

# Mental health and psychosocial wellbeing of Syrians affected by armed conflict

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**Aims.** This paper is based on a report commissioned by the United Nations High Commissioner for Refugees, which aims to provide information on cultural aspects of mental health and psychosocial wellbeing relevant to care and support for Syrians affected by the crisis. This paper aims to inform mental health and psychosocial support (MHPSS) staff of the mental health and psychosocial wellbeing issues facing Syrians who are internally displaced and Syrian refugees.

**Methods.** We conducted a systematic literature search designed to capture clinical, social science and general literature examining the mental health of the Syrian population. The main medical, psychological and social sciences databases (e.g. Medline, PubMed, PsycInfo) were searched (until July 2015) in Arabic, English and French language sources. This search was supplemented with web-based searches in Arabic, English and French media, and in assessment reports and evaluations, by nongovernmental organisations, intergovernmental organisations and agencies of the United Nations. This search strategy should not be taken as a comprehensive review of all issues related to MHPSS of Syrians as some unpublished reports and evaluations were not reviewed.

**Results.** Conflict affected Syrians may experience a wide range of mental health problems including (1) exacerbations of pre-existing mental disorders; (2) new problems caused by conflict related violence, displacement and multiple losses; as well as (3) issues related to adaptation to the post-emergency context, for example living conditions in the countries of refuge. Some populations are particularly vulnerable such as men and women survivors of sexual or gender based violence, children who have experienced violence and exploitation and Syrians who are lesbian, gay, bisexual, transgender or intersex. Several factors influence access to MHPSS services including language barriers, stigma associated with seeking mental health care and the power dynamics of the helping relationship. Trust and collaboration can be maximised by ensuring 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.

**Conclusions.** Sociocultural knowledge and cultural competency can improve 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.

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## Introduction

The current conflict in Syria has caused the largest refugee displacement crisis of our time. While neighbouring countries have hosted the majority of the refugees since the beginning of the war, it was not until the summer of 2015 that Europe began to witness a surge of Syrian citizens crossing through Turkey to enter

Greece, with the ultimate aim of reaching Western Europe. The ensuing debate about the role of European countries in resolving this crisis has included calls for European politicians to exercise moral leadership, and some countries have done so (Abassi, 2015). In October 2015 alone, the European countries received more than 171 000 asylum applications from Syrians. Germany, with its open door policy, along with Serbia, has allowed the resettlement of more than half of these applicants (UNHCR, 2015a). The number of refugees resettled in Germany is expected to reach 800 000 by the end of 2015 (De Maiziere, 2015). Other European countries have had mixed responses to the crisis (see <http://data.unhcr>.

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[org/mediterranean/regional.php](http://org/mediterranean/regional.php) for updated numbers in every European country). With the steadily increasing proportion of Syrian refugees crossing to Europe, it is essential to advise mental health and psychosocial support (MHPSS) staff (e.g. psychiatrists, psychiatric nurses, psychologists, counsellors, social workers and others) as well as non-specialized health care staff (e.g. general physicians, midwives and nurses) with information on the mental health and psychosocial wellbeing issues facing Syrians affected by the current crisis (Multi Agency Guidance Note, Ventevogel *et al.*, 2015).

This review paper aims to inform the design and delivery of interventions to promote mental health and psychosocial wellbeing of Syrians affected by armed conflict and displacement in countries hosting refugees from Syria. Interventions designed to promote mental health and psychosocial wellbeing aim at improving positive aspects of mental health in a recovery-based approach and may be initially focused on assistance for settlement and advocacy or crisis resolution. The interventions however also include specialised interventions such as preventive or therapeutic interventions that address the longer-term consequences of war and displacement on mental health. The specific objectives of this paper are to: (1) inform on the mental and psychosocial effects of war and displacement; (2) discuss issues of language, culture and religion in the assessments of problems and intervention planning; and (3) discuss the designing of contextually appropriate mental health and psychosocial services.

