major cause of the increase of this form of violence, and as such, MHPSS practitioners should offer evidence based services to men (that have been shown in other contexts) to reduce domestic violence, including anger management and parenting programmes. In addition, as part of the psychosocial services provided to survivors, they should be helped to identify supportive members of their social network, further, risks of social stigmatisation and further abuse need to be carefully assessed and addressed.^[109]

Prevalence and associated risks of early marriage have both increased as a result of poverty, insecurity and uncertainty caused by displacement.^[100, 115, 116] Both inside Syria, and among refugees from Syria to neighbouring countries, early marriage of girls has become a coping mechanism and is perceived as a means to protect girls and better secure their future when faced with general insecurity, poverty, absence of male family members and uncertainty.^[116-119] However, early marriage may be a significant source of distress for girls, and is often associated with interruption of education, health risks and increased risk of domestic violence.^[118] Feelings of abandonment, loss of support from parents and lack of access to resources to meet the demands of being a spouse and a mother may create additional stress in married girls.

Survivors of torture

Many Syrians have to deal with the effects of having been tortured.^[120] While there are limited research data on the specific mental health and psychosocial problems of Syrian survivors of torture, in general, survivors of torture are vulnerable to developing psychological problems, particularly depression, posttraumatic stress reactions, chronic pain, and medically unexplained

somatic symptoms.^[121, 122] Emotional and social support can buffer the severity of posttraumatic stress disorder and depression, while ongoing insecurity, economic difficulties, and social isolation can aggravate symptoms.^[123, 124] Practitioners working with Syrian survivors of torture report that many of their clients have multiple problems, including psychological, social, economic and legal issues.⁶ Conventional diagnostic classifications are often insufficient as many clients have symptoms of various torture-related problems, including depression, posttraumatic stress disorder, panic attacks, chronic somatic symptoms and suicidal behaviour. Providing a client with multiple diagnoses may not be helpful, but symptom reduction in one area can have beneficial effects on other stress-related problems.

LGBTI Syrians

The specific challenges facing lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals in Syria are often overlooked. Same-sex acts among consenting adults are illegal in Syria.^[125] Overt societal discrimination based on sexual orientation and gender identity is present throughout Syrian society. In order not to risk tainting their families' honour, gay men and lesbians are often under strong pressure to get married and to conceal their sexual orientation. The risks for LGBTI persons, particularly gay men, have increased since the conflict, resulting in high levels of stress and vulnerability to exploitation and abuse.^[126, 127] The specific protection risks faced by Syrian LGBTI refugees and IDPs, combined with difficulties accessing safe and supportive services, and extreme stigma and discrimination create very specific psychosocial and social difficulties for Syrian LGBTI persons in their social relations, integration, and identity.

Older refugees and refugees with specific needs

Older refugees, particularly those who have health problems and a limited social support network, are vulnerable to psychosocial problems.^[92] A study among older refugees in Lebanon found that 65% presented signs of psychological distress, around three times as high as in other refugees.^[128] Another survey, among older Syrian refugees in Lebanon, also found high levels of

6 Information obtained from staff working for the Centre for Victims of Torture in Jordan (dd. 2 June 2015)

feeling anxious (41%), depressed (25%), unsafe (24%) or lonely (23%).^[129] Many elderly refugees in this study felt powerless, and had a desire to return to Syria, even while realising this was now impossible. Almost a third of the older refugees in this sample said that these negative emotions caused serious impairment to their ability to do what a healthy person of their age would be expected to do. Those with poor physical health were significantly more affected.^[129]

Refugees with specific needs due to disability, injuries or chronic disease constitute another group with elevated psychological stress levels. A study by Handicap International and Help Age International among Syrian refugees in Jordan and Lebanon found that people with such specific needs were twice as likely to report psychological distress.^[128]

As for other Syrian refugees, the distress in older people or those with specific needs is often connected to fear and anger about their own situation, compounded with worry about the situation in Syria and all that was lost. For people with specific needs and older refugees, additional distress is related to various factors, such as high levels of social isolation as well as widespread discrimination, both of which are exacerbated by displacement and poverty. Many also have fears of being separated from families or caretakers, or of being left alone when the others have to move on to other settings. Moreover, many have lost facilitating and supportive social and physical environments in Syria built up over the years, including accessible housing and social spaces for people with mobility problems. Many also reported feelings of powerless and felt they would be perceived as a burden by their caretakers.^[128]

Mental health and psychosocial wellbeing of Syrian children

Children continue to suffer immensely as a result of conflict and displacement. More than 50% of Syrians displaced internally or as refugees are children, and of these, nearly 75% are under the age of 12.^[119] Some have been wounded and many have witnessed conflict first-hand or endured the destruction of their homes and communities, surviving forced displacement, family separations and recurrent

violence. Inside Syria, children continue to face violations of their safety and protection, including exposure to physical and sexual violence, recruitment by armed groups and lack of access to basic services.^[130, 131]

These forms of violence and deprivation result in high levels of psychosocial distress. Although refugee children may find safety from conflict and persecution when they arrive in host countries, they and their families often need ongoing support in order to cope with the effects of conflict.^[132] In addition, during displacement, separation from friends, families and neighbours, and lack of basic services, increases the likelihood that children will be exposed to violence in their homes, communities and schools. Various parties to the conflict are involved in recruitment of children for support functions and combat, putting them at great risk of death, injury, psychological distress or torture.^[133, 134] Approximately half of displaced Syrian children, especially older children, are unable to continue their education.^[135-137] Incidents of sexual violence towards children have been widely reported in Syria, as well as to a lesser extent in refugee host countries, particularly against girls.^{[50, 138-140], [114, 140, 141]}

Generally, studies have found that Syrian refugee children experience a wide range of psychosocial problems resulting from both their experiences in the war, and their current living situation. Problems include: fears, difficulties sleeping, sadness, grieving and depression (including withdrawal from friends and family), aggression or temper tantrums (shouting, crying and throwing or breaking things), nervousness, hyperactivity and tension, speech problems or mutism, and somatic symptoms. Violent and war-related play, regression and behavioural problems are also reported among children.^[37, 131, 132, 142]

Research among Syrian refugee children in Turkey indicated high levels of emotional and behavioural problems; nearly half of children had clinically significant levels of anxiety or withdrawal, and almost two thirds were fearful.^[143] In a qualitative study among Syrian adolescents in Lebanon and Jordan, the girls mentioned that they experienced enormous physical and social isolation, as well as wide spread discrimination and harassment.^[144] Syrian adolescent boys also faced discrimination and were

commonly subject to bullying and other forms of physical violence. Adolescent boys had a profound sense of humiliation resulting from exploitation as child labourers, with poor pay and dangerous conditions as well as the mounting social tension between Syrian refugees and host communities.^[144] A recent study in Jordan found that adolescent girls face more problems overall than boys, and are more likely to feel sad, depressed and fearful, although they are also more likely than boys to feel supported by parents and friends.^[37]

Key sources of stress for children include: discrimination by members of the host community, war-related fears (including worries about family left in Syria), as well as their own traumatic experiences and educational concerns. Family violence and parental stress, economic pressures and confinement to the home are also reported to contribute to children's distress.^[145] Girls more commonly report confinement and harassment as key stressors, while boys are more likely to report physical abuse and bullying. There is some evidence that over time, and with the right support from family, the surrounding community and service providers, many aspects of refugee children's distress are reduced. For example, adolescents in Za'atari camp in Jordan were found to be less depressed and fearful than those who lived out of camps, and also felt more supported by their parents, siblings and friends in mid-2014, compared to mid-2013.^[37] Changing roles for children can be a major stress factor, with children often shouldering responsibilities and concerns well beyond their age, however, for some children, this may also be a source of pride and sense of purpose in caring for and supporting their families.^[119]

5. CULTURAL FRAMEWORKS OF MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING

CULTURE-SPECIFIC MENTAL HEALTH SYMPTOMS AND IDIOMS OF DISTRESS

In cultural psychiatry, *cultural idioms of distress* refer to common modes of expressing distress within a culture or community that may be used for a wide variety of problems, conditions or concerns. *Explanatory models* refer to the ways that people explain and make sense of their symptoms or illness, in particular how they view causes, course and potential outcomes of their problem, including how their condition affects them and their social environment, and what they believe is appropriate treatment.^[146]

Understanding local illness models and idioms of distress will allow better communication, and in turn, this knowledge can be used in interventions designed to mobilise individual and collective strength and resilience. In general, MHPSS practitioners should avoid psychiatric labelling because this can be especially alienating and stigmatising for survivors of violence and injustice. For clinical mental health practitioners, building a solid therapeutic alliance with their clients will allow both practitioner and client to navigate among diverse explanatory models and sources of help that may include both formal and informal medical systems, religious or community resources and strategies.

