A COMPREHENSIVE OVERVIEW OF SYRIAN REFUGEES' MENTAL HEALTH

By

COOPER PHILIP TEMPLE

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A Thesis Submitted to the Honors College

In Partial Fulfillment of the Bachelors Degree
With Honors in

Middle Eastern and North African Studies

THE UNIVERSITY OF ARIZONA

D E C E M B E R 2 0 1 7

Approved by:

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Dr. Faten Ghosn
Department of Middle Eastern and North African Studies

Abstract

The Syrian Civil War has led to a devastating refugee crisis unlike any seen in modern history. Millions of people have fled their country and resettled elsewhere, either in refugee camps or host communities. While much of the international focus is on their physical conditions, little attention and funding have been given to the mental health needs of the Syrian refugees. Although ensuring their safety and physical well-being is of primary importance, addressing mental health needs to be better prioritized to avoid the development of significant problems in the future. This paper discusses the significance of the mental health problem in the broader context of the crisis overall, examines the current methods being utilized and their drawbacks, provides a case study of three local refugee organizations, and finally, highlights other programs experiencing success to identify potential opportunities for improvement of care.

A Comprehensive Overview of Syrian Refugees' Mental Health

Over the past six years, the situation in Syria has morphed from local protests and civil unrest to a full-fledged bloodbath bordering on genocide, complete with significant international influence that has brought the fighting into the global spotlight. Most of the news coverage and public concern surrounds the rise and proliferation of the so-called Islamic State in Iraq and the Levant (ISIL), a military group whose brutality and methods geared toward shock value have horrified even similar groups like Al-Qaeda, which was previously considered the most brutal. And their notoriety is for good reason—a report in August 2016 revealed more than 33,000 people around the world have been killed in attacks carried out by ISIL.[1] The overarching issue, however, is far more complex and multifaceted than the brutal tactics of this one terrorist group. According to the most recent figures, over 480,000 people in Syria have been killed, approximately 50,000 of whom were children,[2] while 4.8 million have fled the country altogether, representing an astounding 21% of Syria's total pre-war population.[3] Amid all of the chaos and geopolitical distractions surrounding this war, the human toll is too often not given the

[1] Julia Glum, "How Many People Has ISIS Killed? Terrorist Attacks Linked To Islamic State Have Caused 33,000 Deaths: Report," *International Business Times*, last modified August 10 2016, http://www.ibtimes.com/how-many-people-has-isis-killed-terrorist-attacks-linked-islamic-state-have-caused-2399779.

[2] Angus McDowall, "Syrian war monitor says 465,000 killed in six years of fighting," *Reuters*, last modified March 13, 2017, https://www.reuters.com/article/us-mideast-crisis-syria-casualties/syrian-war-monitor-says-465000-killed-in-six-years-of-fighting-idUSKBN16K1Q1.

[3] "Syria Emergency," *UNHCR*, last modified May 30, 2017, http://www.unhcr.org/en-us/syria-emergency.html.

attention it deserves. Even when the refugee crisis is discussed in international news, it comes in the form of a lone dead infant washed up on the frigid Mediterranean shores, or a dust-covered child shell-shocked and bleeding in a foreign aid tent. The reality is that the obstacles faced by Syrian refugees—displaced from their homes, often separated from their families, and struggling against a constant threat of violence—reach into every facet of their lives. The priorities, obviously, are to secure a safe environment for the refugees, reunite them with their families when possible, and provide them with basic sustenance (all of which are no easy task), but a looming issue that has, of yet, gone nearly untreated is their mental health. Although regarded as a secondary, backburner issue in much of the world, the mental health of refugees is particularly dire, given their exposure to frequent violence and intense trauma. In one refugee camp in Germany, at least half of the refugees arriving were suffering from trauma-related mental issues, with more than 70% having witnessed violence and 50% having experienced it directly.[4] Despite the Syrians' desperate need for adequate mental health care, the world lags in terms of funding, awareness, research, and on-the-ground-action. Compounded with the recent United States executive orders signed by President Donald Trump, the situation has become even more severe. If refugees are denied entry into the United States to reunite with family or escape from the hellish conditions of civil war, not only will their basic safety be in jeopardy, but also their mental stability. This paper will address the substantial instances of mental illness within refugee populations and the implications of the illnesses, what has been done to combat the problem of mental illness and the subsequent consequences for other areas of concern within the refugees' lives, and what needs to occur for significant improvement of the situation,

[4] Mateo Congregalli, "The Mental Health Crisis Facing Europe's Refugees," *VICE News*, last modified October 15, 2015, https://news.vice.com/article/the-mental-health-crisis-facing-europes-refugees.

I. Identifying the Problems

Mental illnesses and the lack of treatments available for these illnesses continue to be global issues. Stateside, more than ¼ of Americans suffer from a mental health disorder of some type, primarily anxiety, depression, and mood disorders. Although significant progress has been made in the U.S., these issues are still stigmatized by all ages, which causes many to be hesitant while seeking treatment.[5] When examining developing nations and, especially, nations embroiled in civil war, the problem becomes significantly more drastic. Refugees and internally displaced persons, who frequently suffer from rates of mental illness higher than 50% in the years after their displacement, are some of the most vulnerable groups of people. Many suffer from a variety of traumas in the country from which they are fleeing, and the conditions in Syria are particularly severe. Between the violent government crackdowns on protesting that are considered to be the spark that began the war, the brutality of groups like ISIL that indiscriminately torture and kill, and the air strikes by foreign governments, a significant number of Syrians have experienced extensive suffering. Depending on the study cited, up to 2/3 of refugees have experienced anxiety or depression, and many also experience comorbidity with issues such as panic attacks, agoraphobia, poor sleep, memory problems, social isolation, and post-traumatic stress disorder, (PTSD).[6] These rates, when contrasted with relatively healthy Western populations, are incredibly high. Additionally, using a 6,000-refugee caseload, the International Medical Corps

[5]Angela M. Parcesepe and Leopoldo J. Cabassa, "Public Stigma of Mental Illness in the United States: A Systematic Literature Review," *Administration and Policy in Mental Health* 40, no. 5 (2013): 384-399, accessed November 4, 2017, https://link.springer.com/article/10.1007%2Fs10488-012-0430-z.

[6]Angela Burnett and Michael Peel, "Health Needs of Asylum Seekers and Refugees," *The British Medical Journal* 322, no. 7285 (2016): 544-547, accessed November 4, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119741.

found that 31% suffered from severe emotional disorders, such as bipolar, and 10% suffered from schizophrenia.[7] The diversity of mental illnesses refugees face makes it more difficult to create adequate care programs, especially with the limited funding available both to refugee programs and mental health programs in general. Some lucky refugees have successfully migrated to Europe or other safe nations in recent years, but this does not prevent their health concerns from following them. According to a study on refugee populations in Sweden, disorders developed in war zones, such as PTSD, are further exacerbated by the stresses of moving to a new country, often leaving behind wealth, possessions, and family members. These stressors can include social and economic strain, feelings of alienation, discrimination from the host community, status loss, and threats of violence.[8] The importance of the environment to which refugees migrate should not be underestimated. Without a basic system of care and supportive atmosphere, already vulnerable people see increases in their symptoms of depression and anxiety. Sarah Holliday, the clinical therapist and program supervisor of the center for wellbeing at the International Rescue Committee (IRC) in Tucson, explained that refugees who are isolated from their culture or who do not adapt well to American culture are more likely to be emotionally triggered by events that remind them of their past—such as an Air Force plane flying overhead or a police officer in public—than those who have found community integration.[9] Even though some refugees successfully migrate to Europe where access to care is

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[7] Diamond, Nicholas J., "Three Challenges for Mental Health and the Syrian Refugee Crisis," *O'Neill Institute*, last updated February 2, 2016, http://www.oneillinstituteblog.org/three-challenges-for-mental-health-and-the-syrian-refugee-crisis.