This paper is a synthesis of the main results and conclusions of the report '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' (the report can be found on <http://www.refworld.org/docid/55f6a8b84.html>, among other websites) and prepared for United Nations High Commissioner for Refugees (UNHCR) by the authors (Hassan *et al.* 2015).

## Methods

This report is based on an extensive search strategy 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 May 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, intergovernmental organisations and agencies of the United Nations. A librarian scientist set the key words and search strategy, and conducted literature searches in academic databases. A research team of four conducted the grey literature searches, selected relevant papers/documents and conducted the literature review. The draft report was extensively reviewed and refined by more than 40 professionals with clinical experience working with Syrian populations.

## Results

### *Refugees from Syria and internally displaced people in Syria*

Since March 2011, nearly half of the Syrian population has been displaced, comprising almost eight million people inside Syria and more than four million registered refugees who have fled to neighbouring countries (UNOCHA, 2014; UNHCR, 2015b). 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. Both refugees from Syria and internally displaced people 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. Increased levels of poverty, loss of livelihood, soaring unemployment and limited access to food, water, sanitation, housing, health care and education, have all had a devastating impact on the population putting them at further risk of exploitation (Norwegian Refugee Council, 2014; UNHCR, 2014a; UNHCR and REACH, 2014) (see Syrian Centre for Policy Research (SCPR), 2014, *Syria – Alienation and Violence: Impact of Syria Crisis Report 2014*).

### *Mental health and psychosocial wellbeing among conflict-affected Syrians*

Central issues in armed conflict settings are loss and grief, whether for missing or deceased family members or for other emotional, relational and material losses. Ongoing concerns about the safety of family members

are reported to be a significant source of stress (UNHRC, 2013; IMC and UNICEF, 2014). In displacement settings, the social fabric of society is often severely disrupted, hence many Syrian families become isolated from larger support structures (Thorleifsson, 2014). Feelings of estrangement, yearning for the lost homeland and loss of identity, run high as displaced Syrians struggle to adapt to life as refugees within a foreign community (Care Jordan, 2013; Moussa, 2014). 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 may rarely leave their homes due to concerns over safety or lack of opportunities (International Rescue Committee, 2014; Boswall & Al Akash, 2015). Women and children may be vulnerable to forced or child marriage, survival sex and child labour (IRC, 2013). This same sense of isolation can affect boys, with some refugee boys rarely leaving their homes (UN Women, 2013). In the current protracted crisis, with no end in sight, a pervasive sense of hopelessness is setting in for many Syrians (Al Akash & Boswall, 2014; International Rescue Committee, 2014).

Conflict affected Syrians may experience a wide range of mental health problems including (1) exacerbations of pre-existing mental disorders; (2) new problems caused by the conflict related violence and displacement; and (3) issues in adaptation related to the post-emergency context, for example living conditions in the countries of refuge. Psychological and social distress among refugees from Syria and internally displaced persons (IDPs) in Syria manifests in a wide range of emotional, cognitive, physical, and behavioural and social problems (De Jong *et al.* 2003; Mollica *et al.* 2004; Momartin *et al.* 2004; Pérez-Sales, 2012; El Masri *et al.* 2013; IMC and JHAD, 2013; IRC, 2013; IMC and UNICEF, 2014; Vukcevic *et al.* 2014; Wells, 2014a, b). Emotional manifestations include sadness, grief, fear, frustration, anxiety, anger and despair. Cognitive manifestations include loss of control, helplessness, worry, ruminations, boredom and hopelessness as well as physical symptoms such as fatigue, problems sleeping, loss of appetite and medically unexplained physical complaints. Symptoms related to past traumatic experiences have also been widely documented, such as nightmares, intrusive memories, flashbacks, avoidance behaviour and hyperarousal (Vukcevic *et al.* 2014; Acarturk *et al.* 2015). Social and behavioural manifestations of trauma-related disorders include withdrawal, aggression and interpersonal difficulties. While common among Syrian refugees, these symptoms do not necessarily indicate mental disorders, which must be assessed on the basis of configurations of symptoms and associated functional

impairment. Most refugees and IDPs are tremendously resilient and MHPSS practitioners must work on establishing the conditions that promote such resiliency.

