Karama means dignity: Ecological factors affecting adaptation to displacement among Syrian refugees living in Jordan

ABSTRACT

People who have been displaced to Jordan by the ongoing conflict in Syria may face multiple challenges including exposure to conflict, forced migration, as well as ongoing daily stressors such as lack of access to basic rights and resources. This thesis explores the ways in which the discipline of clinical psychology may be prepared to assist members of the Syrian refugee community to respond to these challenges. Following initial examination of academic literature regarding cross-cultural validity of psychological constructs, a theoretical model was generated from qualitative synthesis of psychosocial needs reported by Syrians in Jordan, obtained through systematic search of grey literature. Three field work trips to Jordan were undertaken between 2013-2016 in which the author conducted interviews with Syrian and Jordanian psychosocial workers who were key informants regarding factors affecting uptake and implementation of psychosocial services for Syrian refugees in Jordan. Grounded theory analysis generated a model describing how the crisis has led to changes in attitudes to mental health care within the community. The Community Readiness Model was used to understand community level stage of change to guide implementation of a participatory action program to train local psychosocial workers in clinical psychology skills. Finally, an ecological framework was employed to build a theoretical model to guide future research and practice with displaced communities. Throughout, the analysis was shaped by the emergence of key concepts used by participants to describe reactions to the crisis of conflict and displacement including *Karama* (dignity) and *Sadme* (shock). The foregrounding of these concepts is integrated into an ecological framework which may help to broaden the scope of clinical psychology formulation to include more of issues of central importance to members of the Syrian refugee community in Jordan.

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TITLE PAGE

Ruth Wells

Karama means dignity: Ecological factors affecting adaptation to displacement among Syrian refugees living in Jordan

Faculty of Science

The University of Sydney

A thesis submitted to fulfil requirements for the degree of Doctor of Philosophy

This is to certify that to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Ruth Wells

CHAPTER 1:

INTRODUCTION: A PARTICIPATORY RESEARCH PROGRAM IN THE SYRIAN REFUGEE COMMUNITY IN JORDAN

CHAPTER 1: INTRODUCTION: A PARTICIPATORY RESEARCH PROGRAM IN THE SYRIAN REFUGEE COMMUNITY IN JORDAN

The chapters of this thesis represent a journey taken from an initial starting point of seeking to understand how psychological therapies may need to be culturally adapted to meet the needs of Syrian refugees living in countries of first asylum. The selection of Jordan as a case country for fieldwork enabled the building of links with Syrian refugee psychosocial workers who were working to address the needs of the local Syrian refugee community. Through qualitative interviews and participatory engagement I came to understand the need to broaden my focus from a project to culturally adapt existing individualised psychological therapies, to a more sustained engagement that explored the challenges faced by displaced Syrians within ecological context. I began to see that understanding needs as described by people working on the ground and working to support these people to address those needs would be more useful than seeking to impose a biomedical framework. This thesis is an attempt to give voice to knowledge imparted by these people, to synthesise this within a scientific framework and to use qualitative research methodologies to engage in participatory action.

The political uprising in Syria began as peaceful protests in 2011 (Yazbek, 2012) but these calls for political participation were swiftly and brutally repressed (Halasa, Omareen, & Mahfoud, 2014). Decades of systematic propaganda engineered to erode civic life (Wedeen, 2015) and entrench sectarian divisions (Van Dam, 2011) was mobilised, along with considerable international military intervention leading to the development of full scale war. Over 500, 000 people have lost their lives (SOHR, 2018), over 5 million refugees have left the country, and 6 million people have been internally displaced (UNHCR, 2017b). The majority of refugees remain in surrounding countries such as Jordan, Lebanon and Turkey, where resources to address their health needs are often limited (Murshidi, Hijjawi, Jeriesat, & Eltom, 2013). At the beginning of this research project in 2013 there were approximately 490,880 refugees (United Nations, 2013) living in Jordan. That number has now grown to over 600,000 Jordan (UNHCR, 2017b). The majority of these Syrians live in the host community, where services to address their needs may be limited (Murshidi et al., 2013). Many have been subjected to

an array of potentially traumatic events (PTES) (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). The routine use of torture by the Syrian government (Human Rights Watch, 2012), and the likelihood that those fleeing may have witnessed human rights violations, the deaths of community or family members or experienced situations where they feared for their safety (CARE, 2013) are all risk factors for trauma related pathologies (Silove, 1999; Steel et al., 2009).

THE BROAD FOCUS OF THIS THESIS

Rationale for research: In this rapidly changing context there is a need to address the most basic needs of displaced people. In addition, mental health issues in the local context are often poorly understood. There are cultural, social and economic factors which shape the ways that psychosocial services may be implemented and received by the local population on the ground. There is a need for greater understanding of how factors specific to the Syrian refugee community in Jordan impact on the uptake and implementation of psychosocial services. It is only from such a foundation that appropriate interventions may be designed. In addition, there is a need to include members of this Syrian refugee community in this process, along with people in the Jordanian host community, to help ensure both that the findings are congruent with their perceived needs and that community members may be engaged in the action which flows from those findings.

Aims: This thesis employs qualitative research methodologies to explore:

a) The need for cross cultural validity along with psychosocial needs
b) Concepts of distress and wellbeing
c) Community readiness

as described by Syrian refugees living in Jordan.

Findings will be synthesised into a framework for psychosocial intervention which focuses on understanding how displacement impacts on adaptation in ecological context, broadening the focus of clinical psychology to include a wider range of contextual factors.

THE STRESSORS OF DISPLACEMENT ARE A MAJOR DETERMINANT OF DISTRESS

In addition to exposure to PTEs during conflict and flight, refugees are also exposed to considerable stressors in the displacement environment which often compound the psychological impacts of war (Chapter 6). Theorists have called attention to a tradition in psychology which has tended to focus on the impact of discrete PTEs on the prevalence of posttraumatic stress disorder (PTSD) (Ryan, Dooley, & Benson, 2008), while ignoring the ongoing exposure to human rights violations often observed in displacement and associated wide ranging psychological outcomes. Some have argued these stressors may be more personally and culturally meaningful to refugees (Summerfield, 1999b). The work of Miller and Rasmussen (Miller & Rasmussen, 2010; Miller & Rasmussen, 2014; Miller & Rasmussen, 2017) has done much to bring both the medical model with its focus on the diagnosis of PTSD and psychosocial focused research traditions together, highlighting the ways in which ecological factors impact on adjustment within the displacement setting (Silove, 2013).

THE COMPLEXITIES OF THE REFUGEE EXPERIENCE ARE POORLY UNDERSTOOD WITHIN A MEDICAL FRAMEWORK

The refugee experience can lead to complex trauma pathology (Mollica, 2008) yet refugee mental health is poorly understood (Tol, Barbui, et al., 2011). Estimates of PTSD amongst conflict affected populations range from 0 to 99% (Steel, Chey, Marnane, Bryant, & Ommeren, 2009) while clinical research is primarily focused on non-refugee western populations (Tol & Van Ommeren, 2012). This lack of specificity in detecting PTSD diagnosis in these settings may be due to both a lack of appropriate cultural adaptation of measurement

tools, and the likelihood that measurement of symptoms of PTSD in situations of ongoing threat may capture normal reactions to acute stress, rather than psychopathology (Silove, 1998).

CULTURAL FACTORS IMPACT ON UPTAKE AND IMPLEMENTATION OF PSYCHOSOCIAL SERVICES

In order to promote care seeking, available treatment models need to be congruent with local understandings and expressions of distress. The expression of psychological distress differs between cultures (Rasmussen, Katoni, Keller, & Wilkinson, 2011). A culturally informed analysis is required in order to understand how these idioms of distress can be integrated into existing models to improve treatment (Rechtman, 2016). For example, Hinton (Hinton, Pich, Chhean, Safren, & Pollack, 2006) incorporated detailed knowledge of the cultural meanings of internal sensations for Cambodian refugees into Wells' model of panic (McKay, 2009) to develop an effective cognitive behaviour therapy (CBT) protocol for this population (Hinton, Hofmann, Pollack, & Otto, 2009). It is necessary to integrate culturally specific meanings into treatment formulation (Kleinman, 1988) yet common measures (e.g. the Beck Depression Inventory (BDI)) can fail to identify symptoms in non-majority populations (Nicolas & Whitt, 2012) as items may lack cultural relevance.