[8] F. Lindencrona, S. Ekblad, and E. Hauff, "Mental health of recently resettled refugees from the Middle East in Sweden: the impact of pre-resettlement trauma, resettlement stress and capacity to handle stress," *Social Psychiatry and Psychiatric Epidemiology* 43, no. 2 (2008): 121-31, accessed November 4, 2017, https://www.ncbi.nlm.nih.gov/pubmed/18060523.

[9] Sarah Holliday in discussion with the author, January 2017.

at least more available, many more are forced into refugee camps in surrounding nations where any type of health care is scarce, let alone programs to address ongoing mental illnesses. Considering the importance of a supportive environment, it is hardly surprising that those in refugee camps are unable to cope with their mental disorders.

Although the close quarters of others from the refugees' own country seems as though it would indicate a strong possibility for community resilience, the opposite is often the case: the severe overcrowding in the camps leads instead to conflict, destabilization, and a lack of community assimilation.[10] Without the ability to form strong community bonds in a bleak situation, many of the refugees are left without a means of coping. An assessment by *The Forced Migration Review* found that, of the almost 8,000 individuals who participated, 15.1% reported feeling so afraid and 28.4% feeling so angry that nothing could calm them down; 26.3% felt "so hopeless they did not want to carry on living"; and 18.8% felt "unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset."[11] The climate in refugee camps is clearly detrimental, but due to a variety of factors which will be discussed later in this paper, few solutions have been implemented. Unfortunately, the damaged Syrian health systems and overrun healthcare facilities in other countries create nearly insurmountable barriers to mental health. In fact, a mere 2 psychiatric inpatient facilities

[10] Anne Barnard, "Swollen with Syrian Refugees, Lebanon Feels Its Stitching Fray," *New York Times*, last modified February 23, 2013, http://www.nytimes.com/2013/02/24/world/middleeast/syrian-flood-into-lebanon-stirs-fear-of-looming-disaster.html.

[11] Leah James, Annie Sovcik, Ferdinand Garoff, and Reem Abbasi, "The mental health of Syrian refugee children and adolescents," *Forced Migration Review* 47, (2014): 42-44, accessed November 4, 2017.

continue to operate in Syria[12] which, for a displaced population numbering in the millions, is clearly inadequate. Overall, according to the Syrian UNICEF report, only 26% of hospitals, in general, are still functioning, which leaves 42% of the remaining population without any type of basic healthcare.[13] Many Syrian refugees must endure the inhumane conditions in these camps, originally intended as short-term solutions, for years while waiting for a visa and/or asylum papers to process. Others never leave. The camps are also unsafe; refugees are vulnerable to physical violence, torture, sexual assault, and rape. This has led to a sharp increase in the rate of underage marriages among the Syrian population in Jordan because parents believe arranging marriages will lower the girls' risks of being raped or sexually assaulted. In terms of coping in the camps, one study by Noor Baker from Columbia University highlighted the distinct lack of positive strategies. The report discovered that the most reported coping strategy was "'nothing;' forty-one percent reported they did nothing to cope." The next most frequent response was socializing (15%), followed by praying (13%), and fighting or getting angry (11%).[14] The fact that 52% do nothing or get violent, while only 28% socialize or pray demonstrates the dire need for programs within the camps to teach culturally sensitive coping strategies. Without an increased international focus, though, the camps will continue to overflow, creating more issues for the Syrians instead of addressing the ones already present.

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[12] Mohamed Elshazly and Sarah Harrison, "The Syrian crisis needs targeted mental health research," *SciDev.net*, last modified March 16, 2016, http://www.scidev.net/global/health/opinion/syrian-crisis-targeted-mental-health-research.html.

[13] "UNICEF Syria Crisis Situation Report July 2017 – Humanitarian Results," *UNICEF*, last modified July 31, 2017, https://reliefweb.int/report/syrian-arab-republic/unicef-syria-crisis-situation-report-july-2017-humanitarian-results.

[14] Noor Baker, "Current Research on the Mental Health of Syrian Refugees," *Columbia University*, last modified 2015, https://www.apa.org/international/pi/2015/09/noor-baker.pdf.

Furthermore, regardless of the location to which the refugees relocate, any prior mental health disorders not only go untreated but are often compounded due to the pressures of their new environment. According to Dana Halawi, a journalist for Reuters, "The daily stresses of living as a refugee - lack of access to basic necessities and limited work and education opportunities - add to the pressure" that is already present as a result of the refugees' original displacement.[15] Many who have successfully relocated to safer nations either near Syria or in Europe have spent some time living in refugee camps and/or conflict zones, which makes the adjustments even more difficult. The International Medical Corps (IMC) has warned, in response, that Syrians who harbor untreated mental health conditions may "gradually lose their ability to function in society" which includes difficulty keeping a job, as well as forming relationships with and caring for their children.[16] If the latter occurs, the process becomes cyclical. Children who go uncared for in camps or new environments are then at risk of developing mental disorders of their own if such disorders were not already present after exposure to war and violence. Without treatment, this issue threatens to create a lost generation in Syria, i.e. an unhealthy populace without education or job security, which will make an eventual rebuild of Syria more difficult.

Mental issues are also not limited solely to the adult refugees who were given the ever-stressful task of ensuring their family's wellbeing despite the overwhelming challenges. Children within refugee populations have begun to be diagnosed with severe mental issues, as well. Children under the age of 18 represent approximately half of the entire Syrian refugee population

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[15] Dana Halawi, "Lebanon Struggles to Help Syrian Refugees with Mental Health Problems," *Reuters*, last modified February 29, 2016, http://www.reuters.com/article/us-mideast-crisis-syria-health-idUSKCN0W32YI.

[16] Ibid.

and more than 40% of them are under the age of 12. More than 2 million children have left Syria and are living in camps or communities in nearby nations.[17] Women and children are often the majority demographic in refugee populations, as men more frequently are involved in the domestic conflicts. Before or during their exodus, however, children are regularly exposed to horrors that leave lasting impacts. According to a report by the Migration Policy Institute, "79 percent [of children] had experienced a death in the family; 60 percent had seen someone get kicked, shot at, or physically hurt; and 30 percent had themselves been kicked, shot at, or physically hurt."[18] The study went on to state that a full 50% of Syrian refugee children had developed symptoms of PTSD, which is a rate ten times larger than the occurrence in children elsewhere.[19] When children suffer from severe traumas it can affect their mental stability in ways that are different from adults, who tend to have more developed coping mechanisms. Symptoms in children tend to take on a more physical nature and can include intense stomachaches, extreme physical/mental fatigue, insomnia, flashbacks, anxiety crises, dissociative episodes, hallucinations, and/or general pain. In refugee camps, the children are usually left without any schooling or formal discipline to occupy their time. Instead, they develop aggressive and emotional behaviors that are influenced by their previous trauma, the overcrowding of the camps, and the possible absence of one or two parents due to death or war-related displacement. The study from the Migration Policy Institute also found that 79% of the children they studied

[17] Selcuk R. Sirin and Lauren Rogers-Sirin, "The Educational and Mental Health Needs of Syrian Refugee Children," *Migration Policy Institute*, last modified October 2015, http://www.migrationpolicy.org/research/educational-and-mental-health-needs-syrian-refugee-children.

[18] Ibid.

[19] Ibid.

had experienced a death in the family, and more than 60% experienced an event that caused them to believe someone was in danger. Overall, nearly half of the children had experienced 5 or more of a series of stressful events (including violence, threats, or witnessing violence), compared with an average of 3 events for children in the West.[20] The children in the study were also asked to draw a person, which led to 9% who "spontaneously added blood, tears, death, or guns to their drawings— [which are] strong indicators of trauma."[21] Clearly, the ordeals to which Syrian children are exposed are pervasive enough to leave lasting impacts and influence the ways in which these children function after they find refuge outside of their home country. Untreated trauma could affect their abilities to integrate into aspects of their new societies such as school.