#### *Emotional disorders*

As with other populations affected by collective violence and displacement, the most prevalent and clinically significant problems among Syrians are symptoms of emotional distress related to depression, prolonged grief disorder, posttraumatic stress disorder and various forms of anxiety disorders (De Jong *et al.* 2003; Mollica *et al.* 2004; Momartin *et al.* 2004). These problems can amount to a mental disorder if they include high levels of suffering and functional impairment, but psychosocial problems or emotional distress in themselves do not necessarily imply that the person has a mental disorder (Bou Khalil, 2013; Almoshmosh, 2015). Difficult life circumstances often contribute to phenomena such as demoralisation and hopelessness, which may be related to profound and persistent existential concerns of safety, trust, coherence of identity, social role and society (El Sarraj *et al.* 1996; Ellsberg *et al.* 2008; IRC, 2012; Parker, 2015; Usta & Masterson, 2015).

#### *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 symptoms will have gone up given the increase of risk factors, such as potentially traumatic events, forced migration and 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. The International Medical Corps has treated more than 6000 people in their centres in the region, of whom almost 700 were diagnosed with psychotic disorders (Hijazi & Weissbecker, 2015).

#### *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 was traditionally low (WHO, 2014). However, use of alcohol may have increased in recent years: a study among Syrian refugees to Iraq found that about half of the respondents had more than five alcoholic drinks per week (Berns, 2014). Figures on the use of illegal drugs are not available, but may have increased due to the greater production and trade of illegal drugs as a result of the crisis (Arslan, 2015). 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 (Rahim *et al.* 2012). Use of fenethylamine is reportedly popular among combatants because of its stamina-enhancing effect (Kalin, 2014). Adults, especially women dealing with loss, are also prone to substance abuse. In some refugee camps, several cases of addiction to prescription medications were reported (Mohammed & Abou-Saleh, 2015).

### *Specific groups*

#### *Survivors of torture*

Many Syrians have to deal with the effects of having been tortured (Leigh, 2014). 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, panic attacks, chronic pain or medically unexplained somatic symptoms and suicidal behaviour (Shrestha *et al.* 1998; Steel *et al.* 2009). 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 (Gorst-Unsworth & Goldenberg, 1998). Conventional diagnostic classifications are often insufficient as many clients have symptoms of various torture-related problems, but symptom reduction in one area can have beneficial effects on other stress-related problems.

#### *Mental health and psychosocial wellbeing of Syrian children*

More than 50% of Syrians displaced internally or as refugees are children, and of these, nearly 75% are under the age of 12 (UNHCR, 2014b). Some have been wounded and many have witnessed violence first-hand or endured physical and/or sexual abuse (Refugees International, 2012; UNHCR, 2012; Assessment Working Groups for Northern Syria, 2013; Care Jordan, 2013; Research Center at La Sagesse University and ABAAD, 2013; SGBV Sub-working Groups Jordan, 2014), the destruction of their homes and communities, lack of access to basic services and recruitment by armed groups (IMC, 2014; UNHCR, 2014c) putting them at further risk of death, injury, psychological distress or torture (UNICEF, 2014a, b). About half of displaced Syrian children, especially older children, are unable to continue their education (UNHCR, 2013a; UNICEF, 2014c; UN Security Council, 2014a).

Studies of Syrian refugee children have documented a wide range of psychosocial problems (Mercy Corps,

2014; Cartwright *et al.* 2015) including: persistent fears and anxiety; difficulties sleeping; sadness, grief 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 found among children (IMC and UNICEF, 2014; IRC and C. International, 2014; James *et al.* 2014). Adolescent boys may have 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 (Mercy Corps, 2014).