To promote acceptable and effective care, we need to understand perceptions and attitudes regarding mental health problems in the Syrian refugee community. Expressions of distress are shaped by culturally specific idioms of distress and explanatory models of illness which impact on care seeking behaviour (Kleinman, 2008). At the outset of this research project, there was very limited research on psychological functioning or sociocultural factors affecting uptake and implementation of psychosocial services in Syrian populations (Hassan et al., 2016), and even less specific to displacement experiences. Data from Za'atri refugee camp in Jordan in 2013 indicated that 0.002% of approximately 100,000 camp residents presented to available clinics offering assistance for mental health difficulties within a biomedical framework in a 1 week period (Calvo & Burton, 2013), possibly indicating that many people experiencing distress did not choose to seek care within a medical framework.

There have been no population level epidemiological studies of mental disorder in Syria. Where mental health problems have been identified within the broader context of neighbouring countries, there is evidence of limited care seeking (Gearing et al., 2013). World Health Organisation epidemiological study among a nationally representative sample of 2857 adults in neighbouring Lebanon (Karam et al., 2006), found that exposure to two or more traumatic war events significantly elevated the odds of developing a mental disorder, yet only 10.9% of those with disorders sought care. In order to appropriately identify and treat mental health issues among people from this region, we need to understand what factors will influence how people seek help for mental health disturbance (Tol, Patel, et al., 2011).

A thorough understanding of how cultural factors affect patient's conceptualisation of the aetiology of psychological disorder is required to design mental health programs which are perceived to address the needs of the local population, yet prior to the conflict, research with people from Syria was very limited. One study among 450 university students in Douma, close to the capital Damascus, using an Arabic version of the BDI and a health information questionnaire, found that while 35% reported moderate to severe depression on the BDI and 31% endorsed having current mental health problems, only 1% had sought care (Goncalves, Zidan, Issa, & Barah, 2012). Another, among 412 low income women in Syria's second largest city (Aleppo) in primary health care settings, found high rates of psychiatric distress (55.6%) as defined by a 7/8 cut off on the Self Reporting Questionnaire 20 (Harding et al., 2009). Psychiatric distress was associated with illiteracy, polygamy and physical abuse (Maziak, Asfar, Mzayek, Fouad, & Kilzieh, 2002a). The authors hypothesized that low uptake of mental health services was a result of stigma, however they did not measure this. Another possible explanation is that people did not perceive the available mental health services to be relevant to their psychosocial needs.

COMMUNITY LEVEL ASSESSMENT MAY HELP TO ENSURE THE RELEVANCE OF SERVICES

Community members must believe that health services can address their specific needs in order for them to engage with services. The Community Readiness Model (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000) draws on the Transtheoretical Model's stages of change (Prochaska & De Clemente, 1982) to assess a community's resources and preparedness to address local issues while taking group processes into account. The guiding framework draws on the knowledge and skills of key informants and operates on the assumption that change is best achieved when community members and leaders recognise the presence of a problem. Readiness to change is assessed through a semi-structured interview. Through the combination of readiness assessment and more open-ended interview questions, this research used the community readiness model as a tool to engage with psychosocial actors within the Syrian refugee community in Jordan to determine appropriate modalities and therapeutic techniques which may encourage community engagement.

THE CURRENT RESEARCH

In summary, this PhD research program was conducted contribute to our understanding of Syrian perspectives on mental health care. Despite the poor evidence base, action was underway to provide psychosocial support to Syrians from both international humanitarian and local grassroots Syrian and Jordanian organisations. Therefore, I sought to study how attitudes to mental health, cultural modes of help-seeking and practical barriers influenced uptake and implementation of psychosocial services. I did this in the process of supporting action at a grassroots community level. To do this, I chose Jordan as a case country, as it is small and accessible to foreigners. I aimed to promote access to culturally appropriate mental health care by building the capacity of a local, grassroots, sustainable mental health organisation in Amman, the capital city of Jordan. In the process, I sought to use grounded theory to develop data-based theories about how cultural factors may influence Syrian refugee interactions with psychosocial services.

This thesis is comprised of a literature review and five publications which represent a journey taken between 2013 and 2018. This included three field trips to Jordan. The first was a 6-week trip in December 2013 which

involved conducting 22 semi-structured qualitative interviews with Syrian and Jordanian psychosocial activists regarding cultural factors affecting uptake and implementation of psychosocial services for Syrian refugees in Jordan. The interviews were guided by the community readiness model (Jarpe-Ratner et al., 2013) in order to determine a focus and develop partnerships for future participatory action and capacity building work. During 2014 I focused on reviewing the relevant literature (presented in Chapters 2, 4, and 5), which also culminated in the publication of a theoretical examination of reasoning principles impacting measurement validity in cross-cultural settings (Chapter 3).

SYSTEMATIC REVIEW OF PSYCHOSOCIAL NEEDS REPORTED BY SYRIANS LIVING IN JORDAN

Between 2014 and 2015, I undertook a systematic review of psychosocial needs assessments conducted by humanitarian organisations working with Syrian refugees in Jordan (Chapter 5). This paper was a response to the lack of evidence in the peer review literature regarding the psychosocial needs of Syrians, an understandable lack given the time and resources needed to publish in peer reviewed journals and the recent nature of the crisis. Humanitarian organisations utilise rapid needs assessments as tools to design psychosocial programming, and these are made publicly available. Since these findings could be important for determining public policy, I decided that synthesising and presenting these findings within a scientific framework may aid in this process. In addition, I took the opportunity to assess the methodological quality of assessment techniques commonly used in the humanitarian organisation space and make recommendations for improvements.

COMMUNITY READINESS TO ADDRESS PSYCHOSOCIAL NEEDS

Between August 2015 and January 2016, I conducted fieldwork in Jordan. Drawing on the findings from my first trip, I used the community readiness model as a tool to develop a capacity building program. Results from the CRM indicated that psychosocial programs were up and running, responding to the large increase in need in response to the crisis. However, many local staff reported becoming overwhelmed and burnt out

due to a lack of training, resources and supervision. In response, we designed a clinical skills training program to be implemented within a grassroots Syrian psychosocial organisation. In a focus group conducted in September, staff members requested training in CBT skills, so I undertook to design and implement a training program along with a member of my supervisory team, Associate Professor Catalina Lawsin. Together we conducted the course in Amman, Jordan in November 2015 and provided ongoing supervision via skype for a period of 6 months. In addition, we worked closely with organisation management to design procedures which would help improve internal referral pathways within the organisation and ease staff workload. This work is briefly discussed in Chapter 8 in the context of the Community Readiness Model. This participatory action served to build reciprocal relationships with research participants to support ongoing research, and the outcomes of the training will not be discussed in detail in this thesis.

EXPLANATORY MODELS OF DISTRESS AND HELP-SEEKING BEHAVIOUR

During 2015 I continued to develop thematic elements from the first round of interviews. Using a grounded theory approach (Charmaz, 2014), I presented emerging theoretical models to interviewees to obtain feedback. This iterative process resulted in large changes to my ongoing coding and analysis procedures. In 2016 I published my first article resulting from these interviews (Chapter 7). This paper focused on exploring how the ways in which Syrians understood, perceived and explained distress in response to the crisis influenced care seeking behaviour. I presented a model explaining how changes in attitudes to mental health had resulted in normalisation of mental health concerns within the community, leading to increases in help-seeking.

The findings from the community readiness model assessment are presented together with outcomes from the training program in Chapter 8. In this paper, I highlight the usefulness of this approach for rapidly determining needs within a crisis setting, taking into account community attitudes, resource availability and community preparedness to engage with psychosocial programs. I provide further detail and context for

these findings with a thematic analysis of the interviews and focus group. I also draw attention to the utility of this approach in developing links and networks with the community to promote future action and discuss the ways that research can be considered a first step in participatory engagement.

AN ECOLOGICAL MODEL OF PSYCHOSOCIAL ADAPTATION IN DISPLACEMENT

Between August and December 2016, I spent a further 6 months in Jordan developing my theoretical approach further and conducting interviews until it became apparent that no new themes were emerging. During this period, I began to apply some of the emerging concepts within an ecological framework. I worked to draw together models of psychosocial functioning from the traditions of community psychology, resource-based theories, cognitive behavioural approaches and global mental health. This deeper engagement with both theoretical concepts and the qualitative data culminated in the final publication in this thesis (Chapter 9). In this chapter I attempt to synthesise theoretical approaches to post-displacement adaptation to provide a model of how adaptation may occur in ecological context. My aim is to provide a detailed framework which can guide future research and clinical formulation among displaced populations.