While living abroad, either in camps or in host communities, education is nearly impossible for refugee children to access. When they are lucky enough to be in school, many have mental health issues that prevent success and development. In the article by Halawi, one case from Lebanon is used to illustrate the problem: "[Mohamed was] a seven-year-old Syrian who was having serious problems adjusting to life as a refugee, and was, therefore, failing at school. Therapy was helping, but his family stopped his treatment because they could not afford transport to the clinic." [22] Instead of continuing the education they began in Syria, some children fail or are forced to drop out, either due to mental health concerns or the necessity of finding work to help support their families. The lack of education has still further implications. According to the Migration Policy Institute, "Children who are not formally educated are more

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[20] Ibid.

[21] Ibid.

[22] Dana Halawi, "Lebanon Struggles to Help Syrian Refugees with Mental Health Problems."

likely to feel marginalized and hopeless, making them vulnerable targets for radicalization… ISIL is believed to be actively recruiting Syrian youth in Lebanon, taking advantage of their anger and disillusionment."[23] The recruiters seek out adolescents not enrolled in school and lure them with the promise of financial aid for their families. Many boys become child soldiers and are forced to reenter the war, while girls in the camps face other types of trauma. As Sirin writes, "girls who are not enrolled in school are at risk for sexual assault, sexual exploitation, and early marriage, all of which can contribute to depression, PTSD, and other mental health disorders—both for them and their children."[24] The reality is that Syrian refugee children with mental health issues, both in and out of the refugee camps, face an imminent risk of developing lifelong psychological and/or social problems that may prevent them from succeeding in school and maintaining consistent employment as adults. Those whose families can afford therapy, or support themselves while the children are in school, are both uncommon and fortunate; many are, instead, faced with mental health problems, active terrorist recruiters, and threats of sexual assault and child marriage.

The overall scope of the mental health crisis among Syrian refugees is at once both daunting and saddening. People in need of help receive little-to-no care or must overcome significant barriers to access the limited services available, as discussed below. And, despite the known stigmas surrounding mental health and the myriad other problems they face, refugees understand their need for mental health support. According to the UNHCR, "in needs assessments, Syrian refugees often rank services for mental health and psychosocial support as

[23] Selcuk R. Sirin and Lauren Rogers-Sirin, "The Educational and Mental Health Needs of Syrian Refugee Children."

[24] Ibid.

very important. For example, among Syrian refugees to [sic] Dohuk Governorate in Iraq, the majority cited mental health services as the most-needed service in their setting."[25] The fact that they reported mental health needs above others highlights the suffering many are enduring as comprehensive, well-funded mental health care continues to be absent in the region. While some success has been achieved, a variety of issues continue to plague the current responses and reform must occur for effective, large-scale treatment.

II. Current Responses and Their Drawbacks

The circumstances Syrian refugees, both old and young, are forced to endure are dismaying and grim, even without consideration of the mental conditions of the refugee populations. For those who suffer from PTSD, depression, anxiety, or other mental health disorders the outlook is bleaker still. The primary concern is funding. It is becoming increasingly well known that mental health is grossly underfunded in the United States, but the lack of funding is especially jarring within the world's displaced populations. Because mental health gets placed behind other basic needs—such as school, housing, and jobs—in terms of priority, fewer than 1% of refugees will get care for mental health problems, despite the fact that between 20 and 60 percent of all refugees suffer from mental disorders as a direct result of their displacement and subsequent living conditions.[26] Another global report showed that fewer than

[25] Abdelwahed Mekki-Berradi et al., "Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians," *UNHCR*, 2015, accessed November 4, 2017, http://www.unhcr.org/en-us/protection/health/55f6b90f9/culture-context-mental-health-psychosocial-wellbeing-syrians-review-mental.html.

[26] Megan Cassella and Serena Maria Daniels, "As US braces for Syrian Refugees, mental health services lag," *Reuters*, last modified October 28, 2015, https://www.reuters.com/article/us-usa-syrians-refugees/as-u-s-braces-for-syrian-refugees-mental-health-services-lag-idUSKCN0SM18L20151028.

$1 USD of every $1000 spent on global humanitarian aid goes to mental health care.[27] It is understandable that the majority of funding should be allocated toward basic needs like safety, food, water, and shelter, and perhaps even employment. Spending little-to-no amount of aid on mental health, however, does not provide enough to address the vast need present in displaced populations, nor does it prepare them adequately for potential asylum in other countries in the future. And those who experience difficulties coping will be less likely to succeed in other areas once they migrate. Despite the focus on other aspects of the refugees' lives, such as employment, one study showed that "refugees who learn to cope early on with PTSD tend to settle more easily into the US and benefit more from other services."[28] Still, the spending lags. Much of the healthcare concern regarding refugees is typically focused on their physical health. This focus should absolutely be a priority for injuries, chronic pain, and diseases that threaten their well-being and livelihoods. When the funding and attention are disproportionately directed to physical health at the sacrifice of mental health, however, long-term physical ailments can occur as a result of the mental ones. For example, a study by Prince et al found that "mental disorders increase an individual's risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury," leading to a lower life expectancy.[29] Prioritizing physical health over mental is important, but only to a certain extent past which lingering mental disorders may worsen the physical conditions of those who suffer from them. This is particularly relevant to refugee camps in which international workers can be overwhelmed by the sheer number of

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[27] Ibid.

[28] Ibid.

[29] Martin Prince et al., "No Health without Mental Health," *The Lancet* 370, No. 9590 (2007): 859-877, accessed November 4 2017, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61238-0/fulltext.

refugees who arrive with physical ailments from the war they left behind. Persisting mental issues that go untreated can worsen the situation.

In camps, refugees are at a disadvantage when it comes to accessing any type of health care, and especially for mental trauma. Few international organizations focused on health, like Doctors Without Borders, send personnel trained in mental health care—the vast majority of them are specialists in physical health. Of the limited mental health care that does exist within the camps or refugee quarters within cities, much is ineffective due to language barriers, cultural differences, and social stigmas surrounding mental illness. Several international organizations are active within the camps, but a common mistake is to apply Western interventions blindly without considering cultural diversity of Syrians.[30] For example, the same types of care might be practiced on all Syrians, regardless of background, or the relatively more liberal process of Western mental health diagnosis may be used without taking stigmas into account. This leads to unrealistic expectations and frustration on behalf of both Western humanitarians and the refugees. Furthermore, according to Mohamed Elshazly, a mental health and psychosocial support consultant currently working for the UN High Commissioner for Refugees in Iraq, the programs already in place "need more support from scientific evidence — an agenda for research priorities — to ensure quality and feed into an overall mental health strategy for Syrians whether in or outside the country."[31] Without an understanding of how best to tackle the problem the well-meaning foreign workers may continue to implement what works in their own countries without empirical evidence to prove it works for Syrians, as well. The time spent in the camps by foreign aid workers is also fleeting and unpredictable. Contracts run out, funding dries up, or the

[30] Elzhaly and Harrison, "The Syrian Crisis Needs Targeted Mental Health Research."
[31] Cassella and Daniels, "As US braces for Syrian Refugees, mental health services lag."

situation on the ground changes, which may force the evacuation of workers from the conflict zones. Besides the obvious resulting implication of fewer doctors to treat the Syrians, this also threatens to disrupt any rapport that was built between the patient and the mental health professionals. If a patient wanted to continue treatment in such a situation, he or she would have to establish a relationship with an entirely new specialist and begin the process anew. The volatile nature of the foreigners' long-term schedules additionally prevents or slows the progress of any long-term structural mental health system from being established within the camps.