In Syria, where concepts such as ‘psychological state’⁷, ‘psychological wellbeing’⁸, or and ‘mental health’⁹ are not commonly understood and often carry negative connotations, suffering is commonly understood as a normal part of life, and therefore, not necessitating medical or psychiatric intervention, except in severe and debilitating forms. Within clinical settings, people who are distressed may use indirect expressions when asked about their

current wellbeing, such as *ana ta’ban* (أنا تعبَان, ‘I am tired’, or *nafsiyti ta’banah* (نفسيتي تعبَانه, ‘my psyche is tired’). This refers to a general state of ill being and may stand for a range of emotional symptoms, but also for relationship difficulties. Such statements, therefore, need further assessment to understand what they mean for an individual within a particular context.

Patients with psychological or mental problems often first present at medical services with a physical complaint, before addressing the psychological, relational or spiritual dimensions of their predicament.^[147] Most Arabic and Syrian idioms of distress do not separate somatic experience and psychological symptoms, because body and soul are interlinked in explanatory models of illness. People may resort to images, metaphors and proverbs that assume the interconnectedness of the psychological and the physical. Some of the most common idioms of distress are described below. Understanding local idioms of distress is important for communication with refugees. Local expressions can be used to convey empathy as well as to explain and support interventions.^[148] These common expressions serve to express many forms of distress, including those associated with mental disorders. In general, there is no simple one-to-one correspondence between idioms or explanations and specific mental health problems or social difficulties.

In clinical contexts, the use of everyday expressions and proverbs or metaphors to express distress may be misunderstood as ‘resistance’ to direct communication, or even misinterpreted as psychotic symptoms.^[149, 150] For instance, some Syrians attribute obsessive rumination to satanic temptations, using the Arabic word *wisswas* (وسواس) meaning both the devil and unpleasant recurrent thoughts.^[150] Careful, systematic inquiry into the personal and local cultural meanings of these expressions is always necessary.

7 Psychological state: *al hala al nafsiyah* (الحالة النفسية), *al wad’ al nafsy* (الوضع النفسي), or *al rafah el nafsi* (الرفاه النفسي)

8 Psychological wellbeing: *al saha al nafsiyah* (الصحة النفسية)

9 Mental health: *al saha al ‘akliyah* (الصحة العقلية)

SPECIFIC EXPRESSIONS AND IDIOMS IN THE SYRIAN CONTEXT

A number of key concepts of distress are listed below that have been identified in the academic literature and MHPSS assessments used by Syrians, both prior to and following displacement. While these concepts may be grouped differently in various studies, the following reflects the most common concepts identified across the literature.

General distress

Heaviness in the heart, cramps in the guts, or pain in the stomach or in the head may all be expressions of fatigue. The experience of oppression, tightness in the chest, pain in the heart, numbness of body parts, or having the feeling of ants crawling over the skin are all common expressions in which bodily organs are perceived as unable to contain the distress.^[151]

Fear and anticipated anxiety

Habat qalbi (هبوط قلبي) or *houbout el qalb* (هبوط القلب), literally ‘falling or crumbling of the heart’, correspond to the somatic reaction of sudden fear. *Khouf* (خوف, ‘fear’) or *ana khayfan*, (أنا خائفان, ‘I am afraid’) are direct expressions of fear. *Kamatni kalbi* (قمطني قلبي, ‘my heart is squeezing’) or *atlan ham* (هم عتلان, ‘I am carrying worry’) generally refers to anticipated anxiety and worry.

Feeling nervous or tense

Syrian people use different terms to describe an anxious or nervous person: *Asabi* (عصبي, nervous) is used to describe anxiety as a character or personality trait. The word *masseb* (مُعَصَّب) is used to describe a person who is currently nervous (a temporary state). The term *mitwatter* (مُتَوَتِّر), ‘I feel tense’) is used for tension due to a specific situation, such as waiting for the results of an exam or expressing or having an opposing opinion to someone else. There is considerable variation in the use of such terms: for example, Syrian adolescents in Jordan used *asabi* to describe feeling easily irritated, angry or tense, and associated it with ‘getting upset over little things’.^[37]

Sadness and difficulty in adjustment to an acute stressor

Hozon (حزن, ‘sadness’) and difficulty in the face of an acute or sudden stressor may be referred to as *al-hayat sawda* (الحياة السوداء, ‘a black life’), or *iswadat al dounia fi ouyouni* (اسودت الدنيا في عيوني, ‘life has blackened in my eyes’). Somatic complaints may include feeling a burden or weight on the chest, resulting in pain in the chest area or inability to breathe and the need for air, as well as loss of appetite, pain in the abdomen and chest, and/or sleep disturbances. The concept of *hozon* can also be used for a state of grieving. For example, Syrian adolescents in Jordan used the term when they described how they missed their friends in Syria, thinking often about their losses and withdrawing from social life.^[37]

Depression

While *hozon* may signify a state of depression, this is more directly referred to by laypersons and mental health practitioners alike as *halat ikti’ab* (حالة اكتئاب, ‘condition of *ikti’ab*’). *Ikti’ab* may hold complex concepts, such as brooding, darkening of mood, aches and a gloomy outlook, and may be accompanied by a variety of medically unexplained somatic symptoms and fatigue, as well as signs of social isolation (no friends, not talking much).^[37]

Lack of resources and helplessness

Lack of resources and financial hardship is often referred to as *al ayn bassira wal yadd kassira* (العين بصيره و الإيد قصيره, ‘the eye sees but the hand is short or cannot reach’). Expressions often used by Syrians to express helplessness are: *mafi natija* (ما في نتيجته, ‘there is no use’), *hasis hali mashlol* (حاسس حالي مشلول, ‘I feel like I’m paralysed’) or *inshalit, ma a’d fini a’mel shi* (انشأيت، ما عاد فيني أعمل شي), ‘I am hopeless’ and ‘I cannot do anything anymore’), *mou tali ‘ bi’idi shi* (مو طالع بإيدي شي, ‘nothing is coming out of my hands’, which refers to the inability to do anything to change an undesirable situation). Another common idiom of distress in Arab and Syrian societies, used in relation to helplessness, is *ihbat* (إحباط), which refers to a mix of

depressive feelings, frustration, a sense of defeat, disappointment and loss of hope.

Cognitive symptoms

People may also present with symptoms of loss of concentration and memory, expressed with terms such as *mou aader rakkezz* (مو قادر ركز, 'I can't focus' or 'I can't concentrate').

Anger and aggressive behaviour

Some Syrian men find it difficult to acknowledge feeling such as sadness and anxiety. Anger may be the emotion that surfaces the most easily and be expressed as aggressive behaviour, both within the family and outside of it. Syrian men may hold views that men don't cry and are not afraid or sad, associating this with weakness.^[89] In focus groups among Syrian adolescents in Jordan, the expression *mashkalji* (مشكلجي, 'troublemaker') was used to indicate children and adolescents who were often getting into trouble with neighbours or friends complaining about his/her behaviour.^[37]

Madness

In colloquial Arabic, persons with severe mental disorders and disabilities are often described as *majnoon* (مجنون), which means 'crazy', 'mad' or 'insane'. *Majnoon*, as a category for mental disorders, overlaps with the psychiatric category of psychotic disorders, such as schizophrenia, but not with those of 'common mental disorders' such as depression, anxiety and posttraumatic stress disorder. Although historically derived from possession by *jinn*, the term *majnoon* is mostly used without any reference to possession or malevolent acts by *jinn*.^[152] The word *majnoon* is also used in daily language for those who generally behave in a strange, abnormal or unexpected way, but do not necessarily have a mental disorder. The word *majnoon* has strong negative connotations.