CONCLUSIONS

In Chapter 10 I engage in some critical examination of my own position as a researcher. I discuss the alternative methodological paths I could have taken, while reflecting on the ways in which the process of conducting this qualitative research has enabled me to develop my voice as a clinician, community psychologist and critical theorist. I discuss the ways in which the clinical, personal and political journeys I went on have contributed to the nature of this research project. In the discussion (Chapter 11), having summarised the main outcomes and findings of the research as a whole, I detail my plans for future research, especially focusing on broader morbidity prevention strategies for both psychological and physical health. I also explore the difficulties involved in providing psychosocial care in contexts where people are exposed to ongoing threat and rights violations.

CHAPTER 2:

THE CULTURAL AND POLITICAL CONTEXT OF PSYCHOSOCIAL INTERVENTIONS FOR SYRIAN REFUGEES: A LITERATURE REVIEW

CHAPTER 2: THE CULTURAL AND POLITICAL CONTEXT OF PSYCHOSOCIAL INTERVENTIONS FOR SYRIAN REFUGEES

As a first step to examining the need for cultural adaptation of psychological therapies for Syrian refugees, this chapter explores the existing psychological research among refugee and post-conflict populations. Firstly, I examine the context and likely consequences of the conflict in Syria. This is followed by an examination of the psychological category of posttraumatic stress disorder (PTSD) and whether this is an appropriate frame to assist with understanding the refugee experience. This includes a discussion of the ways in which repeated human rights violation, torture and complex trauma may lead to a broader range of psychosocial challenges than those typically described within the discourse on PTSD. Finally, I examine the validity of applying the category of PTSD to culturally and linguistically diverse populations and describe some transcultural psychiatry critiques of this process.

SECTION 1: THE PSYCHOLOGICAL EFFECTS OF WAR AND DISPLACEMENT

"In the encounter with tortured refugees, therapists may be brought close to unfathomable cruelties and evil and at times may find themselves in the uncertain position of trail-and-error learning in adjusting the treatment to the unique qualities of each client. Nevertheless, the significance of trying to contribute even a modicum of balance and redress on the scale against the widespread inhumanity to one's fellow man and woman makes the effort one of psychology's more important mandates"

(Gorman, 2001)

The United Nations (UN) has labelled the Syrian conflict the worst humanitarian crisis in the 21st century (Lancet, 2014). It has displaced over 9 million people and led to the deaths of over 500,000 (SOHR, 2018). The UN conservatively estimates at least 650,000 Syrian refugees in Jordan (UNHCR, 2018), many living in the host community (Murshidi et al., 2013). While some families found accommodation with family living in Jordan, most Syrians live in rented apartments in urban centres or in makeshift settlements outside official refugee camps . Many Syrians have witnessed atrocities as a result of the conflict. These include bombings, chemical attacks, arbitrary arrest and torture (including torture of children) (Hassan et al., 2015), sexual abuse and humiliation (Ouyang, 2013). Displaced Syrians face these challenges in the context of living conditions in which they may have difficulty satisfying their basic needs and are isolated from support structures (Taleb et al., 2015), further affecting both physical and psychological health (Hassan et al., 2015).

In the context of such a crisis, myriad international actors are seeking to address the psychological needs of Syrians. However, two key issues affect the validity, efficacy and social justice of such efforts. Consideration of the cultural validity of psychological intervention strategies and the role that they play in either challenging or maintaining unequal power structures is a necessary first step. This review begins with a brief outline of

the research concerning psychological outcomes of traumatic experiences related to conflict. In the second section, models for approaching transcultural practice in psychiatry and psychology are explored, along with an examination of Syrian and Arabic cultural factors which may influence expression of distress and service utilisation. Chapter 4 examines the political context of international humanitarian psychological intervention, including the processes through which such programs are evaluated. Finally, Chapter 5 four outlines key participatory methodologies which may help to mitigate structural power inequalities and improve validity in both psychosocial research and practice.

THE CRISIS IN SYRIA

Syria is a lower middle-income country (M. Abou-Saleh & M. Mobayed, 2013a) with a population of approximately 22 million (Taleb et al., 2015). Ethnic groups include majority Arabs (90%) along with Kirimanji-Kurdish, Armenians, Turkmen and Circassians. There is also wide religious diversity, with the majority of the country being Sunni Muslim followed by Alawites, Christians, Druze, Ismailies and Shiites (Hassan et al., 2015). Syria has a long history spanning 4000 years during which the capital city of Damascus has been contested by successive Persian, Greek, Roman, Egyptian, Turkish and French empires (Hourani, 2013). Damascus is the resting place of Salah al-Din, the revered leader who unified the Arab response to the European crusades, a source of cultural pride (Maalouf, 1984). During the French mandate following World War I, France stoked sectarian and ethnic divisions as a divide and conquer tactic to suppress revolt. The great Syrian Revolt of 1925 began in the remote southern towns of Dera'a and saw France destroy much of Damascus with aerial bombardment (Provence, 2005). A period of instability following World War II culminated in a coup in 1963 in which Hafez al-Asad founded a regime which exists to this day under his son Bashar al-Asad. While presenting itself as a secular, pan-Arab force, and with ongoing support from Russia, the Asad regime has subtly continued the French tactics to entrench sectarian and ethnic divides in order to maintain power. This has included brutal repression of dissent, for example, the massacre of tens of thousands in the city of Hama in 1982 (Van Dam, 2011).

The events of 2011 echoed elements and symbols of this history, interconnecting with complex geopolitical forces which have led to a conflict which is likely to continue. As in 1925, protests began in Dera'a. The regimes response to a peaceful protest movement which aimed to enable Syrian citizens to participate in civil society, recalled Hama of 1982, which became a rallying cry to continued dissent (Abbas, 2014). The violent assault on a historical heartland of Sunni Muslim power and prestige known as *Bilad al-Sham* centring in Damascus, by Asad's minority Alawite (Shia) Muslim government, has led to growing involvement of regional Sunni power brokers (e.g. Saudi Arabia, Qatar) and foreign Sunni fighters. Meanwhile, Iran has invested heavily in ensuring that Syria remains in Shia control (Filkins, 2013). The Syrian intellectuals and activists involved in the 2011 peaceful uprising, who fought so hard to contradict cultural tropes of Arabic peoples as inherently violent and fractured (Yazbek, 2012) have had to watch as their democratic aims are subverted by those who seek to benefit from violence. The scale of violence in the conflict has important implications for how Syrians interpret their current plight. As the conflict continues, it is increasingly difficult to maintain feelings of hope that can frame loss within a meaningful narrative which promotes emotional health.

PSYCHOLOGICAL CONSEQUENCES OF WAR AND DISPLACEMENT

Research and understanding of refugee mental health is in its development (Nickerson, Bryant, Silove, & Steel, 2011) and clinical research on the effects of trauma is primarily focused on non-refugee western populations (Tol & Van Ommeren, 2012). Estimates of Posttraumatic Stress Disorder (PTSD) amongst refugees vary wildly (Steel et al., 2009). Research comparing displaced, war-affected populations to non-refugees indicates elevated levels of psychopathology (Porter & Haslam, 2005), yet there is no psychological treatment for refugees which is firmly supported by a strong evidence base (Crumlish & O'Rourke, 2010, Palic & Elklit, 2011).