The refugee camps are also horribly overcrowded. In Lebanon, the Shatila camp now has a population of approximately 22,000, which swelled from 3,500 after the onset of the Syrian Civil War. In Jordan, the Azraq camp served as the temporary home to 32,000 refugees in March 2016, despite only having enough shelter space for 25,000. The Zaatari camp, also in Jordan, became the country's fourth-largest city when the number of refugees increased from 15,000 in August 2012 to over 156,000 in March 2013. Even if international aid workers were plentiful, they would be overwhelmed with caseloads numbering in the thousands if they sought to treat every refugee with mental health issues in each camp. As stated earlier in this paper, the cramped quarters tend to exacerbate mental health problems rather than contribute to their alleviation, which makes treatment more difficult. "After all," says Elshazly, "beneath fresh divisions and factions created by the conflict, there is an ancient mosaic of different subcultures and ethnicities."[32] Forcing so many people into spaces designed to hold far fewer only serves to heighten tensions between diverse groups, leading to more stress, aggression, and potential for

[32] Ibid.

violence. These uncertain conditions increase the refugees' chances of developing anxiety problems.

For those who haven't relocated to the camps and are still living in Syria, access to mental health treatment is nearly nonexistent. Some aid organizations are unwilling to send personnel into Syria itself due to the dangers faced by Westerners in the current conflict. According to a study by The Lancet published in *The Guardian*, Syria has become the most dangerous place in the world for healthcare providers because of "the 'weaponisation' of healthcare in Syria, involving the targeted destruction of medical facilities and the killing of hundreds of healthcare workers, [which] is unprecedented and has profound and dangerous implications for medical neutrality in conflict zones."[33] In 2016 alone, 200 attacks were carried out against healthcare facilities which contributed to the overall death toll of 814 medical workers since the study began in 2011.[34] The risk outweighs the reward for health professionals considering entering the conflict zone, as attacks designed to discourage foreign intervention continue. Moreover, the World Health Organization (WHO) has reported "Even before the conflict, mental health care was in short supply in Syria, whose 21 million people were served by only 70 psychiatrists. There were only two public psychiatric hospitals. One is located in a rural area outside Damascus but now operates with limited capacity because of security concerns. The second one, in Aleppo, has closed its doors."[35] The piece went on to describe a former drug

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[33] Sarah Boseley, "Syria 'the most dangerous place on earth for healthcare providers' – study," *The Guardian*, last modified March 14, 2017, https://www.theguardian.com/world/2017/mar/15/syria-conflict-study-condemns-weaponisation-of-healthcare.

[34] Cassella and Daniels, "As US braces for Syrian Refugees, mental health services lag."

[35] Elizabeth Hoff, "Mental Health Care in Syria: Another Casualty of War," *World Health Organization*, last modified September 22, 2013, http://www.emro.who.int/syr/syria-news/mental-health-care-in-syria-another-casualty-of-war.html.

addiction treatment center that has begun to take in mental health patients due to the vast demand and lack of supply. Dr Eyad Yanes, an employee in the mental health program of the Syrian office of the WHO claims that "'most of the people who were in treatment for mental health conditions before the conflict are trying to continue their treatment by consulting their doctors by phone and buying what medicines are available on the market, but many have had to stop the treatment altogether.'" Despite attempted interventions by non-governmental organizations (NGOs), Yanes claims that 'the problem is that there is not enough capacity for further interventions."[36] Instead, local clinics such as the substance abuse treatment center are forced to refocus their efforts to help as many Syrians who are still living in the country as possible. Unfortunately, though, the clinic now only has 51 beds and 30 consultations per day, and is only accessible to people living in Syria's capital, which means "People in the rest of the country, especially those living in areas hardest hit areas by conflict, are virtually without mental health services."[37] Leaving internally displaced Syrians on their own to access mental health care is not only unfeasible and irresponsible but also dangerous. Given the low number of operating hospitals in the country and constant attacks on foreign health workers, it is not plausible to expect Syrians to achieve any lasting success in their mental health while remaining in the country.

Among the population who now live abroad, access to mental healthcare is certainly more accessible but is not easy to obtain. The International Medical Corps (IMC) conducted a study targeting the availability of mental treatment to Syrian refugees and found "that services

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[36] Sarah Boseley, "Syria 'the most dangerous place on earth for healthcare providers' – study."

[37] Ibid.

provision across countries varies; for example, early childhood development activities are not currently available in Turkey as they are in the other countries, and non-pharmacological management of mental disorders by specialized mental health care providers is not available in Syria as it is in the other countries."[38] Although life is generally better in urban areas than the camps and unquestionably better than life in the warzones, healthcare remains an issue for refugees in the surrounding nations of Jordan, Lebanon, and Turkey. In Jordan, for example, health services used to be free for refugees, as they are for Jordanian citizens, until the crisis in Syria escalated and the number of people Jordan had to support swelled considerably. According to the IMC, "the government now charges Syrian refugees for health services outside camps, which results in many Syrians traveling long distances to access free INGO (International Non-Governmental Organization)-based services."[39] The paradox this creates for refugees leaves them with few options. The majority live in the urban communities outside of the camps—which maintain better standards of living—but to access free health services they must travel to the camps rather than the local medical clinics. Furthermore, the mental health programs that do exist in Jordan are "often too theoretical, and licenses are difficult to obtain."[40] So, even when programs are available, they fall short of their potential for success because of a lack of effective training and licensing of the workers.

Lebanon, of the three countries, has made the most progress in improving their mental health system to adapt to the increase in population. The influx of refugees galvanized the health

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[38] Inka Weissbecker and Ashley Leichner, "Addressing Mental Health Needs among Syrian Refugees," *Middle East Institute*, last modified September 22, 2015, http://www.mei.edu/content/article/addressing-mental-health-needs-among-syrian-refugees.

[39] Sarah Boseley, "Syria 'the most dangerous place on earth for healthcare providers' – study."

[40] Ibid.

sector in Lebanon to act in response to the crisis. The reforms began in 2014 when, in coordination with the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF) and IMC, the Lebanese Ministry of Public Health created the first National Mental Health Program, designed to reform the system and expand its services.[41] Through a collaborative effort, Lebanon has been able to tackle a large portion of the ever-growing need successfully, despite perennial funding concerns and increasing demand. In an article from Al-Monitor the author, Florence Massena, discusses her experience visiting mental health sites in Lebanon: "Every day, around 15 doctors and trainees who specialize in psychology gather to talk about the best techniques to treat their patients before visiting the nearby camps… [where] they may discover new cases, as well as follow up on ones they have already started to treat."[42] It is important to recognize that daily meetings by the doctors who discuss best practices before reentering the field. Rather than apply Western methods without cultural sensitivity—as occurs in some refugee camps—or rely on theory rather than evidence—as occurs in Jordan—the system in Lebanon is constructed to allow for more adaptive care. Furthermore, the doctors who are treating the patients are often Syrians themselves who have left their country but been granted permission to practice in neighboring Lebanon. In an entry in *The Lancet*'s psychiatry journal, Dr. El Chammy et al attempt to explain why Lebanon is experiencing a degree of success:

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[41] Rabih El Chammay, Elie Karam, and Walid Ammar, "Mental Health Reform in Lebanon and the Syrian Crisis," *The Lancet* 3, no.3 (2016): 202-203, accessed November 4, 2017, http://thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)00055-9/fulltext.

[42] Florence Massena, "Syrian Refugees in Lebanon Face Mental Health Crisis," *Al-Monitor*, last modified July 21, 2015, http://www.al-monitor.com/pulse/originals/2015/07/lebanon-syrian-refugees-mental-health-amel-doctors-of-world.html.

> "Against all odds, Lebanon's mental health system is not only coping with the escalating needs but is also growing. The factors that have led to this growth are many and some remain unknown to us. The following seem to be instrumental: using the momentum and increased interest created by the Syrian crisis, the clear policy to avoid building a parallel system of care, a complex, yet very effective collaboration between the Ministry; UN agencies; and national and international non-governmental organisations, achieving national consensus on a mental health strategy involving all health-care sector workers and policymakers in the country, and high level political support within the Ministry for mental health reform."[43]

Although it required significant coordination between several groups, Lebanon's ability both to begin to address the mental health concerns of the Syrian population within its borders and simultaneously begin to reform its entire mental health system is impressive given the subpar options often available to Syrian's seeking mental healthcare. It is necessary to note, however, that these successes are, overall, entrenched in an unpredictable situation and could easily be reversed via a change in government, a separate regional crisis, or spillover of the Syrian conflict into Lebanon. Until the underlying cause of the conflict is resolved, Syrians will continue to flee across the border and expect to be treated by a Lebanese system that is still new, growing, and subject to instability.