Suicidality

In Arabic-speaking cultures, in general, suicide and suicide attempts may be a source of stigma, shame and social exclusion. In addition, some aspects of *shari'a* (Islamic) law are codified in Syrian national law, making attempting suicide a crime in Syria.^[153] In some surrounding countries, mental health practitioners are required to report attempted

suicides to the authorities under national law, which can create challenges for people to disclose such attempts or thoughts and mental health practitioners response to this disclosure. Syrians may use indirect expressions, such as they wish they could sleep and not wake up (*itmana nam ma fik*, (اتمنى نام ما فيق)). People will be more likely to answer queries about suicidal thoughts openly once a trusting relationship is established. Mental health practitioners are usually taught to approach the topic of suicide gradually, by first asking about other aspects of distress and posing questions that may make it easier for a person to answer frankly, such as: 'have you ever thought that death is better than this life?', 'do you sometimes wish God would let you die?', or 'in such cases, some people might think of ending their life; have you ever considered it?' However, within the Syrian context, people may also express the wish that God take their lives as a way to convey that they are in distress, with no intention of ending their own lives.

Table 1 (Syrian Arabic version) and Table 2 (Kirmanji Kurdish version) give a brief overview of common expressions and idioms of distress, used by Syrian people with problems related to mental health, psychological wellbeing, social problems, and corresponding physical symptoms.

TABLE 1: COMMON EXPRESSIONS AND IDIOMS OF DISTRESS IN SYRIAN ARABIC			
Arabic term or phrase	Transcription	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
متضايق كثير هالفتره حاسس حالي متضايق ضايح نفسى مخنوقه	- Meddayyek ketir hal fatra - Haassess haalii meddayyek - Dayej - Nafsi makhnouka	- I am very annoyed these days - I feel annoyed - To be cramped - My psyche is suffocating	- Rumination tiredness, physical aches, constriction in the chest, repeated sighing - Unpleasant feelings in the chest, hopelessness, boredom
حاسس روحي عم تطلع	- Hassess rouhi 'am tetla'	- I feel my soul is going out	- Dysphoric mood, sadness - Inability to cope, being fed up - Worry, being pessimistic
قلبي- مقبوض انعمى على قلبي	- Qalb maqboud - In'ama 'ala kalbi	- Squeezed heart - Blindness got to my heart ¹	- Dysphoria - Sadness - Worry, being pessimistic
تعبان نفسيا- حاسس حالي تعبان- حالتى تعبانة- نفس تعبانة	- Taeban nafseyan - Hassess halii ta3ban - Halti taebaneh - Nafs ta'bana	- Fatigued self/soul	- Undifferentiated anxiety and depression symptoms, tiredness, fatigue
-ما قادر اتحمل الضغط على كثير- مو قادر ركز من الضغوطات -	- Ma ader athammel - El daght 'alaly ketiir - Mou kaader rakkezz men el doghoutaat	- Can't bear it anymore - The pressure on me is too much - Can't concentrate because of the pressure	- Feelings of being under extreme stress or extreme pressure - Helplessness
فرطت-	- Faratit	- I am in pieces	- General state of stress, sadness, extreme tiredness, inability to open up and to control oneself, or to hold oneself together
و الله مو شايف قدامي-	- Wallah mou shayef oddaamii	- By God, I can't see in front of me	- General state of stress, feelings of loss of options, loss of ability to project into the future, - Confusion, hopelessness
-حاسس الدنيا مسكرة بوشي ما في شي عم يزبط معي -	- Hases eddenia msakkra bwishi - Ma fi shi 'am yizbat ma'i	- I feel the world is closing in front of my face - Nothing is working as planned with me	- Hopelessness, helplessness, state of despair
- شو بدى إحكى...الشكوى لغير الله مذلّه - الحمد لله	- Sho baddi 'ehki... el shakwa le gher allah mazalleh -Al hamdullillah	- What am I supposed to say... it is humiliating to complain to someone other than God. - Praise be to God.	- Reference to shame in asking for help - State of despair, surrender
ما يعرف شو بدى إعمل بحالي	- Maa ba'ref shou beddi a'mel be halii	- I don't know what I am going to do with myself	- General state of distress - Feeling upset, edgy, helplessness -Hopelessness, lack of options
متوتر	- Mitwatter	- I feel tense	- Nervousness, tension
خيفان حاسس بالخوف مرعوب	- Khayfan - Hases bil khof Mar'oub	- I am afraid - I feel fear - Frightened, horrified	- Fear, anxiety - Worry - Extreme fear
مُعَصَّب	M3asseb	- I feel angry	- Anger, aggressiveness - Nervousness

Sources: This table is based on suggestions by Arabic speaking mental health professionals, including: Alaa Bairoutieh, Tayseer Hassoon, Ghayda Hassan, Maysaa Hassan, Hussam Jefeé-Bahloul, and Mohamed el Shazli.

TABLE 2: EXPRESSIONS IN KURDISH (KIRMANJI DIALECT)		
Kurdish terms or expressions	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
<i>Bena mn tanga</i> <i>Nafasa mn tanga</i>	- My breath is short	- Low mood
<i>Chi béjim/ chi bikim vala ye</i>	- What am I supposed to say/to do without result	- Helplessness - Hopelessness - Loss of options
<i>Dunia lber mn tari buya</i> <i>Dunya li ber chavé min resh</i> <i>búye</i>	- The world became dark in front of me - The world is closing in front of my face	- Despair - Hopelessness - Helplessness - Depression
<i>Ez dihisim gu ezé bifetisim</i> <i>Béna min dichiki</i>	- I feel I am going to suffocate	- Restlessness - Loss of options, - Feeling constricted
<i>Dil shikestime,</i> <i>Dilé min déshe</i>	- My heart is broken - My heart is aching	- Tightness in the chest - Chest pain - Stress - Anxiety - Sadness
<i>Az taabima</i> <i>Nefsi/ westyame</i> <i>Pir westyame</i>	- I'm tired - Fatigued self - Fatigued soul	- Helplessness - Hopelessness - Fatigue
<i>Az nkarm bshughlm</i>	- I can't fulfil my duties or responsibilities	- Inability or loss of drive or motivation to perform activities
<i>Az galak dfkrm</i>	- I think a lot	- Excessive thinking /excessive worry - Could be associated with anxiety or depression
<i>Lashe mn grana</i>	- My body is heavy	- Fatigue
<i>Kharna mn tunaya</i>	- I have no appetite	- Loss of appetite that could be associated with grieving, anxiety, worry or depression
<i>Az ghaidm</i> <i>Az qahrma</i> <i>Az ejzm</i>	- I am sad - I feel sorrow - I feel incapable or impotent	- Low mood - Sadness - Incapacity - Feelings of injustice or of being defeated by unjust life circumstances
<i>Jisme mn sist dbit</i>	- My body becomes rigid	- Spasm of body parts which may occur in non-epileptic seizures and in epileptic seizures
<i>Tahamula mn kem buya</i> <i>Tahamula mn tunaya</i> <i>Nema tahmúl dikim</i> <i>Ez feritime</i>	- I feel that my ability to bear things is reduced	- Excessive stress - Easily losing control over one's emotions - Difficulty coping, handling stress or pressures
<i>Ez nizanim chi bi seré xwe bikim</i>	- I don't know what I am going to do with myself	- General distress - A state of confusion, loss of options and disappointment

Source: This table is made with expert input of Kurdish speaking mental health professionals: Rawisht Rasheed, Aram Hasan and Naz Baban.

SYRIAN CONCEPTS OF THE PERSON

Historical, religious, ethnic and social dynamics all contribute to shaping Syrian views of the person and the relationship of the person to the world. Cultural concepts of the person influence how people experience and express suffering, how they explain illness and misfortune, and how they seek help.^[154] Within the Syrian context, cultural heritage and religious background both contribute to individual identity and to ways of understanding the place the individual inhabits within the community, and the universe. Religion and social norms are deeply intertwined in Syria, as in the Arab world more generally.

It is important to remember that, despite the general patterns summarised below, there still remains great diversity among Syrian people, as is true of any group of people.