Key sources of stress for children include discrimination by members of the host community and war-related fears, 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 (UN Women, 2013). 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 with adequate support from family, the surrounding community and service providers, many aspects of refugee children's distress are reduced over time (IMC and UNICEF, 2014). Children with intellectual disabilities, including children on the autism spectrum and those with speech difficulties, require extra attention and care. Comprehensive intervention programmes can address their needs by providing adequate information to both specialized and non-specialized support staff members (WHO, 2015).

#### *Mental health and psychosocial distress: diversity and vulnerability*

Vulnerable populations that may face specific challenges include men and women survivors of sexual or gender based violence (SGBV), children who have experienced violence and exploitation, older people and Syrians who are lesbian, gay, bisexual, transgender or intersex (LGBTI).

SGBV has increased substantially due to the conflict and the breakdown of protection mechanisms (Global Protection Cluster, 2013a; IRC, 2014; SGBV Sub-working group Jordan, 2014; UNHCR, 2014b). Refugees who have fled to other countries may avoid further conflict-related SGBV, but continue to face other forms of SGBV, including: domestic violence (IRC, 2012; Global Protection Cluster, 2013a; Middle East Monitor, 2013; UNHCR, 2013a; Masterson *et al.* 2014; UN Women, 2014); sexual violence; early

marriage; harassment and isolation; exploitation; and survival sex (Human Rights Watch, 2012; IRC, 2012, 2014; UN General Assembly, 2014; UNHRC, 2014; Parker, 2015). The psychological and social impacts of SGBV can be devastating for the survivor (Ellsberg *et al.* 2008; Usta & Masterson, 2015), and may have a ripple effect throughout the family and wider community. In addition to the ordeal of sexual violence, women and girls often fear or actually face social repercussions, including rejection, divorce, abuse and ostracism. In a minority of cases they may suffer from 'honour' crimes at the hands of family members (Global Protection Cluster, 2013b; UNHRC, 2014; War Child Holland, 2014). Boys and men who have experienced sexual violence also face negative social consequences.

The prevalence of early marriage and its associated health risks have increased as a result of poverty, insecurity and uncertainty caused by displacement (Child Protection Work Group, 2013; Save the Children, 2013; UNHCR, 2013a). Early marriage of girls has become a coping strategy and is perceived as a means to protect girls and better secure their future (Ouyang, 2013; Save the Children, 2013; UNHCR, 2014b; World Vision International, 2014). 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 (Ouyang, 2013). Feelings of abandonment, loss of support from parents and lack of access to resources to meet the demands of being a young spouse and a mother may create additional stress.

The specific challenges facing LGBTI individuals in Syria are often overlooked. Same-sex acts among consenting adults are illegal in Syria (Syrian Arab Republic, 1949) and overt discrimination is present throughout Syrian society. 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 specific psychosocial and social difficulties for Syrian LGBTI persons in their social relations, integration and identity.

Older refugees, particularly those who have health problems and a limited social support network, are vulnerable to psychosocial problems (Skinner, 2014). 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. Studies among older refugees find high levels of feelings of anxiety (41%), depression (25%), lack of safety (24%) or loneliness (23%). Those with poor physical health are significantly more affected (Strong *et al.* 2015).

Refugees with specific needs due to disability, injuries or chronic disease constitute another group with

elevated psychological stress levels. A study by Help Age and Handicap International (2014) among Syrian refugees in Jordan and Lebanon found that people with such specific needs were twice as likely to report psychological distress.