In Turkey, although access is more readily available than in Jordan, a language barrier exists between the Turkish providers and the Syrian patients. Turkey only recently (in January

[43] Sarah Boseley, "Syria 'the most dangerous place on earth for healthcare providers' – study."

2016) passed legislation that makes it easier for Syrians to obtain work permits[44] which have allowed Syrian doctors to begin practicing under Turkish supervisors. Prior to the law, however, Syrians had significant difficulties obtaining work and were forced, instead, to rely on Turkish doctors to provide care using a language the refugees were unable to understand. From the IMC report: "there is a continued need to allow Syrian (or Arabic speaking) health care providers to work with Syrian refugees in Turkish national health facilities, which would help Syrians and also allow health care providers to continue to practice and build skills."[45] In addition, translators fluent in both languages would aid Turkish mental health providers in attending to the significant caseload of Syrians residing in the country.

Even when services are available, whether in the host country, refugee camps, or host communities abroad, challenges continue to exist. An article in the journal *Epidemiology and Psychiatric Services* from Cambridge, written by G. Hassan et al, claims that barriers to care exist, including language differences, the stigma associated with mental health treatment, and the "power dynamics of the helping relationship."[46] With regard to language differences, the health professional often utilizes informal interpreters who are members of the family or community of the patient which creates ethical dilemmas and potential misinformation if the interpreter does not understand medical terminology in both languages. Stigmas present as issue, as well, because it is culturally taboo in Syria to label emotional suffering as an illness for fear of being

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[44] "Why Don't Syrian Refugees Stay in Turkey?" *BBC News*, last modified July 15, 2016, http://www.bbc.com/news/magazine-36808038.

[45] Sarah Boseley, "Syria 'the most dangerous place on earth for healthcare providers' – study."

[46] G. Hassan, et al., "Mental Health and Pscyhosocial Wellbeing of Syrians Affected by Armed Conflict," *Epidemiology and Psychiatric Sciences* 25, (2016): 129-141.

considered of unsound mind. Mental health workers might use certain emotionally charged language—words such as disorder, illness, or disability, for example—which can turn away potential patients who are in need of care but do not feel as though they are suffering from a disease. The UNHCR addresses this in a study focused on the intersection of culture and mental health in Syria: "…emotional suffering is perceived as an inherent aspect of life. Instead, it is the explicit labeling of distress as 'psychological' or 'psychiatric' that constitutes a source of shame, embarrassment, and fear of scandal.'"[47] Without a cultural understanding of the prevalent stigmas, physicians run the risk of inadvertently creating a barrier to care. Additionally, the scientific diction used by healthcare workers can alienate refugees, especially if a language barrier already exists.[48] Instead, the practitioners should employ simple language free of emotionally charged words and scientific complications to discuss mental health, as well as ensure that the refugees understand any instructions or diagnoses given. The final consideration, power dynamics, is described by Hassan et al as situations 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."[49] Syrians frequently arrive from war zones in which many of their freedoms, personal possessions, and personal securities have been stripped away. If mental health professionals are too domineering, the research argues, their behavior may have adverse effects on the refugees by pushing them away and making them feel out of control in yet another aspect of their lives.

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[47] Abdelwahed Mekki-Berradi et al., "Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians."

[48] Ibid.

[49] Elizabeth Hoff, "Mental Health Care in Syria: Another Casualty of War."

Despite the best efforts of some international organizations, the Syrian mental health emergency continues to exist. Misunderstandings of cultural differences, a reliance on Western conceptions of therapy and mental illness, underfunding, and the sheer size of the population in need of health services all play significant roles in the crisis and its persistence. In the next section, this paper will use local organizations as case studies to provide a context for the problems faced by Syrians in the United States and to describe more concretely the methods such organizations are using to work around funding constraints.

III. Current Responses, Drawbacks, and Opportunities for Improvement in Local Organizations in Tucson, Arizona

For the purpose of this paper, I have decided to profile several organizations assisting refugees in Tucson, which is known as a hub for those seeking resettlement. Arizona overall was ranked fifth per capita in terms of refugee placements over the last 15 years, according to the Bureau of Population, and in Tucson between 2007 and 2011 more than 10% of new arrivals were refugees.[50] Overall, more than 82,000 refugees from more than 40 nations have relocated to Arizona since 1978.[51] Because of the relatively large refugee population, Tucson itself is now home to more than a dozen organizations focused on resettlement and refugee assistance, including 1 of only 27 International Rescue Committee (IRC) agencies in the United States. As discussed above, many of the current approaches to treating refugees' mental health are not

[50] Patty Machelor, "Language Barrier is a Daily Struggle for Refugees in Tucson," *Arizona Daily Star*, last modified March 3, 2013, http://tucson.com/news/local/language-barrier-is-a-daily-struggle-for-refugees-in-tucson/article_0786f125-7042-5d62-bd67-950edd67e26c.html.

[51] "About Refugee Resettlement," *Arizona Department of Economic Security,* accessed November 4, 2017, https://des.az.gov/services/aging-and-adult/refugee-resettlement/about-refugee-resettlement.

working, so in order to determine the most effective strategies firsthand, I interviewed employees from three local organizations: the IRC, Iskashitaa, and the Noor Women's Association. The results were mixed, but one commonality existed: in the face of overwhelming need and limited funding, each of the organizations has begun to adopt more creative approaches to mental health that do not focus solely on traditional therapeutic methods.

During an interview with Sarah Holliday, the clinical therapist and program supervisor of the center for wellbeing at the IRC in Tucson, she expressed that the subpar funding is consistently an object of concern for her and the center, and that the programs and services available to refugees suffering from mental health disorders would be much better if the funding were increased. The Tucson IRC chapter used to have a mere 2 or 3 therapists in-house to deal with all of the refugees in the center, which number in the hundreds. Then, the government funding ran out. The center went without any therapists for an astounding eight months, until Ms. Holliday was hired in the fall of 2016. She, however, is not trained to provide clinical care to the refugees beyond working in limited capacities with survivors of torture. As a result, instead of being able to provide mental healthcare at the center that the refugees visit weekly, the IRC is forced to outsource therapy to other local organizations where the therapists are busy, not trained to work with refugees, and usually unable to communicate with the refugees without a translator. Many of the refugees do not understand the necessity of the therapy, either due to language barriers or a lack of communication, and feel uncomfortable speaking with the psychiatrists. Stigmas about mental issues and medication often present problems, which require creative solutions that the therapists do not have time to implement. According to the Psychiatric Services Journal, though, "Members of cultural and ethnic minority groups tend to delay seeking mental health treatment; they use services only as the last resort, thus prolonging the unnecessary

suffering for both the users and their families."[52] Because many refugees come from cultures that do not discuss mental health as openly as Western nations, they often need more individualized care which is expensive and time-consuming for therapists who are not versed in refugee healthcare. Thus, a blockade is formed where the refugees require more creative, culture-sensitive therapy that the therapists are unable or unwilling to provide.

Transportation, too, is consistently an issue—the IRC does not provide it for mental health visits—so the refugees are forced to find their own way to the appointments, meaning they often do not go at all. Finally, the center is unable to raise enough funds to develop effective community resilience groups. Holliday lamented that the logistics of trying to have a large group of refugees gather weekly for such meetings (either due to transportation or work schedules) present challenges. Populations from the same country or region are also rarely housed in the same apartment complexes or even neighborhoods. The IRC is forced to supply the most inexpensive housing available (after finding landlords who are willing to host refugees), which means concerns for community development are not prioritized. Some refugees form groups on their own or meet through religious institutions, but others suffer from isolation, culture shock, and an inability to develop resilience.