Islamic concepts of the person

Syrian concepts of the person can be characterised as ‘sociocentric’ and ‘cosmocentric’, in that each individual is seen as linked to every other creature created by God, including the world of angels and spirits.^[155] This linkage is symbolised by the double dimension of every individual: a universal dimension that is governed by the will of God and a social dimension governed by social rules of conduct and coexistence. The notion of *qadar* (القَدْر, ‘fate’) is central to this context. This acceptance of fate should not be equated with fatalism, but can be better understood within a framework of self-abandonment, which is reflected in the value of patience in the face of helplessness and adversity, such as illness and loss. Life may be viewed as a transient phase of existence, a testing place for the eternal life that comes after death.^[155] The perception of death as a transition between two lives may also help to give constructive meaning to bereavement. In present-day Syria the word *al that* (ذات) indicates the core of a human personality and is used as a synonym for ‘self’. The term *nafs* (نَفْسٌ) denotes the internal (psychological) system.^[156] Early Arab and Muslim scholarly writings on the concept of the person used the term *nafs* for individual personality, consisting of *qalb* (قلب, ‘heart’), *ruh* (روح, ‘spirit’), *aql* (عقل, ‘intellect’), and *irada* (إرادته, ‘will’).^[154]

Within Muslim cultures, a prevailing view is that the person is created weak. This fundamental ‘weakness’ is

linked to the notion of *taslim* (تسليم), or voluntary and confident surrender to the ‘all powerful God’ (as in the phrase *Allahu akbar*, ‘God is great’)^[154]. However, *taslim* and other expressions of a human being’s weakness, as compared to infinite God’s strength and power, are inseparable from the notion of *taklif* (تكليف, ‘entrusting’), which can provide a Muslim with considerable strength. The notion of surrender may help Syrians better accept hardship as the ‘will of God’, while the notion of *taklif* may help them find the motivation and drive to cope with hardship.^[154] A widespread view among Syrian Muslims, like others, is that catastrophes and illnesses may be seen as an opportunity for growth and an occasion to strengthen one’s faith, and therefore, are not necessarily punitive (i.e. God punishing humans for their misdeeds).^[155, 157, 158]

Diversity

Other religious traditions in Syria may share this Islamic view of the person, but also have specific conceptualisations of personhood, such as the central role of the transmigration of souls (the belief that the soul of person passes from one body to another) among the Druze, a religious and social minority with its own monotheistic theology.

Of course, most people will not refer explicitly to these different philosophies. However, these core values and ideas are interwoven into many aspects of everyday life, and are part of the cultural background knowledge and popular expressions that are simply ‘taken for granted’.

EXPLANATORY MODELS OF MENTAL ILLNESS AND PSYCHOSOCIAL PROBLEMS

Cultural systems of knowledge, belief and practice provide explanatory models for illness that include ideas about causality, course, appropriate treatment and likely outcome. These explanations may be drawn from particular ideas about what makes up the person and the world, and theories of the processes of illness and healing. Explanatory models can have important implications for coping, help-seeking behaviour, treatment expectations, worries about long-term consequences of illness and stigmatisation.

Over recent decades, popular concepts of mental health in Syria have gradually changed. Awareness of mental health

care has increased, particularly in urban settings. Clients in mental health settings often express their distress in bodily terms without invoking supernatural or spiritual explanations. Many Syrians are likely to view the causes of their sufferings or mental health difficulties as emanating from the violence, losses and daily social and economic pressures. The impact of these stressors on mental health and psychosocial wellbeing has been widely reported and is consistent with the impact of war and conflict on populations.^[122, 159-161] However, more context specific religious and/or cultural explanations of distress and illness, or sources of healing, are also common. Additionally, people may use or consider multiple explanations to address different facets of their problems.

Common religious and culturally specific concepts for explanation of illness or distress used commonly in Syria are described below. The aim of this discussion is to complement the existing literature on the effects of violence and daily stressors on the mental health and wellbeing of conflict affected populations, in general, and Syrians in particular. Multiple explanatory models of symptoms and suffering commonly coexist. Mental health practitioners should realise that their own professional explanatory models of mental health problems may not be shared by their clients and that imposing them may alienate their clients and harm the relation between them. It is also important to realise that people may use various explanatory models to explain aspects of their suffering at different moments in time, depending on the context, question or concern. Moreover, while explanatory models are important they should not be used in a restrictive or over-generalising way (i.e. ‘Syrian women think X of X’) as such explanatory models vary between people and over time. Practitioners must try to understand and respect diverse explanatory models used by their clients in order to optimally engage with their clients and provide more effective support.

Numerous mental health practitioners working with refugees from Syria and IDPs have noted that explanatory models of mental disorder and attitudes to MHPSS services are rapidly changing as a result of the shared experiences of violence, loss and displacement, which tends to lessen the stigma surrounding mental health problems.^[57, 162]

Religious explanatory models

Religious value systems also play a significant role in the perception and understanding of psychological problems, and the methods of treatment. In Islamic belief, the soul is not separate from the body; rather, they are interdependent with physical and psychological aspects of experience closely intertwined. Emotional distress is perceived as located in the heart, rather than the head, and the heart is considered the vital source of human psychosomatic health. Therefore, imbalance or disharmony in the heart may be linked to mental illness.^[158, 163, 164]

Among the Druze, for whom reincarnation and the transmigration of souls is a central belief, individuals may understand suffering and mental illness as punishment for misdeeds in a previous life, or as a consequence of the violent death of the sufferer in his former life.^[165-167] Christians in Syria share some concepts and attitudes toward mental afflictions based on an Islamic framework. However, they also have distinctive ways of understanding and dealing with mental illness. There may be a common tendency to suppress emotions and prefer selective sharing of stressful conflicts or predicaments, which may be linked to the Christian tradition of confession.^[79]

Among Syrian Christians, and Muslims, a common way to cope with distress is by prayer, including: reading the Koran, attending religious ceremonies or making religious vows (*nizer*; نذر or *nidher*; نذر). For instance, adolescents in Zaatar refugee camp in Jordan reported reading the Koran as a common coping mechanism (after talking to parents/friends, withdrawal and thinking about good times in Syria).^[37] Some Christians, for example, may make a vow that a female family member will wear a special dress (*taub el adra*, توب العدرا) for a period of time, if God helps them through their difficulties. Christians in Syria also utilise churches and community support for spiritual healing and management of stress. It is common for Christian families to consult a priest to counsel a distressed family member.

Supernatural explanatory models

Some Syrians may seek causes for misfortune and illness in ‘supernatural’ forces. This type of explanation is rooted in popular traditions found in many Arab societies and preceded Islam.^[154, 168-173] People from diverse

socioeconomic, ethnic and religious backgrounds in Syria may refer to the existence of ‘evil spirits’ (*jinn*, جِن), ‘magic’ (*sahr*, سحر), or the ‘evil eye’ (*ayn al-asūd*, عين الحسود) to explain symptoms of ‘madness’. *Jinn* are described in the Quran and form an important part of the worldview of people in Syria. Indeed, believing in *jinn* may be seen as an expression of faith.^[154] Some mental illnesses are attributed to *jinn*, particularly among rural communities. A lack of understanding may mean that clients who complain of being possessed, attacked, or slapped by *jinn* risk being discriminated against by some mental health practitioners. A culturally competent practitioner should explore the notion of *jinn* as an explanatory mode, and an idiom of distress.^[149]

Situations where the person uses supernatural explanations (possession, evil spirit, magic, evil eye) without having a psychiatric condition, must be distinguished from cases in which such explanations coexist with psychotic symptoms, such as thought control, thought insertion or delusion.^[174] Knowledge of local idioms, explanatory models and modes of expression can assist in making these distinctions, but evidence of other symptoms of psychosis and related functional impairment may be essential for diagnosis. As mentioned above, people often use multiple explanatory models in flexible and pragmatic ways in order to make sense of their condition and predicament.

RELIGIOUS AND CULTURE-SPECIFIC HEALING PRACTICES

While many Syrians with mental problems seek help from health professionals, expecting medical or psychosocial treatment, some may also resort to religious or supernatural healing practices and may approach them concurrently, or in succession. Common coping mechanisms identified among conflict-affected Syrians are described in the section “Coping with Psychosocial Distress” above. This section provides essential background information on religious and spiritual healing practices in Syria.