### Challenges with epidemiological studies

The results of psychiatric epidemiological studies among conflict affected Syrians need to be interpreted with caution. Standard instruments usually do not assess local cultural symptoms or idioms of distress and most have not been validated for use in the Syrian emergency context (Wells *et al.* 2015). Some validation research has been done with refugees in the Middle East region, for example with Iraqi refugees (Shoeb *et al.* 2007), Palestinian refugees (Makhoul *et al.* 2011) and with Syrians before the crisis (Alsheikh, 2011). Furthermore, most screening tools focus on symptoms of pathology, with little or no attention to resilience and/or coping. 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 post-displacement context (Miller & Rasmussen, 2010, 2014; Patel, 2014). Studies of distress in populations affected by the crises in the Middle East region have found current living contexts impact strongly on mental health (Jordans *et al.* 2012; Budosan, 2014). New instruments assessing positive coping and growth are being validated for use in conflict affected populations in the Middle East region (Davey *et al.* 2015).

### Challenges for MHPSS services

Even when MHPSS services are available, displaced Syrians and refugees from Syria may still be unable to access services. Several factors influence access to MHPSS services including language barriers, the stigma associated with seeking mental health care and the power dynamics of the helping relationship.

#### Language barriers

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) 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 (Jefee-Bahloul *et al.* 2014). Therefore, MHPSS practitioners need to ensure that trained and competent interpreters are available, and should be aware of the potential stress for interpreters and attend to their wellbeing by debriefing after the interview, with follow-up when indicated (Holmgren *et al.* 2003; Tribe & Morrissey, 2004).

### ***Stigma around psychological distress and mental illness***

In Syria and neighbouring countries, overt expression of strong emotions may be socially acceptable and emotional suffering is perceived as an inherent aspect of life. Instead, it is the explicit labelling of distress as a mental health problem that constitutes a source of shame, embarrassment and fear of scandal, because of the risk of being considered 'mad' or 'crazy'. The potential shame extends from patients to their families and affects the use of mental health services. This influences the decision to seek professional help and treatment adherence (Ciftci *et al.* 2012). Practitioners who avoid using psychological jargon and psychiatric labelling may generate less stigma and be more easily understood, resulting in better collaboration and treatment adherence.

### ***Issues of power and neutrality***

MHPSS interventions with refugees and displaced people 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. Displaced and refugee Syrians have been robbed of power and control over most aspects of their lives. Many clients may experience the expert position of the helper as disempowering and disqualifying of their own agency. They are more likely to regain a sense of empowerment if they are actively involved in decision-making of the intervention planning. A person-centred approach to psychosocial support and clinical interaction, seeking dialogue genuine partnership and collaboration, can contribute to mental health promotion.

### ***Ensuring cultural safety and cultural competence in MHPSS programmes***

Trust and collaboration can be maximised by ensuring 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 can help increase access and reduce stigma if they are provided in non-psychiatric settings, such as general medical clinics, community centres, women's groups, child friendly spaces, schools and other places. Safe spaces are particularly important for women and girls facing physical and social isolation, and can enable participants to build social capital and to discuss intimate issues related to life changes, and emotions, including more sensitive concerns like domestic abuse (Mercy Corps, 2014).

There is also 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 at appropriate times and settings, such as evening activities in community centres, worship centres, sport activities and other gathering places. 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.

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 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 communication and mutual understanding between helper and client.

### ***Clients' expectations of MHPSS services***

MHPSS programmes should 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. Bodily or somatic symptoms accompany most forms of emotional and psychological distress. People who perceive the origins of psychological distress as somatic usually expect their treatment to follow medical lines. As a result of such perceptions and attributions, some Syrians may be reluctant to speak in detail about their memories and experiences, because they do not see the relevance of such personal information to medical condition. Clients who attribute their ailments to bodily problems or social stressors may also expect interventions that assist them in regaining internal and social balance, as well as control over their lives. In precarious living conditions, where daily events may be unpredictable,

people may prefer brief, directive interventions with rapid effect. Some people may hope for a space where they can share their experiences with others, to make sense of with their past experiences and restore some sense of moral order, as well as to find ways to deal with their current situation. This kind of work does not usually require clinical mental health services, but rather community based psychosocial support interventions that can re-establish social support networks, to promote sharing problems to identify solutions and reinforce positive coping strategies, and engaging in meaningful daily activities.