Holliday also discussed the disillusionment experienced by many Syrians who emigrate to the United States as a barrier to their wellbeing and ability to integrate successfully into the community. A common trend, she said, is for Syrian refugees to romanticize the opportunities available to them in the United States and to expect a certain quality of life that would be available soon after arriving in their new country. Due to the suddenness of the Syrian Civil War

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[52] Julian Chun-Chung Chow, Kim D. Jaffee, and Deborah Y. Choi, "Use of Public Mental Health Services by Russian Refugees," *Psychiatric Services* 50, no. 7 (1999): 936-940, accessed November 9, 2017, http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.50.7.936.

and its relative quick escalation compared to the conflicts in other countries from which refugees originate, many Syrians lost significant wealth and well-being rapidly. The reality, according to Holliday, is that refugees often had more personal wealth at home and were hoping for a similar quality of life abroad, but many lost almost everything in the abrupt turmoil of the Civil War. Now, a large portion of the refugees work as unskilled laborers in Tucson in hotel service, dishwashing, and other positions that do not require a proficient grasp of English. As a result of these low-paying jobs held by people who may, in some cases, even have completed degrees, the refugees' senses of self-worth are affected negatively.

On the positive side, a state grant helps fund behavioral healthcare and a separate grant is allocated to survivors of torture, which together provide all of the funding for the IRC Center for Wellbeing. The overall program is 8 weeks in length, focused on pathways to wellness and cultural adjustment, and maintains three goals: help refugees understand the mental health system, reduce the mental health stigma, and normalize the processes necessary for seeking care in the mental health system. The center also attempts to educate healthcare providers on the intricacies of working with refugees, despite the busy schedules of the providers and their quotas. And although she cannot provide formal therapy, Holliday still tries to help survivors of torture and refugees struggling with mental health problems whenever she can. "Anytime you're with a refugee it's therapeutic, even if it's not specifically therapy," she said. "[The refugees] feel heard and get an emotional check-in."[53] In recent months, the IRC also used the funding to create programs that include acupuncture, massage therapy, men's yoga (or "stretching," as they call it, to boost attendance), English practice courses, and seminars that help the refugees develop a basic understanding of the United States and its culture, all aimed at helping refugees suffering

[53] Sarah Holliday in discussion with the author, January 2017.

from trauma and mental health issues. Holliday expressed, though, that relying on grant funding is risky because if the grant is not renewed, the center simply cannot provide its services—which was the case during the 8-month period without therapists. Individual donation money, another source of revenue for the IRC, is also volatile and subject to shifting public opinion. If donors feel threatened by refugees or have their views affected by the current political climate, then the funds raised via donation could decrease, as well.

In an ideal situation, one that hypothetically involves significantly increased funding, Holliday discussed the ideas she believes would work best to benefit the refugees' mental health. First and foremost, an increase in therapists employed by the IRC itself would be the first step, specifically ones who could visit refugees in their own homes and speak their native languages. Simply increasing the staff would be fantastic, but the in-house therapy would also mitigate the issue of transportation and reduce the stigma of needing to go to a hospital or clinic for emotional distress. She also said that, in her experience, many refugees feel uncomfortable discussing trauma within the first year of their arrival, so more programs focused on hands-on experiences rather than Western-style couch therapy would be ideal if funding were increased. Specifically, activities like cooking classes, art classes, cultural events (such as dancing or acting), and field trips around Tucson to help the clients establish roots and get to know their community would help relieve some of the underlying anxieties and stressors experienced by numerous refugees. Holliday discussed at length her desire to have more programs focused less on sitting and talking and more on experiential therapy.

Without increased funding, though, the logistical problems and absence of well-developed programs plaguing the Tucson IRC and aid organizations around the country will persist. Interviews with two other local organizations, Iskashitaa and Refugee Focus Tucson,

revealed similar struggles with funding and capacity for program development. Iskashitaa was founded in 2003 as an organization focused on tackling food waste through local harvesting, but has grown into "a diverse organization securing important needs of the Tucson refugee community. Programs have been developed to empower refugees through education, the development of practical life skills, and food security." [54] In an interview with the founder and director, Dr. Barbara Eisworth, she discussed the mental health of the refugees and highlighted how the programs at Iskashitaa in particular benefit the refugees' mental health indirectly through programs focused on building confidence, community integration, and instilling a sense of belonging.

Although the organization has no organized mental health program, it instead focuses on alternative practices to improve the mental health of the refugees it serves. The primary project is harvesting, which combines local volunteers and refugees from around the globe with the mission of locating, harvesting, and redistributing locally grown produce that is in danger of going to waste. Refugees and citizens carpool to nearby sites and glean produce while interacting with one another and sharing cultures. According to Dr. Eisworth, the focus of these programs is to help the refugees build feelings of purpose. Immigrants want to be integrated into the society, she says, but it is difficult for them to find entry points on their own due to a variety of barriers including language and cultural differences. By uniting refugees and locals in pursuit of a common goal, Iskashitaa actively and intentionally battles the isolation that many refugees experience upon migrating to a new country. The harvesting is familiar to everyone, allows them to work outside, and introduces them to other refugees and local people with whom they can

[54] "About Us," *Iskashitaa Refugee Network,* accessed November 4, 2017, http://www.iskashitaa.org/about-us.

construct lasting connections. It also serves the refugees more tangibly by providing pounds of fresh produce to them and their families, sometimes the equivalent of more than $100 per week.

In addition to the harvesting programs, Iskashitaa has adopted other measures to build community resilience and make the refugees feel more comfortable. They provide English classes at a variety of levels that are focused on practicality (i.e. vocabulary and phrases necessary for basic jobs and day-to-day tasks), optical clinics to fit refugees with eyeglasses, basic safety and health awareness programs with an emphasis on stress alleviation, and visits by a case manager on Fridays who works with refugees in various capacities. The purpose of all of these partnerships is to create a support system and feelings of inclusion for an often-marginalized group of people. The care is by no means clinical, reliant on psychological theory, or based around a certain type of treatment, but Dr. Eisworth has experienced numerous successes related to the refugees' mental health over the past decade.

Primarily, she has seen refugees' confidence increase dramatically through the programs at Iskashitaa. They develop a sense of belonging through the harvests, worry less about access to food, and begin bringing other small problems (such as water bills, job applications, interpersonal conflicts, etc.) to the harvests to seek assistance, a sign of developing trust within their new community. Such behavior is also indicative of the asylum-seekers slowly regaining control over aspects of their lives that were previously uncontrollable. "We've seen this work," says Eisworth, "and the most significant indicator is that the refugees themselves recommend [that] people come to us."[55]

Despite its local successes, Iskashitaa faces the same issues that plague similar organizations, primarily reliance on donations and/or grants for funding, as well as the continued

[55] Dr. Barbara Eisworth in discussion with the author, February 2017.

contention surrounding refugees and immigrants. If funding were to increase, however, Dr. Eisworth discussed several programs she would implement to improve further the well-being of her clients. First, she wants to develop a job-readiness program with stipends that trains refugees in basic skills, cultural orientation, and confidence to prepare them better for entering the workforce. Second, she hopes to design two certificate-generating programs in food service and landscaping that would allow participants to approach employers in those sectors with proof of experience and an obvious investment in themselves to improve at a certain type of job. These programs, she argues, would help to improve community resilience and integration, as well as mitigate the potential for depression, which she says she has seen occur when refugees feel as though they are not contributing to their community. Iskashitaa has also faced institutional challenges, Dr. Eisworth says, related to the sphere in which it operates, namely donation fluctuations resulting from changing political climates and skepticism from other, similar organizations that do not understand the programs. The latter is a persistent problem, claims Eisworth, that prevents effective community integration and the enactment of efficient funding structures. It would be better for refugee organizations to work more closely with one another to fill in gaps within their models and utilize their respective comparative advantages for the benefit of the refugees.