Religious healing for physical and mental illness is often sought through the mediation of saints, by visiting holy places associated with them (such as shrines where a saint is buried) and other holy sites. Some groups, particularly

Alawites and Sufis, as well as Christians, may use shrines or sacred religious icons (associated with saints) to ask for help in the event of illness. Among Shia Muslim families, visiting holy places such as the *Sayyida Zeinab* mosque in Damascus was used in the past as an important healing ritual. However, access to these sites is no longer possible. The religious *hajj* (‘pilgrimage’) may still provide an alternative for some, but lack of financial resources or inability to travel makes this impossible for most.

Common types of religious based, traditional and spiritual treatments in Syria, and other countries in the region, include *rukya* (رُكْيَة) and *hijab* (حجاب). *Rukya* involves reading Quranic verses or prayers, followed by *al nafth* (النفث, ‘blowing a puff of air’) on the wound or ill body part.^[175, 176] A religious leader usually performs this kind of treatment, but a family member can also perform *rukya*. The *hijab* are amulets containing Quranic verses and written prayers, often produced by a *katib* (كاتب), a male healer, and worn on the body to ward off evil spirits.^[171] In both types of treatment, a *sheikh* (شيخ, religious or spiritual leader) will choose the verses or prayers he sees as appropriate for the type of ailment concerned. Traditional healers are also generally called *sheikh*.

Despite the fact that Islam prohibits the use of magic, the existence of magic is widely acknowledged and its potential positive and negative impacts on health can be read in the, for example, *Surat al Baqara* in the Quran. Some see magic as an alternative approach to dealing with afflictions, and it often coexists with other healing practices, including biomedicine. Explanations referring to magic may attribute an illness to the use of evil or malevolent spirits (*jinn*) by others who wish to cause harm.^[177]

Less common traditional and spiritual healers in Syria include: *al-fataha* (الفتاحه, female fortune tellers); the *dervis* or *darwish* (درويش, male or female healers who treat mental illness using a variety of religious and spiritual rituals); and the *moalj bel-koran* (معالج بالقرآن, male Quranic healers who use Islamic scripture to ward off evil spirits).^[178] Special procedures are applied for the treatment of possession by *jinn*. Many people refer to the success of the treatment as being demonstrated by seeing some physical

sign, for example, bleeding from the little toe when the spirit leaves the body. This so-called ‘spirit release’ usually leads to a sudden and spontaneous recovery. Other persons with special powers and connections to *jinn* include the *mkhawi* (مخاوي, ‘brothering the *jinn*’) who are not necessarily consulted for treatment, but to gain knowledge from spirits as mediums (e.g. their body can be used to access and give voice to other spirits). Christians may also experience spirit possession but will usually view it as ‘demonic possession’ and approach a priest for advice and treatment.

When distress is perceived as an act of God, or caused by a supernatural agency, people may be less likely to interpret it as needing biomedical or psychological interventions.^[179] Such illness may be normalised and viewed as a challenge to endure. Assessment of the level of distress may be difficult when the person makes frequent use of proverbs, invokes religion and expresses thankfulness to God. The use of professional care services may be also hampered by the idea that ultimately God is the only healer and that the assiduous practice of one’s religious values is sufficient to cure illness, furthermore, that any ‘shortcut’ to health could actually be detrimental.^[179] Within this context, exploring how people use religious practices for coping is important. Collaboration with traditional healers may be useful to overcome barriers to biomedical and psychological interventions.^[180]

Religion and meaning making

Although, prior to the war, Syria was seen as one of the most secular societies in the Middle East, for many Syrians religious beliefs and practices continue to be an important part of their daily life. Moreover, the role of religion in people’s lives is changing as a result of the conflict, with large parts of the country now under control of armed groups with extremist ideologies. There is thus an important distinction between the politicisation of religion as part of the conflict dynamics and the everyday religious practices and beliefs of displaced Syrians. Clearly, not all people who self-identify as belonging to a religious group are equally committed, devout, or follow specific religious practices, and the broader social and political context may affect individuals views and practices, as well as how they are expressed. The massive violence and injustices of the

current conflict may deeply affect the role of religion within the personal life of people; leading some people to turn more strongly to their religious beliefs as a source of hope and making meaning, while others are left doubting or re-evaluating their religious beliefs.^[181, 182] The politicisation of religion in the current conflict may also influence how people perceive religion and religious practices. Of course, in addition to providing meaning for suffering, religion in the Middle East also functions as a major force in the social organisation of people: belonging to a particular religious group may have important consequences for political security and social support.^[183]

Mental health practitioners working with refugees from Syria report that some clients struggle with existential question such as: ‘*How can God accept this happening to my family?*’, or ‘*Why does God allow others to kill small children and elderly people?*’ It is important, therefore, to assess what religious identity and practices mean for an individual. Most people will fall somewhere on a spectrum that ranges from identifying religion as the centre of their identity and explanations for suffering, to complete secularity and rejection of religion. While religious or spiritual healing beliefs and practices may foster coping and resilience, before encouraging the use of any religiously oriented sources of support it is essential to understand the person’s attitude towards religion and spirituality and the implications of identification and practice within their current context.

6. IMPLICATIONS FOR DESIGNING CONTEXTUALLY APPROPRIATE SERVICES FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

This section of the document is particularly relevant for MHPSS practitioners involved in providing direct mental health services to Syrian clients. It provides a brief overview of the international standards for mental health and psychosocial support and also provides contextually specific information on important issues to take into account when developing MHPSS services for Syrians, such as: language, help-seeking behaviour and stigma surrounding psychological distress and mental illness. This chapter also provides some thoughts on ensuring access to care for specific groups and introduces concepts such as cultural safety and cultural competence.

A CONCEPTUAL FRAMEWORK TO STRENGTHEN MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Since the publication, in 2007, of the *IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings*^[1] and its endorsement by major organisations involved in humanitarian operations, a clear consensus has emerged on how MHPSS services need to be developed.^[184-187] Globally, MHPSS programming has shifted emphasis from vulnerability-based frameworks to resilience and recovery-based approaches, recognising refugees and IDPs as active agents in their lives in the face of adversity.^[187, 188] An important consequence of the use of a broader and more inclusive MHPSS concept is that this cannot be the exclusive domain of some specialists but is, on the contrary, relevant for everyone involved in providing support to refugees and other conflict affected persons. UNHCR in its *Operational Guidance for Mental Health And Psychosocial Support Programming in Refugee Operations* uses the terms *MHPSS approach* and *MHPSS interventions*.^[2]

- Applying an integrated *MHPSS approach* involves providing humanitarian assistance in ways that support the mental health and psychosocial wellbeing of refugees; something that is relevant for all humanitarian actors when implementing their programmes.

- Implementing *MHPSS interventions* means focusing on activities in which the primary goal is to improve the mental health and psychosocial wellbeing of refugees. These are usually implemented by the health, community-based protection and education sectors.^[2]

Mental health practitioners' involvement may be focused on initial support and crisis resolution in the short term, but this should not be at the expense of addressing risks for longer-term consequences due to the profound losses and ongoing daily stressors that many displaced persons and refugees have experienced. Some of the most important factors in producing psychological morbidity in refugees may be alleviated by planned, integrated rehabilitation programmes and attention to social support and family unity.^[114]

There is also consensus that MHPSS interventions should consist of a multi-layered system of services and supports. This has important implications, for both those who work within health services (including clinical practitioners with advanced training in mental health) and those focusing on community-based psychosocial activities (who often have non-clinical backgrounds and are based in social or community work). In order to effectively support the mental health and psychosocial wellbeing of people affected by the Syria crisis it is essential that MHPSS activities are formulated in a broad and inclusive way and that the various services and supports are functionally linked within a coherent system with established mechanisms for reference.^[1, 2] Key documents to be consulted when developing MHPSS programming are listed in Annex A. While it is beyond the scope of this report to present a detailed outline of how this should be done, Box 1 presents a brief overview of some guiding principles for this multi-level systemic approach.

BOX 2: MULTI-LAYERED MHPSS SERVICES

Layer 1: Social consideration in basic services and security

Ensure that the provision of basic needs and essential services (food, shelter, water, sanitation, basic health care, control of communicable diseases) and security is done in ways that respect the dignity of all people and is inclusive of those with special vulnerabilities, but which also avoids exclusively targeting a single group in order to minimise tension among the beneficiaries, and prevents: discrimination, stigma and potential further distress.