### *Mental health services for SGBV survivors*

Because of shame, fear of social stigmatisation and reprisals, as well as concern about lack of confidentiality, SGBV survivors are often reluctant to report instances of sexual violence or harassment, or to seek treatment (IRC, 2012; UNHRC, 2012; Ouyang, 2013; UN Security Council, 2014b). In health settings, such experiences of sexual violence may be expressed by survivors through bodily symptoms or concerns (Al-Krenawi, 2005). 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 (Ellsberg *et al.* 2008). 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 access services and disclose their concerns.

### *Ensuring access for victims of torture*

Syrians who have experienced torture often have specific mental health and psychosocial needs related to their experiences of trauma and loss. 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, including headache, body pains, numbness, tingling sensations, stomach ache, or breathing problems. The split between 'physical health care' and 'mental health care' is unfortunate for torture survivors as labelling problems as 'somatisation' (with the assumption that the 'real' problem is psychological) can be stigmatising. At the same time, physical diagnoses without effective treatment (for example, 'damaged spine' or 'torture-related neuropathy') may contribute to a process of somatic fixation and maladaptive coping that can hinder working toward improved functionality. Some specialised centres for treatment of victims of torture in the

region, therefore, avoid diagnostic labelling and instead work with each client to reduce 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. This may leave survivors emotionally isolated, 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 by others 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.

### *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 wellbeing is rooted in social, cultural and religious contexts. Clinical assessment will be more accurate and appropriate when it integrates questions on the local modes of expressing distress and understanding symptoms (Nasir & Abdul-Haq, 2008; Kirmayer, 2012). 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 (Lewis-Fernández *et al.* 2014, 2015). Extensive information on cultural aspects of mental health such as Syrian explanatory models of illness, idioms of distress and cultural/religious modes of coping is provided in the full UNHCR report (<http://www.refworld.org/docid/55f6a8b84.html>).

### **Conclusion: implications for designing contextually appropriate mental health and psychosocial services**

The ongoing hardships and violence associated with the conflict in Syria have had pervasive effects on the mental health and psychosocial wellbeing of adults and children, both among those internally displaced and those seeking asylum. For refugees, experiences related to the conflict are compounded by the daily stressors of resettlement in a new country, which include language barriers, poverty, lack of resources and services to meet basic needs, difficulty accessing services, risks of violence and exploitation, discrimination and social isolation.

Mental health practitioners' involvement may be focused on initial support and crisis resolution in the short term. However, this initial focus 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 experience. Some of the most important factors contributing to psychological morbidity in refugees may be alleviated by planned, integrated rehabilitation programmes and attention to social support and family unity (Kirmayer *et al.* 2011; Bhugra *et al.* 2014). Art therapy workshops and projects such as the theatre project 'Antigone of Syria', may be helpful in restoring the social cohesion between community members in a culturally relevant manner (Jefee-Bahloul *et al.* 2015).

It is essential for MHPSS to be aware 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 due to 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. MHPSS workers may gain from shifting emphasis from vulnerability-based assessment and intervention frameworks to resilience and recovery-based approaches, recognising refugees and IDPs as active agents in their lives in the face of adversity (MHPSS Working Groups Jordan, 2014a; Rehberg, 2014).

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.

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.

Finally, MHPSS interventions should be part 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). 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 referral (IASC, 2007; UNHCR, 2013b). It is also crucial for general health care practitioners to be well prepared to assess and manage any mental health and substance abuse conditions among conflict affected Syrians. The World Health Organization and the UNHCR have developed the *mhGAP Humanitarian Intervention Guide* to ensure the inclusion of mental health within basic primary care services (Ventevogel *et al.* 2015; WHO, 2015).

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### Conflict of Interest

The authors alone are responsible for the views expressed in this article and they do not necessarily represent the views, decisions or policies of the institutions with which they are affiliated.

### Ethical Standards

This review complies with the ethical standards of relevant national and institutional committees.

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