One organization that tries to build upon the work done by others is the Noor Women's Association (Noor), led by a board of 5 multinational individuals, one of whom is Fran Braverman. She is a retired special education teacher who has worked with the association for 9 years after being asked to serve on its board in 2008. The group overall operates under the

mission of bringing light into the lives of refugees[56] through models focused on individual care and volunteer-based assistance. Noor is given lists of refugees in the Tucson community who were supported short-term by larger refugee organizations (including IRC) but were not fully capable of continuing to integrate independently. The lists contain necessary information about the refugees, including their countries of origin, medical needs, and financial situations. Noor then dispatches volunteers who visit with the refugees in their homes, with permission, and help them in any possible capacity. Braverman has taught English, helped refugees shop, taken them on trips to local community sites, and simply sat and talked with them to develop rapport and a community connection. The organization overall has been operating for 20 years and now has a cohort of 70 volunteers, in addition to the five board members, who reach out to refugees in the community and try to make them feel comfortable while adjusting to their new surroundings. The organization has helped over 1,400 refugee families and distributed over $600,000 to refugees struggling with resettlement. Braverman says that, at this point, she has seen countless problems relating to mental health including extreme fear, PTSD, self-imposed isolation, culturally-imposed isolation, issues with translation services at psychiatry clinics, and overall extreme trauma.[57]

In the face of this intense adversity, however, Braverman has witnessed lives transformed by the relatively simple model of assistance provided by the Noor Women's Association. Like Iskashitaa, Noor focuses on incorporating community members into the lives of refugees, and vice versa, to bolster resilience and instill a sense of belonging. As a mentor, she prides herself on providing support without judgment and has observed both "extensive resilience and progress

[56] "What is Noor?" *Noor Women's Association*, last modified 2007, http://noorwomen.webs.com.

[57] Fran Braverman in discussion with the author, March 2017.

with each visit" to the homes of the refugees. The care is individualized and allows for extensive time with each refugee family, as Noor sets a limit of assisting 30 families at one time. The volunteers focus on listening and kindness while helping the refugees in a multitude of ways and work on a case-by-case basis with those that have mental health concerns, sometimes simply listening and other times (for those with severe problems) referring them to professionals.

Like the other organizations, however, Braverman, too, has ideas for areas in which improvement is needed. She was adamant that the hosts should not try to superimpose their values onto asylum-seekers and complained of a lack of culturally appropriate social services available in the community. She also said that more volunteers are always needed and that an increase in funding would allow Noor to reach a larger number of people in need. Furthermore, she claims that the overall system of refugee settlement is too complicated for refugees to navigate on their own and that coordination between organizations is necessary in order to provide the best care possible.

Although the evidence is anecdotal, the success of Dr. Eisworth at Iskashitaa, Mrs. Braverman at Noor, and the beginning of mental health reform at IRC should not be ignored in the broader context of refugees' mental health, especially considering the challenges faced by traditional treatment methods both in the U.S. and abroad. Despite limited funding, both Iskashitaa and Noor have mobilized a significant core of volunteers who spend time getting to know the refugees, understanding their struggles, and helping them assimilate into the Tucson community. IRC, though it went without a mental health specialist for months due to funding, responded by instituting other methods of care including arts and exercise. The sense of place gained from acceptance and a concrete, if short-term, purpose provide significant health benefits, as explained in the following sections.

IV. Examples of Programs Experiencing Success and Opportunities for Improvement

The first and foremost solution is, of course, to increase funding for organizations such as Iskashitaa and the IRC so that they can implement some or all of the programs which are currently unavailable. The amount of funding allocated to mental health programs abroad, around 0.1% of total international medical aid, is also unacceptable. Given the current political responses to the refugee crisis in the United States and continued budgetary cuts, however, it seems unlikely that an increase in funding will be approved in the near future. Thus, it is important to discuss the ways in which the current funding can be used more effectively and efficiently in the context of the refugees' mental health crisis. Certain methods of treatment work better than others and should, therefore, be prioritized when helping Syrian refugees struggling with mental illness both domestically and abroad. Many of these methods are surprisingly simple, but often do not align with Western understandings of therapy, mental health treatment, and the stigmas surrounding mental health. The primary consideration, it seems, should always be cultural differences, yet such differences are often overlooked in favor of established Western practices. As a result, refugees living abroad may suffer from a discrepancy between the care that could be most effective for them and the care they are receiving.

One method of alternative care, the community resilience model, has experienced some success, especially in Lebanon. "Individual resilience can determine how a refugee deals with trauma," writes Esther Doron in a study in the *Community Development Journal*, "but for dealing with long-term stress, community resilience has a significant influence on lives," where community resilience is defined as "the ability to thrive, mature and increase competence in the face of adverse circumstances… [which] may include biological abnormalities or environmental

obstacles [and] may be chronic and consistent or severe and infrequent."[58] Assessments like this are important when looking at how refugees are settled in host countries. It may be possible for them to overcome short-term implications of trauma individually, but they need a strong community environment to mitigate the long-term challenges of trauma and the daily stressors associated with integration. Therefore, resettlement policies that fill apartment complexes with refugees of multiple nationalities will be less beneficial than grouping people of the same nationality together. Cultural differences, language barriers, and varied experiences will make it difficult for refugees in such situations to develop resilience with one another. Within the model, there are seven components that are imperative to the development of community resilience: belonging, control, challenges and proportion, perspective, skills and techniques, values and beliefs, and support systems. For the purposes of this paper, belonging, control, and support systems will be discussed as integral to the success of the resilience model when focusing specifically on mental health. This particular study focused on Lebanese refugees who fled Southern Lebanon to settle in Israel, but its overall applications are valid for refugees from other communities as well, especially Middle Eastern ones.

Belonging, or "the experience of personal involvement in a system or environment so the persons feel themselves to be an integral part of that system,"[59] occurs only when there is shared history, experiences, or interests within the group, which can then be built upon by mental health professionals. Examples include establishing memorials for the dead, integrating religious events into programming, providing Arabic lessons for children who are at risk of becoming members

[58] Esther Doron, "Working with Lebanese refugees in a community resilience model," *Community Development Journal* 40, no. 2 (2005): 182-191, accessed November 4, 2017, https://academic.oup.com/cdj/article-abstract/40/2/182/379549?redirectedFrom=PDF.

[59] Ibid.

of a lost generation, and helping to establish organizations run by refugees to support one another and advance their causes. These types of actions encourage communication among the refugee populations and help to establish relationships upon which refugees may depend on in times of crisis.

Control, which is a community's ability to manage crises, is important to overall mental health, as well. As discussed in the section on current responses, refugees often feel as though they have lost control over numerous aspects of their lives, and regaining control over at least some sectors is necessary. The best way to do so, argues the study, is for existing organizations to handle emergencies and social supervision while the refugees acclimate to a new environment, be it a refugee camp or a host country.[60] From there, the refugees would need assistance in developing skills and techniques to manage their lives in the new societies. Having the support of their original community is beneficial as it allows the refugees, as a unit, to address hardship, crises, and trauma, instead of relying on individuals to regain control amid overwhelming circumstances.

Finally, support systems "deal with mutual support, improving social networks and solidarity within a community [and are] crucial in times of crisis, post-crisis and long-term stress."[61] Often, when refugees first migrate, they are left without the social structures and community networks upon which they relied for a variety of needs in their home countries. The added stress of migration, without support systems to alleviate the effects, can cause mental health problems to develop or increase the risk of comorbidity. Although a community may develop some form of a support system on its own, utilizing professional support to establish

[60] Ibid.
[61] Ibid.

trust and subsequently institute support systems has been shown to be more beneficial, specifically through the establishment of women's groups.[62] Due to cultural practices, female refugees typically do not leave the home alone, and so a socially acceptable safe space to interact with other women has proved to be a successful combatant to loneliness and depression.