Layer 2: Strengthening community and family supports

Promote activities that foster social cohesion among refugee populations, including supporting the re-establishment, or development, of refugee community-based structures that are representative of the population in terms of age, gender and diversity. This includes the promotion of community mechanisms and family supports, which protect and support members through participatory approaches.

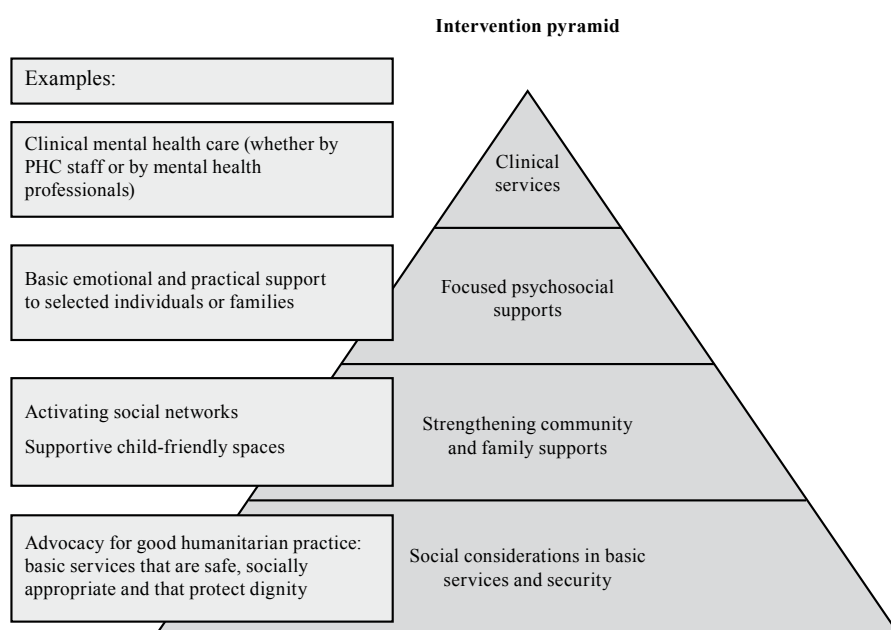
Layer 3: Focused psychosocial support

Provide emotional and practical support through individual, family or group interventions to those who are having difficulty coping by using only their personal strengths and their existing support network. Usually non-specialised workers in health, education or community services deliver such interventions, after training, and with ongoing supervision.

Layer 4: Clinical services

Deliver clinical mental health services to those with severe symptoms or an intolerable level of suffering, which has rendered them unable to carry out basic daily functions. This group is usually made up of those with pre-existing mental health disorders and emergency-induced problems, including: psychosis, drug abuse, severe depression, disabling anxiety symptoms, severe posttraumatic stress symptoms, and those who are at risk to harm themselves or others. Mental health professionals usually lead these interventions.

FIGURE 1: THE IASC PYRAMID (ADAPTED WITH PERMISSION)



SERVICES FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT WITHIN THE CONTEXT OF THE SYRIA CONFLICT

MHPSS services within Syria

Before the conflict, Syrian society had reasonably well-developed medical facilities, although the quality and quantity of mental health facilities were low.^[189,190] MHPSS services in Syria have been disrupted and destroyed by the conflict, and suffer from a critical shortage of qualified staff.^[191] Although mental health services in Syria have been largely institution based,^[190,192] several demonstration projects, focused on Iraqi refugees in Syria a few years ago, proved successful in reaching people with mental health problems and providing access to care through community-based psychosocial activities, community outreach, and mental health care integrated into primary health care.^[193-196] In addition, as part of the humanitarian response to the Iraqi refugee crisis and the Syrian conflict, humanitarian agencies have supported psychosocial services in some areas, and to a lesser extent, mental health services.^[197-199]

MHPSS services for refugees from Syria

National MHPSS services in neighbouring countries of asylum suffer from significant strain on capacity due to the increased demand and pre-existing limitations in the scale and quality of these services, which in turn, creates further barriers to refugees trying to access these services.^[200] As part of the response to the refugee situation, many international and national organisations have provided services for mental health and psychosocial support.^[69, 200-205] Many organisations are now, therefore, involved in delivering MHPSS interventions. A mapping exercise in Jordan mapped the activities of 47 different organisations involved in MPHSS, and a similar exercise in Lebanon counted the MHPSS activities of 36 organisations in Lebanon.^[200,203] In many countries, significant investments have been made to build national capacity of MHPSS, for instance in Jordan, many child friendly spaces are implemented by international NGOs in partnership with local NGOs or CBOs, and in Lebanon and Jordan government and UN agencies cooperate to integrate mental health into general health care systems.^[69,201,206]

CLIENTS' EXPECTATIONS OF MHPSS SERVICES

Many Syrian displaced and refugee families live in very difficult circumstances. Within such contexts, mental health and psychosocial practitioners may be expected to help clients address issues beyond the scope of their own service. MHPSS programmes should therefore address the full range of needs and priorities of their clients by identifying their non-psychological or social needs and referring them to relevant services in their area.

People who perceive the origins of psychological distress as somatic usually expect their treatment to follow medical lines. As a result, many Syrians may be reluctant to speak in detail about their memories and experiences, because they do not see the relevance of such information to their current diagnoses. People with mental disorders, who have taken the step to visit a health facility, often expect to be prescribed medication. This may put physicians under considerable social pressure to prescribe, even when it is not medically required. Clients who attribute their ailments to bodily or social causes may also expect interventions that assist them in regaining internal and social balance, as well as control over themselves and their lives. If they feel they are 'on the verge of madness', or if they don't understand the reactions of others around them, they may hope for reassurance as to the normalcy of their own reactions or the reactions of others. For some patients suffering from severe mental disorders the desire for treatment (which may include hospitalisation), may not come from themselves, but rather from the family or others in the community.

Some people may hope for a space where they can share their experiences with others, to make sense of and find ways to deal with their past experiences and current situation and restore some moral order. This does not usually require clinical mental health services, but rather community based psychosocial support interventions that can facilitate re-establishing social support networks, engaging in meaningful daily activities, sharing problems and trying to identify solutions and positive coping mechanisms.

In precarious living conditions where daily events may be unpredictable, many people expect brief, directive and

effective interventions. This may partially explain non-adherence or dropout with longer term approaches. Some clients may not ask for explanations for, or justification of, the choice of a given intervention, especially when trust is established and the practitioner is perceived as a legitimate expert.

CHALLENGES FOR CONTEXTUALLY RELEVANT MHPSS SERVICES

Even when MHPSS services are available, displaced Syrians and refugees from Syria may still be unable to access mental health care or psychosocial services. One important reason may be lack of financial resources to pay direct or indirect costs, such as transport or medication.^[207-209] There are also other factors that may influence access to MHPSS services, as discussed below.

Language

Most Syrian refugees fled to Lebanon and Jordan where Arabic dialects are spoken that are comparable to Syrian Arabic. In Iraq, a different Arabic dialect is used than in Syria. Therefore, while Syrians understand Iraqi Arabic, the accents and local expressions may differ significantly. Kurds in Syria have been compelled to learn Arabic, but may prefer to use Kurdish dialects to express some aspects of experience related to mental health. The Kirmanji dialect of the Syrian Kurds is considerably different from the Sorani dialect spoken by many Iraqi Kurds. Refugees from Syria hosted in non-Arabic countries, such as Turkey, may face important language barriers. However, Syrians from the northern part of the country, close to the Turkish border, are usually bilingual (speaking Arabic and Turkish), which can help facilitate access to care.^[210]

A general challenge in communication for MHPSS practitioners is to avoid using scientific language and jargon that can be alienating or intimidating for clients. When interacting with clients, use clear and plain language and check whether the client and family have understood. Language problems may also arise when clinicians, who are not familiar with local Arabic terms, supervise and train Arabic speaking MHPSS staff.