THE CATEGORY OF POSTTRAUMATIC STRESS DISORDER

The psychological category of posttraumatic stress disorder (PTSD) has emerged from recent Euro-American history, which has variously accepted and denied the impact of serious threat to life, safety and identity on long term psychological outcomes (Herman, 1997). Following the World Wars and the Vietnam war, a syndrome in response to trauma began to gain increased attention. In the third diagnostic and statistical manual of disorders (DSM-III), the category of PSTD subsumed diverse collections of symptoms observed in survivors of rape, domestic violence, child abuse and military service (Van der Kolk, Weisaeth, & Van der Hart, 1996). Current DSM criteria for PTSD include exposure to threat of death, injury or sexual violence; intrusive symptoms, such as re-experiencing, distressing dreams, recurrent memories; avoidance of trauma reminders; cognitive and mood alterations, such as memory disturbance, anger, guilt, shame, estrangement, anhedonia; physiological arousal; and may or may not include dissociative reactions. Theorists have sought to explain PTSD on the basis of classical conditioning of fear responses to stimuli associated with the traumatic event (Keane, Zimering, & Caddell, 1985); emotional processing theories (Foa & Kozak, 1986) which posit that pathological fear systems are activated by neutral stimuli and that this can be ameliorated by incorporating new, more accurate information into the fear system; and cognitive theories (Ehlers & Clark, 2000) which highlight the role of appraisals of traumatic experiences in leading to elevated threat perceptions. Key elements of traumatic experiences which lead to PTSD are the interpretation of the event as directly threatening; marked arousal, which interferes with emotional and cognitive processing and leads to ongoing over activation of fear circuits including the amygdala (Shin et al., 2004); negative appraisals about the self and the world (Nickerson, Priebe, Bryant, & Morina, 2014); and behavioural reactions, such as avoidance, which reinforce the perception that threat is current (Oflaz, Hatipoglu, & Aydin, 2008).

EFFECTS ON HUMAN DEVELOPMENT

Trauma and chronic stress during childhood can prevent the development of emotion regulation (Van der Kolk, 2017) and lead to neurological, psychological, social and cognitive impairments (Herman, 1992). Across diverse populations, childhood trauma is associated with later development of a wide range of mental health disorders (Kessler et al., 2010; Szymanski, Sapanski, & Conway, 2011), including psychosis (Read, Os, Morrison, & Ross, 2005). Chronic exposure to stress in childhood, whether concerning intense fear induced by intentional harm or an absence of nurturing experienced in neglect, may lead to abnormal physiological responses to environmental events, due to sensitisation of the hypothalamic-pituitary-adrenal axis (Gould et al., 2012). One possible mechanism for this may be that prolonged stress leads to excess glucocorticoid secretion, which may impair neurogenesis and neural plasticity, particularly in brain regions with long periods of postnatal development, such as the prefrontal cortex and the hippocampus, which are crucial for cognitive, emotional and social functioning (Pechtel & Pizzagalli, 2011). Cognitive deficits, such as impaired inhibitory capacity (Noble, Tottenham, & Casey, 2005), and lower IQ have been observed in both people who have experienced childhood trauma in a dose-response relationship which is independent of genetic factors (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003). Childhood trauma is associated with reduced overall cerebral, prefrontal, hippocampal and corpus callosum volume (De Bellis et al., 2002).

RESPONSES TO TRAUMA

Traumatic reactions are the result of a complicated array of interpretations of the meaning of the traumatic event and the individual's role in it (Ajdukovic et al., 2013). For example, Gorman argues that there is no definitive symptom profile for individuals who have experienced torture, rather symptoms will be shaped by culture and individual coping patterns as people find a way to cope with what has happened (Gorman, 2001). The following is a discussion of common emotional reactions and sequelae of traumatic events.

RESILIENCE

The majority of people who experience trauma do not develop psychological pathology, rather innate healing systems can promote resilience (Mollica, 2008). Trauma can lead to posttraumatic growth as it provides opportunities to modify worldviews and integrate the trauma experience into new understandings of the world and the person's place in it (Hijazi et al., 2014). Research among displaced populations has highlighted personal connections, personal qualities, collective identity and religion as promoting resilience (Siriwardhana, Ali, Roberts, & Stewart, 2014). The nature and interpretation of these interpersonal connections has been shown to be important in recovery. For example, Ajdukovic and colleagues (Ajdukovic et al., 2013) interviewed refugees who had previously been diagnosed with PTSD, approximately 10 years following the conflict in the former Yugoslavia. They found that reciprocity in friendship, rather than dependence on others, and future oriented coping were associated with recovery. Having social connections may not be sufficient to promote health; individuals need to be able to integrate this into a frame of meaning which supports self-efficacy and self-esteem. A greater focus on a wider range of adaptive functions following trauma may help to ensure that research and treatment accurately address the subjective experience of survivors (Silove, 1999).

DEPRESSION

Symptoms associated with depression are a common and normal reaction to loss and situations which destroy hope. Number of potentially traumatic events, torture experiences, time since conflict and current residency have been associated with depression (Steel et al., 2009). Depression may be a useful issue to address in post-conflict settings as it has been found to be more prevalent than PTSD in multiple settings (Cardozo et al., 2004). For example, Mollica and colleagues (Mollica et al., 1993), in a randomly selected sample of 993 adults in a refugee camp on the Thai-Cambodian border, found a prevalence rate of 55% for depression compared to 15% for PTSD. Similarly, Hinton and colleagues found higher rates of depression (11.5%) than PTSD (3.5%) among conveniently sampled Vietnamese refugees in the US (Silove, 1999). Gorst-

Unsworth and Goldenberg found that number of physical tortures and a history of mock execution were more strongly associated with depression than with PTSD (Gorst-Unsworth & Goldenberg, 1998).

ANGER

Trauma, loss and injustice can understandably lead to anger and aggression (Brooks, Silove, Steel, Steel, & Rees, 2011; Nickerson, Priebe, Bryant, & Morina, 2014; Novacoi & Chemtob, 2002; Quosh, Eloul, & Ajlani, 2013) . A sense of injustice as a result of human rights abuses may lead to ongoing rage, a phenomenon which current psychiatric categories fail to describe (Silove, 1999). Refugees with long term chronic PTSD describe ongoing difficulties with regulating anger and describe avoiding social situations due to fear that they will not be able to control angry outbursts (Ajdukovic et al., 2013). Displacement stressors which increase feelings of powerlessness, such as loss of role, can lead to increased interpersonal conflict and domestic violence (Hinton, Rasmussen, Nou, Pollack, & Good, 2009; Wirtz et al., 2013).

GUILT

Survivors often describe feelings of guilt and a sense of collusion in abuse (Gorman, 2001; Hassan et al., 2014). In order to survive in violent contexts, people may be forced to act in ways which contradict their values. What is understandable behaviour in such a context may be difficult to integrate into a coherent identity as life goes on.

"On one of those days in which I was wasting away from hunger and thirst, I remember that I woke up from a disturbed sleep to find my face in one of those pools [another's blood]. I unconsciously started drinking from that blood in order to sooth my thirst. From the moment I got freed until now, I haven't been able to get rid of the feeling of guilt and shame of what I did in that basement."

A Syrian refugee in Lebanon describes his experience being held in prison in Syria.

(Bou Khalil, 2013*, pp. 1396.)*

Considering these feelings of guilt, societal reactions to rights abuses which place the responsibility upon the victim serve to compound the damage. For example, blaming the victim is a reaction to gender based violence

that is common to many cultures, which serves to compound the trauma (Herman, 1997). Van der Kolk argues that violent acts of deliberate harm undermine our sense of safety in the world, as they break the illusion that we can trust others in society. In order to maintain this illusion, and thereby be able to operate as a society, we find a way to argue that the victim is in some way responsible for the crime. We thereby avoid acknowledging that senseless acts of violence can occur in any society (Van der Kolk, Mcfarlane, & Weisaeth, 2012).

Interpretations of the meanings of violence and attributions of responsibility are culturally shaped and dynamic. Atlani and Rousseau (Atlani & Rousseau, 2000) describe how, among Vietnamese refugees, cultural interpretations of rape shifted in response to changing environments which resulted in blaming the victim. While fleeing on boats, women's acquiescence to being raped by pirates was configured as a means to protect their family from further violence. However, once these groups moved into long term refugee camps, rape was reinterpreted as retribution for the wrongs of the women's ancestors, implying moral responsibility lies with the victim. The authors reason that this shift served to displace responsibility from bystanders, who could not intervene in violent contexts, and absolve the group of guilt. In order to move on with self-respect and dignity following traumatic events, everyone must find a way to understand how their actions cohere with their sense of personal and collective identity. Unfortunately this process often recapitulates narratives which maintain inequality.