These three aforementioned factors are the most important to consider when developing models of community resilience to combat the post-migration development of mental illnesses among refugees and to treat existing conditions in a cost-effective manner. Rather than placing the burden of mental health solely on the individual, as is often the case in Western practice, viewing the problem as one which can be addressed by an entire community helps the members of that community build trust among one another, realize the commonalities of their problems, and become better prepared to overcome additional traumas in the future. Often, the problems and weaknesses of refugees are discussed at length by mental health professionals and researchers, while less time is spent focusing on their potential for recovery and development resiliency. One study of Iraqi refugees in London, however, found that more experienced depression due to subpar social support than prior experiences with torture.[63] This suggests that focusing less on any horrible pain of the past and more on the potential for resilience through social structures in the future will help to improve the mental well-being of refugees.

Another group, the Center for Mind-Body Medicine, has begun instituting a separate type of therapy that incorporates mindfulness practices such as meditation, self-expression (through

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[62] Ibid.

[63] C. Gorst-Unsworth and E. Goldenberg "Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared to social factors in exile," *The British Journal of Psychiatry* 172, (1998): 90-4. Accessed November 4, 2017, https://www.ncbi.nlm.nih.gov/pubmed/9534840.

writing, art, and dance) and group support to combat mental health disorders. This organization has worked with refugees in Kosovo, Gaza, and presently the nations neighboring Syria to integrate mind-body reforms into traditional mental healthcare practices, and the results have been positive. The techniques used by the center are relatively simple: the leader teaches slow deep breathing, which "after five minutes gives most people who are overwhelmed and powerless a direct, often singular, experience of being able to calm the agitation and anxiety that are hallmarks of post-traumatic stress."[64] The premise of the center is that there is no overarching cure for disorders like PTSD, but that small exercises like deep-breathing and periods of laughter (even if forced) will help to alleviate feelings of powerlessness. The full program includes practices such as biofeedback and yoga which seek to help lessen mental illness symptoms in a cost-effective, easy-to-teach set of methods. And the results have proven positive. In one study, completed at a postwar Kosovo high school, "the percentage of students having symptoms indicating mild to severe levels of PTSD dropped from 88% before the program to 38% following the program."[65] Another survey, taken in Gaza after administration of mind-body programming, showed that 56% of PTSD scores and 29% of depression scores in children were lowered.[66] Though this type of treatment is relatively new and not widely integrated into current responses, it is worth mentioning the significant success it has experienced in places where it is

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[64] James Gordon, "For Syrian Refugees, a Mental Health Emergency," *The Atlantic*, last modified March 20, 2013, https://www.theatlantic.com/health/archive/2013/03/for-syrian-refugees-a-mental-health-emergency/274176.

[65] James S. Gordon et al., "Treatment of Posttraumatic Stress Disorder in Postwar Kosovo High School Students Using Mind-Body Skills Groups: A Pilot Study," *Journal of Traumatic Stress* 17, no. 2 (2004): 143-147, accessed November 4, 2017, https://cmbm.org/wp-content/uploads/2016/07/PTSD-in-Postwar-Kosovo-Pilot-Study.pdf.

[66] JK Staples, JA Abdel Attai, and JS Gordon, "Mind-body skills groups for posttraumatic stress disorder and depression symptoms in Palestinian children and adolescents in Gaza," *International Journal of Stress Management* 18, no. 3 (2011): 246-262.

currently being implemented. Reform is necessary in order to address the overwhelming mental health needs of Syrians both now, as refugees, and in the future when the war ends and the process of rebuilding begins. Because funding will inevitably be limited, ideas such as those promoted by the Center for Mind-Body Medicine will be essential to consider as part of a larger response.

One such response is the reform currently occurring in Lebanon, discussed briefly earlier, during which the Lebanese government and healthcare sector have coordinated to improve Lebanon's entire mental health sector in response to the influx of Syrian refugees. The National Mental Health Programme (NMHP), established in 2014, has attempted to change the way mental health is treated and improve treatment overall. According to its website, the program:

> "…has been working on many fronts: integration of mental health into primary care, engaging universities and scientific societies, mapping of the mental health system in Lebanon, developing key documents for mental health, to name a few. In addition, the MOPH [Ministry of Public Health] established and is currently chairing the Mental Health and Psychosocial Support Task Force (MHPSS TF). Co-chaired by WHO and UNICEF, this task force includes around 40 organizations working on the Syrian Crisis response in Lebanon with the aim of harmonizing and mainstreaming MHPSS in all sectors and improving access to care."[67]

The task force mentioned above is also focused on coordinating between agencies to utilize their various strengths as part of the overall goal. The goal itself is "to ensure the

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[67] "The National Mental Health Program," *Republic of Lebanon Ministry of Public Health*, accessed November 4, 2017, http://www.moph.gov.lb/en/Pages/6/553/the-national-mental-health-program.

development of a sustainable mental health system that guarantees the provision and universal accessibility of high-quality mental health curative and preventive services through a cost-effective, evidence-based and multidisciplinary approach, with an emphasis on community involvement, continuum of care, human rights, and cultural relevance."[68] It is one thing to announce an objective, of course, but the important conclusion is whether or not the Lebanese ministries have been keeping their promises. Though it remains to be seen how well they are implemented, the plans have been far-reaching and significant. Specifically, Lebanon is creating a user association, which will be led by people who have suffered from mental illness, and will advocate for the rights of those with mental illness while monitoring the NMHP overall. Additionally, to accompany expensive, private, long-stay psychiatric wards which are typically unneeded for the average patient, the Ministry will pilot a publicly-available online program designed to help users manage symptoms of distress. Finally, the NMHP is "fighting to improve access to both preventive and curative mental health services for vulnerable groups," such as refugees.[69] Facing the Syrian refugee crisis, Lebanon chose to use it as motivation to restructure and improve its mental health system. The reforms are practical and seek to solve obvious weaknesses in the current health structure. Furthermore, Lebanon is expanding its research into mental health, with an emphasis on stigma reduction and cultural adaptation of treatments, stating "it is not enough to implement evidence-based treatments that are effective in other cultures. In Lebanon, for instance, research is being conducted into the effectiveness of

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[68] "Humanitarian Crisis and Mental Health Reform in Lebanon," *The Mental Health Innovation Network*, accessed November 4, 2017, http://www.mhinnovation.net/innovations/humanitarian-crisis-and-mental-health-reform-lebanon.

[69] Nour Azhari, "Syrian Refugee Crisis a Trigger for Mental Health Reform," *The Daily Star*, last modified April 20, 2017, http://www.dailystar.com.lb/News/Lebanon-News/2017/Apr-20/402567-syrian-refugee-crisis-a-trigger-for-mental-health-reform.ashx.

interpersonal therapy as a treatment for depression."[70] This recognition that methods of therapy utilized effectively elsewhere might not be universally applied, but rather that cultural considerations are imperative to successful treatment.

V. Conclusion

Though the cases discussed above represent only a small segment of current responses, it is beyond the scope of this thesis to address all of the programs currently in operation. Instead, this paper has provided several examples of programs that have experienced success to highlight strategies that may be beneficial if implemented on a wider scale. Furthermore, the case studies in Tucson, while not comprehensive, allow for an in-depth look at some of the ways smaller organizations are attempting to address mental health for refugees without requisite funding or established mental health programs. At the time of this writing, however, the war in Syria is ongoing, and refugees continue to flood into neighboring countries at unsustainable rates. Their mental health is important, yet too often ignored, and the crisis overall is underfunded and underpublicized. Targeted reforms that focus on mind-body wellness practices, sustainable models such as those currently being implemented in Lebanon, and community resilience need to be implemented as soon as possible to mitigate the ongoing mental health epidemic present throughout the Syrian refugee population. Even if funding is not present, which is too often the case, creative tactics are available that will provide some relief. For Syrians to have any hope of reintegration in the future—in their own country or abroad—these concerns need to be addressed without delay.

[70] Ibid.

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