When language barriers are present, collaboration with Arabic speaking colleagues or the use of a well-trained, professional interpreter who is familiar with mental health terminology may be essential for accurate assessment and treatment delivery. The use of informal or *ad hoc* interpreters from the community (or family) may be inevitable due to practical constraints, but this poses ethical and practical challenges in terms of safety, confidentiality and quality of communication because of their personal involvement in the client's social network, traumatic experiences, and/or a lack of understanding of key terms and the process of clinical inquiry and intervention.^[211] Therefore, MHPSS practitioners need to ensure that interpreters are sufficiently competent to assist, and should be aware of the associated stress for interpreters and attend to their wellbeing by debriefing after the interview, and follow-up when indicated.^[212, 213]

Gender and help-seeking behaviour

Many segments of Syrian society have sharply defined gender norms that may influence all aspects of mental health and psychosocial support, including the sources of stress, expressions of distress (see section "Stigma surrounding psychological distress and mental illness"), coping mechanisms and help-seeking behaviour. There are significant gender differences in how and when males and females access services, particularly for adolescent boys and girls, and men and women. In many Muslim societies, women have less interaction in public settings, which may limit their ability to access mental health and psychosocial services.^[214, 215] However, within the current context of conflict and displacement, women, often along with their children, may be more likely than before to seek mental health care and psychosocial support. This is particularly true if services are presented with (more) neutral terms such as 'counselling', are integrated into an overall women's programme, and are provided in safe spaces for women and children.^[52] For men, other approaches may be needed, such as providing information through routine registration or other basic service points at health centres or in religious institutions. Both men and women may be contacted and successfully engaged through basic needs provision.^[144]

Issues of pride and ‘honour’ related to gender may complicate disclosure of events that could be a source of stigma or shame (e.g. sexual abuse – see sections above). Both men and women may avoid disclosing intimate and stigmatising experiences to a male practitioner because of shame or fear of being judged. It is thus important that clients can choose either female or male mental practitioners, especially to address sensitive issues such as sexual violence.

Issues of power and neutrality

In the context of the current conflict, MHPSS practitioners may be perceived as partisan, either because of their religious denomination, ethnic affiliation, or supposed political orientation. People may feel disappointed by the international community for not helping them, which may also play out in their interaction with humanitarian staff. In addition, different social, economic and cultural backgrounds may influence the interaction between MHPSS practitioners and refugees. Moreover, experiences of the conflict and social tensions between refugees and host communities may influence the interaction between practitioner and refugee. MHPSS interventions with refugees and displaced people also raise issues of power dynamics that must be carefully considered in order to avoid creating situations where people are made to feel subordinate and dependent on the resources and expertise of the practitioner. This kind of power imbalance conveys the unfortunate message that people do not possess the means to help or heal themselves. A person-centred approach to psychosocial support and clinical dialogue, seeking genuine partnership and collaboration, can contribute to empowerment and mental health promotion.

One aim of many MHPSS interventions is to increase individuals’ confidence and self-efficacy. Many clients may experience the expert position of the helper as disempowering and disqualifying of their own agency. Displaced and refugee Syrians have been robbed of power and control over most aspects of their lives, and they are likely to gain a sense of empowerment only if they are actively involved in decision-making of the intervention plan. MHPSS practitioners must avoid being overly directive or judgemental, and listen closely to the wishes and views of the person who seeks help and

help to empower them to make their own decisions. In addition, MHPSS practitioners must be aware that their own experiences, values and beliefs may influence their interactions with their clients, and so ensure that they treat all refugees with respect and dignity.

Stigma around psychological distress and mental illness

In Syria and neighbouring countries, overt and intense expression of emotions is fairly acceptable, although men are often brought up with the idea that crying and expressing emotions are for women and girls who are more likely to discuss emotional and relational issues with friends and family. Men are socialised to suppress the overt expression of emotions associated with weakness, with the exception, perhaps, of crying for the loss of one’s child.^[55, 216] In general, however, emotional suffering is perceived as an inherent aspect of life. Instead, it is the explicit labelling of distress as ‘psychological’ or ‘psychiatric’ that constitutes a source of shame, embarrassment and fear of scandal, because of the risk of being considered ‘crazy’. ‘Madness’ casts shame on patients and their families, and affects the use of services. This makes the decision to seek professional help and adhere to treatment a complex process.^[179] Practitioners who avoid using psychological jargon and psychiatric labelling may generate less stigma, and be more easily understood. Integrating mental health care and psychosocial support into non-stigmatising care settings, such as a general medical clinic, child and family centre or community centres may facilitate better access to and utilisation of MHPSS services.^[180]

In the past, many Syrians had a sceptical view of psychology, psychiatry and of resorting to mental health services in general. This apprehension may reflect the negative perception of mental illness, as well as the fear of stigma and scandal, and in some cases, issues related to the quality and type of the services offered (for instance, lack of community based psychosocial or mental health services). Professionals working with Syrians reported that some refugees from Syria, particularly those with experiences of torture, have become wary of any professional. Many individuals are also unable to clearly distinguish various mental health practitioners, such as psychiatrists, physicians, psychologists, psychotherapists, or psychosocial counsellors. For example, Syrians may

ask for a *tabib al asaab* (طبيب الاعصاب) (neurologist) when they mean *tabib nafsi* (طبيب نفسي) (psychiatrist).

However, many refugees from Syria are increasingly willing to seek help from mental health and psychosocial support services.^[58] In needs assessments, Syrian refugees often rank services for mental health and psychosocial support as very important. For example, among Syrian refugees to Dohuk Governorate in Iraq, the majority cited mental health services as the most-needed service in their setting.^[71]

ENSURING CULTURAL SAFETY AND CULTURAL COMPETENCE IN MHPSS PROGRAMMES

Trust and collaboration can be maximised by ensuring that service users feel that their explanatory models of illness are recognised by practitioners and integrated into the assessment and planning of care. Achieving this requires a culturally safe environment, respectful of diversity and based on mutual respect, in which the perspectives of clients and their families can be carefully explored.

The importance of the setting

The context of service delivery is often an important factor in the acceptability of MHPSS services. Psychosocial programmes are often set up in non-medical settings, such as community centres, women's programmes, child friendly spaces, schools and other places. Psychosocial interventions can contribute to broadening social support networks. Particularly for women and girls, facing physical and social isolation, safe spaces allow participants to build social capital and to discuss intimate issues related to life changes, and emotions, including more sensitive concerns like domestic abuse.^[144]

In addition, there is increasing recognition of the need to engage men in psychosocial programmes in culturally and gender appropriate ways, with a particular focus on providing meaningful activities for men in settings and timings that are appropriate for them, such as evening activities in community centres, mosques, sport activities and other social spaces.

Psychiatric treatment can be carried out in specialised settings, such as mental health outpatient departments, but

there may still be a fear of stigma. For example, a trial of psychological treatment for posttraumatic stress disorder in Turkey was done in a room in the building of a kindergarten and many clients pretended to other refugees that they were just bringing their children to the kindergarten.^[194] Many Syrians may be more comfortable visiting general health care facilities to seek treatment for psychological difficulties, because of the lesser stigma associated with seeing a physician, but also due to their recognition of the deep interconnectedness of physical and psychological suffering. This underscores the need for capacity building, training and support of primary health care providers so that mental health problems and psychosocial distress can be managed within general health care settings. Presenting physical symptoms may provide an opportunity for assessing clients' psychosocial wellbeing and potential mental health problems, particularly as physical ailments, such as headaches, nausea, and insomnia may be caused or exacerbated by psychological and social stressors and concerns.

It is important for MHPSS programmes to engage with the many qualified and educated Syrians refugees who are already working hard to improve community mental health and psychosocial wellbeing through grass roots networks. They can also provide crucial links to community and act as *culture brokers*, or mediators, within clinical and social service settings by explaining background assumptions, in order to improve mutual understanding between helper and client.