RESPONSES TO INTENSE AND COMPOUNDED TRAUMA

HUMAN RIGHTS VIOLATIONS

Human rights violations have the potential to cause lasting emotional distress (Silove, 1999). Deliberate harm, as in the case of torture, is specifically designed to demoralise, fragment and destroy interpersonal connections, at the level of the individual and society. It is a highly effective form of social control, as the enduring harm it causes serves as a warning to others (Gorman, 2001). Among Tamil asylum seekers in

Australia, Steel and colleagues (Steel, Silove, Bird, McGorry, & Mohan, 1999) found that, of the conflict related traumatic events associated with posttraumatic symptoms, those related to being detained and abused were most strongly associated with later symptoms. In a subsequent systematic review, torture was the strongest predictor of PTSD symptoms (Steel et al., 2009). This highlights the specific connection between human rights abuses, involving systematic demoralisation such as torture, and posttraumatic symptoms.

COMPLEX TRAUMA

It has been argued that PTSD is an insufficient category to capture the range of experience of people who have been subjected to repeated traumatisation and rights violations (Gorst-Unsworth, Van Velsen, & Turner, 1993; Herman, 1997; Porter & Haslam, 2005). Herman initially described a syndrome of complex trauma in response to subjection to coercive control (Herman, 1992). Symptoms include a range of somatic, cognitive, affective, behavioural and relational reactions (see table 1). Gorst-Unsworth and colleagues (Gorst-Unsworth, Van Velsen, & Turner, 1993) argue that trauma doesn't necessarily lead to pathology, but it will likely have an enduring impact on character and attitude. Among a group of 31 torture survivors they found that more than half reported change in attitudes to the larger system (55%), personal priorities (58%) or religious or political beliefs (58%). A low expectation that torture was likely prior to exposure was associated with feeling different from others (89%) or misunderstood (86%), indicating that a challenge to worldview as a consequence of rights abuses was associated with a sense of estrangement from others.

Table 1. Symptoms Associated with Complex Trauma

	Source	Symptoms
Complex Trauma	(J. L. Herman, 1992)	Somatisation (chronic hypervigilance, headaches, gastrointestinal disturbance, back pain, nausea, choking sensations); Dissociation (trance states, memory disturbance, multiple personality disorder, disruptions in sense of time); Affective changes (depression, insomnia, helplessness, hopelessness, disruptions to attachments, anger, suicidal behaviours); Characterological changes (relationships, identity)
Torture Survivors	Somnier, Vesti , Kastrup & Genefke (1992) citied in Gorman 2001, pp 444)	"pronounced and homogenous patterns of extreme anxiety, impaired memory, intrusive thoughts and impaired concentrations, insomnia and nightmares, emotional disturbances, sexual dysfunction, occupational and social impairment, somatic symptoms, substance abuse, learned helplessness and depersonalisation and dissociation, fear of intimacy and change in identity"
Gender Based Violence	(pp. 1, Garcia-Moreno & van Ommeren, 2012)	"Sexual violence has numerous social and psychological consequences. Social consequences can include: stigma, discrimination, and abandonment. Psychological/mental health consequences range from distress, self-blame and feelings of isolation to a range of mental disorders, including depression, PTSD and other anxiety disorders, suicidal ideation and other forms of self-harm."
Torture Survivors	(Turner & Gorst-Unsworth, 1990)	Disrupted emotional and cognitive processing; Depressive symptoms related to negative life events; somatisation symptoms which are not consistently a result of physical injury; Existential concerns including changes in attitude and effects on intimate relationships.
Cultural Bereavement	(pp. 676, Eisenbruch, 1991)	"Alterations in affect, such as over-expression of anger, behavior, such as risk-taking, thinking, such as persistent pre-occupation with the perpetrator, inability to trust others, and loss of previously sustaining beliefs (absent from the post-traumatic stress disorder)… can be explained as features of the refugee's cultural bereavement, which are not necessarily pathological"" suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade, but finds constant images of the past (including traumatic images) intruding into daily life, yearns to complete obligations to the dead, and feels stricken by anxieties, morbid thoughts, and anger that mar the ability to get on with daily life."
Torture, mass human rights violations and refugee trauma	(pp. 202, Silove, 1999)	"a lack of motivation, affective instability, cognitive impairments, personality change, somatization, extreme forms of anger, guilt and shame, wide ranging interpersonal difficulties, and a tendency to revictimization."

MODELS OF TRAUMA AMONG REFUGEES

Conflict related trauma occurs in a context of disruptions to a variety of social, personal, cultural and political systems which would normally promote health. Eisenbruch (1991) describes a wide range of reactions to trauma among refugees which he terms cultural bereavement. He argues that grief reactions are a non-pathological reaction to loss, in this case a loss of culture. Silove (Silove, 1999) identifies that trauma impacts on a range of adaptive systems, including safety (threat perception), attachment (interpersonal bonds), identity (role function), justice (leading to rage) and existential meaning (shaking belief in meaning systems). They argue that an exclusive focus on the safety system (through treating PTSD) fails to address the other affected systems. Since refugees are likely to experience multiple, compounding traumas (Silove, 1999), this has important implications for treatment, which generally focuses on addressing discrete traumatic events.

Nickerson and colleagues posit a model of psychological reactions to trauma among refugees (Nickerson & Bryant, 2014; Nickerson, Bryant, Brooks, et al., 2011). They argue that refugees experience distinctive forms of trauma (e.g. strategic violence) which lead to conditioned fear responses to trauma reminders. Following initial trauma, refugees are likely to experience ongoing trauma during flight or in places such as refugee camps, as well as multiple ongoing stressors which may prevent natural recovery from trauma. A number of psychological mechanisms may amplify distress, including memory dysfunction (such as re-experiencing), cognitive appraisals (such as negative beliefs about self and the world) and emotional dysregulation (including self-harm and substance abuse), perceptions of control (powerlessness, reduced self-efficacy); disruptions to interpersonal processes (expectations of harm, decreased trust) and challenges to individual and group identity (self-worth, belonging). Importantly, the authors argue that the reality of actual threat and limited power to control outcomes among refugees needs to be taken into account when determining whether cognitive appraisals are realistic or helpful. Through these mechanisms, refugees may develop trauma related disorders (such as PTSD, complex PTSD, depression and substance abuse) and/or other psychological responses (including anticipatory anxiety, guilt or explosive anger).

There is limited evidence for treatment and outcomes among survivors of repeated abuse (Palic & Elklit, 2011). Many treatments for PTSD operate by replacing fear associations to conditioned stimuli with safety associations through providing corrective experiences and reappraising threat. However, this may be problematic in the case of refugees whose everyday lives contain continued threats (Murray & Davidson, 2010; Nickerson, Bryant, Silove, et al., 2011). Risk of gender based violence continues in the displacement setting, as refugee camps are not secure places, and intimate partner violence is often reported (Hassan et al., 2014). Continued threats may take the form of direct danger to safety, ongoing fear for family members still in danger (Nickerson, Bryant, Steel, Silove, & Brooks, 2010), or symbolic loss, such as loss of culture (Eisenbruch, 1991; Nickerson, Bryant, Brooks, Steel, & Silove, 2009).

THE MEASUREMENT OF TRAUMA REACTIONS IN HUMANITARIAN SITUATIONS

There are few studies on the epidemiology of psychological disorders among Syrians (Hassan et al., 2014). Studies among Syrian refugees in camps in 2012-2013 reported very high prevalence of PTSD ranging between 36-62%, , although the authors did not provide details of methodology (Abou-Saleh & Mobayed, 2013). A World Health Organisation epidemiology study among 2857 Lebanese (Karam et al., 2006), found that exposure to 2 or more traumatic war events significantly elevated the odds of developing a mental disorder. In a systematic review of 181 studies among populations exposed to mass conflict, Steel and colleagues (2009) found that prevalence rates for PTSD varied between 0 and 99%. They calculated a PTSD prevalence of between 13-25% among conflict affected populations, when limiting to methodologically robust surveys. The focus on epidemiology of PTSD means that there is scant evidence about prevalence of severe psychological presentations such as psychosis and neuro-organic disorders (Silove et al., 2000).