Mental health services for SGBV survivors

Because of shame, fear of social stigmatisation and reprisals, as well as concern about a lack of confidentiality, women and girls (as well as boys and men) are often reluctant to report instances of sexual violence or harassment, or to seek treatment.^[118, 217-219] Even if survivors of sexual violence were to seek help, access to safe and confidential medical, legal or psychological support is very limited inside Syria in terms of outreach and scope, and access to services is often difficult.^[98] In countries of asylum, services for survivors of SGBV may be more readily available, although access and quality varies. In health settings, such experiences of sexual violence may be expressed by survivors through somatic

or physical complaints.^[220] Services for SGBV survivors may be more acceptable if they are provided within a non-stigmatising environment, such as general health centres or women's centres, without initially addressing the issue of abuse explicitly. Providing safe, non-stigmatising and supportive services with trained specialised staff to receive and respond to disclosures of SGBV in a confidential and appropriate manner, increases the likelihood that survivors will feel comfortable to disclose and access services. Survivors of rape and other forms of sexual violence have an elevated risk of developing mental disorders and therefore, offering mental health services as part of the multi-sectoral services provided to survivors of these kinds of violence, should be a priority.^[110]

Ensuring access for victims of torture

Syrians who have experienced torture often have specific mental health and psychosocial needs. Many of them have a range of psychological, social and somatic symptoms. Shame and guilt, related to the often humiliating and degrading experiences of torture, prevent some people from seeking help at general or mental health services. Presenting complaints are often somatic, such as: headache, body pains, numbness, tingling sensations, stomach-ache, or breathing problems. Often, these are a mix of problems due to organic lesions related to the torture and 'somatisation', that is, bodily expressions of emotional distress. The split between 'somatic health care' and 'mental health care' is particularly unfortunate for torture survivors as labelling problems as 'somatisation' (with the assumption that the 'real' problem is psychological) is usually not helpful. At the same time, physical diagnoses without effective treatment (for example, 'damaged spine' or 'torture-related neuropathy') may trigger a process of somatic fixation and maladaptive coping that can hinder working toward improved functionality and lead to worsening of symptoms. This can occur, for example, when a diagnostic label leaves people reluctant to make certain movements for fear it will cause further damage. Some specialised centres for treatment of victims of torture in the region, therefore, avoid diagnostic labelling and instead work with each individual client to deal with symptoms and improve physical, psychological and social functioning.

Torture survivors also commonly face a range of social issues, including difficulties in maintaining relations with friends and family, and feeling not understood or welcomed by community members. Survivors, as well as family or friends, may have strong feelings about the torture, but have difficulties discussing these issues. This may leave survivors isolated in terms of their experience, while family or friends also struggle with undisclosed feelings, such as guilt for not having been able to protect the survivor from torture. The experience of sexual violence during torture (or even the assumption that a torture survivor experienced sexual violence) can lead to social stigma and further isolation of the survivor. Providing mental health services with specialised staff and training in appropriate services for survivors of torture should therefore be a priority, particularly in areas with high concentrations of Syrian refugees.

Ensuring access for LGBTI refugees

In the Middle East, mental health practitioners are regularly approached by families, and sometimes by gay men themselves, who request that they "cure" the "disease" of homosexuality, with some mental health practitioners claiming to offer such services.^[128] LGBTI refugees have reported low levels of trust in mainstream mental health and psychosocial services due to such discriminatory attitudes and lack of confidentiality. Ensuring that mental health and psychosocial services are respectful and sensitive to the issues facing LGBTI displaced Syrians, and that confidential counselling and support groups services are available, is highly important given the very specific stressors and emotional and social issues facing LGBTI Syrians.

Culturally relevant assessments

For clinical mental health professionals, such as psychiatrists and clinical psychologists, it is critical to realise that their clients' understanding and manifestation of mental illness and psychosocial (un)wellbeing is rooted in social, cultural and religious contexts. Therefore, clinical assessments will be more accurate and appropriate when they integrate questions on the local modes of expressing distress and understanding symptoms.^[221, 222] The *Cultural Formulation Interview* in the Diagnostic and Statistical Manual (*DSM-5*) of the American Psychiatric Association

provides one simple approach to assist mental health practitioners in this aspect of assessment.^[223, 224] Moreover, clinical assessment should not only look for symptoms, but also assess whether the person has social dysfunction, as well as assess strengths and coping abilities.

7. CONCLUSION

Refugees from Syria and internally displaced people in Syria constitute a highly diverse population in terms of religious, ethnic, linguistic and socio-economic backgrounds. The ongoing hardships and violence associated with the conflict have had pervasive effects on the mental health and psychosocial wellbeing of Syrian adults and children. Experiences related to the conflict are compounded by the daily stressors of displacement, including: poverty, lack of resources and services to meet basic needs, risks of violence and exploitation, discrimination and social isolation. Many refugees and IDPs have endured conflict related violence, and women and girls have been particularly exposed to SGBV (such as domestic violence, sexual violence, early marriage, harassment and isolation, exploitation and survival sex) both in Syria and in countries of asylum. Central issues for many Syrians are loss and grief, whether for deceased family members or for emotional, relational or material losses.

For most Syrians, the first source of support is the circle of family and friends. However, displacement, violence and the dynamics of the conflict can disrupt social support structures and alter social networks and gender roles, which may contribute to undermining the ability to cope and increase levels of family violence and psychological distress. In the current protracted crisis, with no end in sight, increasing levels of poverty, lack of options for livelihood, increasing limitations on refugees' right to seek international protection and access services in countries in the region, there is a pervasive sense of hopelessness setting in for many Syrians. This may lead to negative coping strategies in dealing with stress, and addressing the daily struggle to provide for themselves and their families. Furthermore, dependency on external aid and inability to provide for themselves often negatively affects people's dignity and sense of agency.

Levels of psychological stress are high among women, girls, boys and men. People with pre-existing mental disorders

are becoming even more vulnerable, and significant numbers of Syrians are experiencing increasing levels of emotional disorders, such as depression, prolonged grief disorder and posttraumatic stress disorder.

Cultural and religious value systems play an important role in the perception and understanding of psychological and social problems, and the methods of treatment. For practitioners, national and international, involved in mental health and psychosocial support programmes, it is important to understand and explore clients' *cultural idioms of distress* (common modes of expressing distress within a culture or community) and *explanatory models* (the ways that people explain and make sense of their symptoms or illness), which influence their expectations and coping strategies. Cultural concepts of the person also influence how people experience and express suffering, how they explain illness and misfortune, and how they seek help. To assist Syrians, MHPSS practitioners need to develop knowledge of culture and context. Understanding local illness models and idioms of distress, as well as sources of support and coping, and how these are changing as a result of conflict and displacement will allow better communication. This knowledge can be used to design interventions that mobilise individual and collective strengths, and resilience. In addition, the specific ways that gender, age, disability, sexual orientation and experiences of violence can impact on the psychosocial and mental health difficulties and coping strategies of Syrian refugees needs to be understood, and integrated, into health promotion programmes and practice.

It is essential for all humanitarian actors to use an MHPSS approach and be cognisant of the effects of their actions and attitudes on the wellbeing of refugees and displaced persons. MHPSS professionals should be careful not to over-diagnose clinical mental disorders among displaced Syrians, especially among those facing insecurity who have many ongoing daily stressors. In general, MHPSS

practitioners should avoid psychiatric labelling because this can be especially alienating and stigmatising for survivors of violence and injustice. For clinical mental health practitioners, building a solid therapeutic alliance with their clients will allow both practitioner and client to navigate among diverse explanatory models and sources of help that may include the formal and informal medical system, as well as religious, community, family and individual resources. Clinical interventions need to go hand-in-hand with interventions to mitigate difficult living conditions, and strengthen community based protection mechanisms, in order to help individuals regain normalcy in their daily lives. Interventions aimed at improving living conditions and livelihoods may significantly contribute to improving the mental health of refugees and IDPs, perhaps more than any psychological and psychiatric intervention.

There is broad interagency consensus that mental health and psychosocial support services need to go beyond clinical services to include interventions to foster community and family support and strengthen positive coping mechanisms. MHPSS interventions, therefore, should include activities that foster social cohesion among displaced populations, and provide emotional and practical support. It is essential that all MHPSS interventions are based on mutual respect and dialogue, and that the perspectives of refugees are taken seriously. Finally, in times of extreme violence, people often turn to collective cultural systems of knowledge, values and coping strategies to make meaning in the face of adversity. In this context, providing culturally safe environments for respectful dialogue and collaborative work is essential to assist IDPs and refugees from Syria to construct meaning from suffering and finding adaptive strategies to cope with their situation.

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