Notwithstanding the need to devote scarce resources to immediate aid provision in the aftermath of conflict, the epidemiology of psychological disorder in humanitarian settings is faced by a number of methodological

challenges. Across studies, methodological factors account for significant variance in PSTD and depressive symptoms (Steel et al., 2009). PTSD prevalence among refugees has been demonstrated to vary with sample size and sampling procedure. With highest rates in clinic samples, then convenience samples and the lowest in epidemiological sample (Silove, 1999). Varying diagnostic cut-offs, different measurement instruments, sampling bias, varying levels and type of trauma exposure and sample size, heterogeneous refugee populations in resettlement countries (Murray & Davidson, 2010) make it difficult to make general conclusions across contexts (Porter & Haslam, 2005).

It is clear that the effects of trauma have the potential to have a lasting negative impact on individuals and groups, although this will not be the case of everyone involved. Given the limitations to current understanding, how can the mental health consequences of conflict and displacement be adequately addressed? There is considerable debate about how to ensure programs avoid doing more harm than good.

Two key issues to be addressed when designing psychosocial interventions are:

a) Western biomedical concepts of psychological health may not be relevant in other cultures. Their application may lead to misdiagnosis and the pathologising of normal responses to traumatic events.
b) The political and economic impacts of the industry of humanitarian intervention, in the context of a history of colonialism, has the potential to disempower aid recipients

The following is a discussion of how concepts from transcultural psychiatry and participatory action research can be applied in order to mitigate this potential for harm in humanitarian settings.

SECTION 2: THE APPLICATION OF PSYCHOLOGICAL CONCEPTS IN DIVERSE CULTURES

TRANSCULTURAL CRITIQUES OF PSYCHIATRY

In discussing culture as a unit of analysis, it is not assumed that Arabic culture is a single bounded entity. Rather, it is recognised that it is neither homogenous nor static. Culture is a system which responds to a changing environment (Atlani & Rousseau, 2000). Kirmayer (2006) defines culture as practices and codes within institutional settings; as a means of understanding reality and making representations which can influence others; a dynamic system, constructed and shaped through narratives.

Arthur Kleinman presented a major challenge to the study of international psychiatry in his seminal work, *Rethinking Psychiatry* (Kleinman, 1988). He questions western psychiatry's focus on the biological and disease elements of distress at the expense of meaning and illness conceptions (the individual's understanding of their own experience). On the basis of long term ethnographic work, Kleinman proposed a model for understanding how psychiatric phenomena are influenced by universal human characteristics as well as being shaped by cultural conceptions of health, illness and disease. He argued that culturally specific norms inform the way that emotional, cognitive and behavioural phenomena are interpreted, contributing to understandings of what constitutes normal and abnormal within a given society. Each society has its own understanding of the factors which cause distress and psychological pathology; these are explanatory models. These conceptions will, in turn, determine the ways in which distress is expressed. Therefore, each culture will have specific idioms of distress, of which western psychiatric categories are an example. He advocated anthropological approaches which can provide insight into local symbolic meanings that produce the various factors shaping the experience of mental phenomena.

Kleinman provides a list of criteria which may be used to compare and contrast healing systems at the level

of culture. Through this comparison process he identified that all systems employ some form of symbolic healing, but western biomedicine is unique in its place within the larger health system and separation between mind and body. All practitioners "must configure the patient's illness narrative, within his therapeutic system's taxonomy" (Kleinman, 1988:119). Patients and healers co-construct expectations to create a clinical reality which may vary in terms of whether it is sacred or secular, disease or illness oriented, symbolic or instrumental, or in whether they perceive the locus of responsibility for recovery as lying with the patient or the practitioner.

Biological models of PTSD may privilege the role of biology over that of culture in determining psychological adjustment (Eisenbruch, 1991), obscuring their bidirectional relationship (Kirmayer, 2006). Kirmayer (2006) argues for a development of the focus of cultural psychiatry to include examination of a broad range of themes that would likely benefit the understanding of mental phenomena regardless of specific culture. He calls for a multidisciplinary approach which recognises the constructed nature of culture and integrates our understanding of cultural phenomena into models of human biology. He calls upon the field to recognise the impact of interpersonal processes on psychological functioning in a social context and to attend to power structures within which psychiatry operates.

These critiques caution against a culture blind application of psychological principles which seek to employ western conceptions of mental disorder without an eye to cultural context. Despite this, in my experience, clinical psychology training in Australia offers little in the way of serious critique of this Western medical model. As a result, practitioners and researchers trained within such a framework may apply Western psychological categories in ways that may risk causing harm to the people they are seeking to help. The next chapter will explore some logical errors which may occur in this process and lay out some principles necessary to ensure valid assessment of distress in cross cultural settings.

CHAPTER 3:

UNDERSTANDING PSYCHOLOGICAL RESPONSES TO TRAUMA AMONG REFUGEES: THE IMPORTANCE OF MEASUREMENT VALIDITY IN CROSS-CULTURAL SETTINGS

Given the problems associated with attempts to apply psychological diagnostic categories in cross-cultural contexts, the next chapter examines the issue of measurement validity in more detail. In particular, we draw attention to the potential for logical errors if measurement tools are applied in an uncritical fashion. This highlights the need for ethnographic techniques to ensure that the tools we use to measure distress accurately measure what they are intended to. This publication provides a conceptual basis for the need to attend to the perceived needs of community members, and to ground psychosocial programming for displaced populations on a thorough examination of local ecological context, as the empirical papers in this thesis attempt to do.

CHAPTER 3: UNDERSTANDING PSYCHOLOGICAL RESPONSES TO TRAUMA AMONG REFUGEES: THE IMPORTANCE OF MEASUREMENT VALIDITY IN CROSS-CULTURAL SETTINGS [1]

BACKGROUND

The current conflict in Syria has led to the deaths of over 200,000 people (IAS, 2014). There are currently approximately 3.7 million registered refugees in surrounding countries (UNHCR, 2015). Many Syrians have been subjected to human rights violations as a result of the conflict (Hassan et al., 2014; Ouyang, 2013). Displaced Syrian's face these challenges in the context of living conditions in which it may be difficult to satisfy their basic needs, and where they are isolated from support structures (Taleb et al., 2015). In this context, a myriad of international actors are seeking to address the psychological needs of Syrians. However, in a rapidly changing environment, how can we be sure that the tools we use to measure and alleviate distress are appropriate? In order to *do no harm*, we must work to validate our tools. While there is pressure to act immediately in a crisis, ensuring the efficacy of action must remain paramount.

The following is a discussion of factors which affect the validity of psychological measurement tools in humanitarian settings. This discussion is part of an ongoing PhD research program exploring factors affecting uptake and implementation of mental health services among Syrian refugees living in Jordan and Turkey. Our preliminary qualitative research has explored community readiness to address mental health difficulties, cultural factors which influence care seeking behaviour and culturally specific explanatory models used to understand mental health problems among Syrians living in Jordan. The next phase of our research will build on these foundational concepts with a Train the Trainer approach

[1] This chapter is a published manuscript: Wells, R., Wells, D., & Lawsin, C. (2015). Understanding Psychological Responses to Trauma among Refugees: the Importance of Measurement Validity in Cross-cultural Settings. *Proceedings of the Royal Society of New South Wales, 148*, 60–69.

to build the capacity of a Syrian founded mental health organisation serving the refugee community in Turkey.

Scientific Validity

Most of the tools used to measure psychological disorders have been developed among western populations (Kleinman, 1988). In fact, most of the categories employed to understand what constitutes normal and abnormal behaviour may represent culture bound constructs which cannot be meaningfully applied in diverse cultural settings (Summerfield, 1999a). This calls into question both the conceptual framework and scientific validity of research into psychological health among refugees.

In the field of clinical psychology, establishing the validity of psychological categories and how we measure them can be a complicated process. Firstly, we must define what constitutes psychological disorder. Most experiences associated with psychological disorder exist on a continuum within a population. If we take the example of depression, most people experience sadness at some time in their life. However, some people experience such intense feelings of sadness that they find it difficult to cope. They can no longer go to work or participate in healthy relationships. It is a clinician's job to determine whether a given individual's level of sadness is so severe that it may be the product of a pathological process, understand what this process might be and help the person overcome it. Traditionally, psychologists have sought to define psychological pathology by measuring reported experiences and behaviour within a given population, in order to determine what may be considered *normal*. Experiences which fall at the extreme ends of a given continuum are then defined as *abnormal*. As such, the definition of pathology in the field of psychology is a normative exercise, reflecting the values of the culture in which it operates (De Vos, 2011). The category of *psychological*

disorder labels individuals as falling within or without a range which has been classified as *normal* (Plante, 2013).

The purpose of defining and measuring *normality* is so that we can learn more about the underlying processes which contribute to distress. Through the generation of psychological measures, psychologists can discover what kinds of processes are related to psychological disorder. For example, repetitive negative thinking is often associated with depression (Papageorgiou & Wells, 2004), a process for which we now have efficacious, evidence-based treatments (Kenny & Williams, 2007), thereby helping people to overcome depression. The ability of this scientific research to uncover useful constructs relies on the use of valid measures to identify relationships between variables.

Establishing the validity of measures is integral to interpreting empirical data in any discipline. For example, if a biochemist wanted to measure the amount of a certain protein within a sample of tissue, she would require a special tool. She could chose to label the protein with a florescent tag which would light up, enabling her to identify and count the protein. She would first need to ensure that this given tag accurately identifies the protein she is measuring. That is, that her measure is valid. In her field, her data would not be accepted as indicating the presence of the protein unless she used a validated measure. Similarly, in order to be confident that measurement in the field of psychology is accurate, validated measures are required. However, in the case of cross-cultural research, validated measures may not be readily available (Hassan et al., 2014).

PSYCHOLOGICAL CONSEQUENCES OF WAR AND DISPLACEMENT

War and displacement can lead to a complex array of negative psychological outcomes (Mollica, 2008) yet mental health among refugees is not clearly understood (Nickerson, Bryant, Silove, & Steel, 2011; Tol, Patel, et al., 2011) as psychological research into the effects of trauma is primarily focused on non-refugee western populations (Murray, Davidson, & Schweitzer, 2010). Estimates of the prevalence of psychological disorder in humanitarian settings have ranged between 0-99% (Steel et al., 2009). Accurate measurement of prevalence has been hampered by methodological constraints including sample size, sampling procedure (Silove, 1999), and heterogeneous refugee populations (Murray et al., 2010) as well as difficulties in conducting research in crisis situations. Research comparing displaced, war-affected populations to non-refugees indicates elevated levels of psychopathology (Porter & Haslam, 2005), yet there is no psychological treatment for refugees which is firmly supported by a strong evidence base (Crumlish & O'Rourke, 2010; Palic & Elklit, 2011). Research has tended to focus on posttraumatic stress disorder (PTSD). PTSD is a reaction to traumatic experiences characterised by intrusive symptoms, such as re-experiencing the event or nightmares; avoidance of trauma reminders; cognitive and mood alterations, such as memory disturbance, anger, guilt and estrangement; and physiological arousal (Apa, 2013).

Trauma leads to a wide variety of sequelae, including effects on brain development (De Bellis et al., 2002); cognitive function (Koenen et al., 2003); depression (Cardozo et al., 2004); uncontrollable anger (Brooks, Silove, Steel, Steel, & Rees, 2011); and guilt (Gorman, 2001). In the case of individuals who have experienced ongoing and extreme rights abuses, PTSD may not adequately capture the experience of survivors (Gorst-Unsworth, Van Velsen, & Turner, 1993; Herman, 1992; Herman, 1997) In addition, there is limited research which explores individuals' capacities for resilience during the refugee experience (Hijazi et al., 2014). Conflict related trauma occurs in a context of disruptions to a

variety of social, personal, cultural and political systems which normally promote health. Clinical frameworks for understanding refugee mental health need to take into account impacts on cognitive, interpersonal, social and existential functioning (Nickerson, Bryant, Brooks, et al., 2011). A greater focus on a wider range of adaptive functions following trauma may help to ensure that research and treatment accurately address the subjective experience of survivors (Silove, 1999).

Logical Fallacies in the International Application of Western Psychiatric Categories in Diverse Settings

When epidemiologists measure the prevalence of categories like PTSD in humanitarian settings, the interpretation of findings is constrained by the validity of the measures used. In order to arrive at the conclusion that these individuals suffer from the same discrete disease entity as that described in western populations, a number of logical fallacies may have been committed.

Fallacy 1

Arthur Kleinman (1988) identified the category fallacy, the assumption that the identification of symptoms in a different cultural context carries the same significance as they do in western culture. For example, hopelessness in an affluent society in which people have the opportunity to exercise their rights, may be a sign of psychological disorder. However, in a context of continuing loss where "powerlessness is not a cognitive distortion but an accurate mapping of one's place in an oppressive social system" (Kleinman, 1988: 15), hopelessness may be a normal reaction.

Kleinman argued that culturally specific norms inform the way that emotional, cognitive and behavioural phenomena are interpreted, contributing to understandings of what constitutes normal and abnormal within a given society. Each society has its own understanding of the factors which cause distress and psychological pathology. These are explanatory models. These conceptions will, in turn, determine the ways in which distress is expressed. Therefore, each culture will have specific idioms of distress, of which western psychiatric categories are an example.

Since distress may be expressed in a different manner in different cultural contexts, psychological measures which have been validated in one context, may not be valid in another, as items lack cultural relevance and do not include local idioms of distress (Van der Velde, Williamson, & Ogilvie, 2009). For example, the Beck Depression Inventory (BDI) is a measure of depression which has been validated in numerous western samples (Beck, Steer, & Carbin, 1988). However, when (Nicolas & Whitt, 2012) compared qualitative responses of Haitian women to scores on the BDI, they found that these women did not identify with the symptoms on this checklist. That is, the identified symptoms did not carry meaning as expressions of distress within their cultural framework.

FALLACY 2

The assumption that the identification of symptoms associated with PTSD means that individuals have PTSD, may be an example of the fallacy *affirming the consequent*. This error in reasoning takes the form:

If you have PTSD, then you have these symptoms.

You have these symptoms.

Therefore you have PTSD.

Although having PTSD entails having particular symptoms, those symptoms may be the result of causal conditions other than PTSD. For example, recurrent memories and re-experiencing of traumatic incidents may be normative responses in the immediate aftermath of a traumatic event and may in fact be adaptive, as they aid in processing the experience (Gorman, 2001).

Researchers who go into diverse cultural settings and use measurement scales to identify cases of PTSD may be committing this fallacy. The scientifically valid procedure is to first assess the scale for criterion validity in the local context. Criterion validity is established by examining the relationship between scores on the checklist and some external criterion (Van Ommeren, 2003). For example, diagnostic cut-offs for a given checklist are established by comparing scores on the checklist to diagnosis following an in-depth clinical assessment.

Establishing criterion validity in a given community is vital to understanding the contextual factors associated with the identification of a given set of symptoms, and whether or not these symptoms constitute an *abnormal* reaction within that society. The blanket use of unvalidated symptom checklists in humanitarian settings may pathologise reactions to stress, for how are we to determine what a *normal* reaction to an extreme situation is (Eisenbruch, 1991)?

FALLACY 3

Another logical problem arises when the identification of symptoms associated with PTSD is taken as evidence to support the conclusion that PTSD is a cross-cultural phenomenon. This may take the form of *begging the question*, a form of logical fallacy in which truth of the conclusion is assumed in the premise. That is, the person making the argument has assumed that the conclusion they are attempting to prove is self-evident, using it as an axiom to support their argument (Garner, 2001). It

is a form of circular reasoning (not to be confused with its incorrect usage to mean "raises the question"). In this case, researchers who employ western derived measurement instruments to measure PTSD symptoms in diverse cultures and take this as evidence that PSTD is a universal phenomenon, have actually assumed this by applying western categories as if there were self-evident (Summerfield, 1999a).

ETHNOGRAPHIC RESEARCH CAN HELP VALIDATE ASSESSMENT TOOLS

It is circular to apply culture-bound western psychiatric categories (Kirmayer, 2006) as first principles in cross-cultural research. Ethnographic and qualitative research can help us to understand what constitute concepts of "mental" and "health" in local taxonomies. Through this process we can validate the basic assumptions upon which assessment instruments are based (Kleinman, 1988). It is only once we have taken these initial steps that the prevalence of mental disorder in a given context can be established.

A psychiatric ethnography would hope to make clear local conceptions of health and disease from the perspective of daily practices and coping strategies. (Bolton & Tang, 2012) seek to do this by applying ethnographic methods in a rapid assessment participatory model for use in humanitarian settings. They trained local health workers in ethnographic techniques as a primary step to epidemiology and intervention planning. Participants' unconstrained listing of concerns generated a prioritised list of local problems which identified the most pressing psychosocial issues to be discussed in in-depth key informant interviews. The outcomes of this qualitative analysis were used to develop a modification to the Hopkins Symptom Checklist (HSCL) which could measure the prevalence of locally described idioms of distress consistent with depression. In a large randomly selected sample they further found

that scores on this checklist were associated with both locally defined measures of functional impairment and western defined criteria for depression (Bolton & Ndogoni, 2000).

THE IMPORTANCE OF IDENTIFYING DISTRESS

Despite the theoretical limitations raised above, many clinicians seek to apply psychiatric theory in diverse cultures with the aim of achieving practical outcomes (Kirmayer, 2006). The link between traumatic events, such as torture, mental health disorder, such as PTSD or depression has been demonstrated across a wide range of countries (Steel et al., 2009). Whether or not these categories are always valid, they may often indicate an increased level of distress. Many survivors of trauma do not require psychological treatment, however it is imperative that treatments are available for people who do (Garcia-Moreno & van Ommeren, 2012). Hopefully, work which seeks to gain a deeper understanding of local healing norms (for example the work of (Al-Krenawi & Graham, 2000; Hinton et al., 2009; R. F. Mollica et al., 1993)) can assist in identifying individuals in need of assistance.

Some argue that, while valid, these theoretical issues have led to polarisations which risk obscuring practical realities for the severely mentally ill (Kirmayer, 2006; Silove, Ekblad, & Mollica, 2000). However mental disorder is classified, the fact remains that across cultures, a subset of people suffer marked functional and social impairment as a result of mental health difficulties (Kleinman, 1988), most notably among those with severe problems such as psychosis, neurological disorder and epilepsy (Silove et al., 2000). The mentally ill are at increased risk in crisis situations. For example, when a psychiatric hospital in Aleppo, Syria, was bombed in 2012, patients had to flee and were left without support. There is evidence that some of these patients were subsequently killed by sniper fire while wandering the streets (Abou-Saleh & Mobayed, 2013).

IDENTIFYING DISTRESS AMONG SYRIANS

In order to appropriately diagnose and treat mental health issues among Syrian refugees, it is necessary to understand how they perceive and describe mental health problems (Tol, Patel, et al., 2011). There are, however, no standard clinical instruments for assessing trauma which have been validated in Syrian populations (Hassan et al., 2014). In fact, psychiatric services have historically not been widely available in Syria. For example, in 2012 there were < 0.5 psychiatrists, 0 psychologists and 0.5 psychiatric nurses per 100,000 population in Syria (Okasha, Karam, & Okasha, 2012a). Prior to 2011, available services were generally residential and restricted to major cities (1200 beds) (Abou-Saleh & Mobayed, 2013). In addition, public health systems have come under attack in Syria and are no longer fully functional (Kherallah, Alahfez, Sahloul, Eddin, & Jamil, 2015).

In addition to having limited practical access to treatment options, stigma may prevent individuals from seeking help. There is limited research on the impact of stigma among Syrians in particular, however, a review of 22 publications of psychological interventions adapted for Arabic speaking patients reported that a high number of papers identified fear of stigma as a barrier to care (Gearing et al., 2013). Arabic speaking people interviewed in Sydney reported that having a heritable disease (such as schizophrenia) may be considered appropriate grounds for divorce and 51% said that isolating people with mental health disorders was considered normal (Youssef & Deane, 2006). Fear of social consequences may lead to disclosure of somatic symptoms only (Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001) and patients may be unlikely to attend dedicated mental health clinics for fear that they will be observed. Provision of mental health services in the primary health care context may help to overcome this (Nasir & Al-Qutob, 2005).

While it is important to ensure that professional help is available to those who would like it, Syrians

may have alternative ways of coping with distress with which they identify more strongly. For example, Syrian refugees in southern Turkey reported reasons for not seeking care, including only needing God, preferring to speak to family or friends and stating that their emotional reaction to the circumstance is normal, so they do not require specialised treatment (Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014). It is possible that members of the Syrian refugee community are best placed to understand the mental health needs of their compatriots. In which case, interventions which work to strengthen indigenous coping systems may be an effective means to overcome validity concerns in translating cultural conceptions of distress.

REBUILDING COMMUNITY STRUCTURES

Silove and colleagues (Silove, 1999) identify how the breakdown of systems of social networks, justice and other support structures in post-conflict settings undermine community structures which might otherwise provide support to individuals. Programs which help to rebuild these structures can promote healing at the community and individual level. For example, greater trust in the community and a sense of community cohesion has been associated with better social support and reductions in mental health difficulties, in a longitudinal study of displaced children in Burundi, indicating that programs which build a sense of community may help children to marshal social resources in order to improve health (Hall, Tol, Jordans, Bass, & de Jong, 2014).

Situations of dependency associated with living in refugee camps, or lack of recognition of previous roles and qualifications in resettlement countries leads to major disruptions to individuals' identity (Silove, 1999). Involvement in meaningful action leading to recognition as a valuable member of the community has been identified by refugees as contributing to recovery from PTSD following conflict and displacement (Ajdukovic et al., 2013).

CONCLUSIONS

For humanitarian organisations, mental health practitioners and scientific researchers working in conflict and post-conflict settings, questions of validity cannot be overlooked when applying empirically based methods to provide care to individuals who have experienced considerable adversity. However, there are limited opportunities to establish validity in the context of humanitarian crises. One solution to this problem may be to employ measurement methods which have been validated in different contexts, and hope that they produce meaningful data. An arguably superior solution is to take advantage of the skill and understanding of people within the local community. The detailed cultural knowledge of these individuals enables them to make valid assessments of distress, whether conducting clinical assessments or research. While some members of refugee communities will be in need of assistance in coping with the experiences of war and displacement, others are likely to be resilient. These individuals may be in a position to play a leadership role in rebuilding community support systems. All humanitarian organisations are in a position to support these leaders to facilitate the generation of culturally appropriate psychosocial programs. Respecting their knowledge engenders respect and human dignity.

CHAPTER 4:

CONCEPTS OF MENTAL HEALTH IN LEVANTINE ARABIC CULTURE: A LITERATURE REVIEW

CHAPTER 4: CONCEPTS OF MENTAL HEALTH IN LEVANTINE ARABIC CULTURE: A LITERATURE REVIEW

The preceding chapters have examined the scientific validity of applying psychological categories both across cultures and to displaced populations. Uncritical application of Western psychological concepts risks pathologizing behaviour which may not indicate emotional disturbance within a specific cultural context or may be considered normal in situations of exposure to extreme violence. For these reasons it is important to undertake to understand the cultural and social context of a displaced population prior to seeking to engage in psychosocial intervention. The following chapter examines the extant English language literature regarding social organisation, religion and cultural norms and how they may impact on the ways in which Syrian refugees seek support for distress. Understanding socially defined issues, such as gender or concepts of the self, may help psychosocial workers to engage in productive ways with members of the Syrian refugee community and assist in the uptake and implementation of psychosocial programs which address the needs of this community.

The following is an exploration of what the English language literature can reveal about Arabic cultural elements which may be relevant to understanding conceptions of psychosocial distress. This review is limited to English language sources and does not benefit from a wealth of information available in Arabic. Arabic culture is not a monolithic entity and there are wide variations in dialect and culture between peoples of the Maghreb (northern Africa), the Levant (Syria, Lebanon, Palestine, Jordan) and the Gulf states (e.g. UAE, Oman). However, there is a degree of shared history and culture between Levantine countries (Murshidi et al., 2013). Given the multidisciplinary nature of the literature reviewed, I have sought to organise the information under thematic headings. This means that, at times, research concerning Arabic speaking communities in diverse contexts (including those resettled

in non-Arabic speaking countries) is presented alongside research from Levantine countries and Syria. Although this is not ideal, the reader is encouraged to keep the differences between these populations in mind. These concepts should not be applied in a given situation without testing their relevance to the individuals involved.

Modern Syrian culture is a is born out of one of the oldest continuous civilisations in the world, replete with myriad idenities found in a wide range of ethnic, religious, philosophical and artistic communities. These identities range from urban intellectuals, who practice sophisticated high art forms (Shannon, 2010), to people whose lives focus solely around subsistence agriculture (Yazbek, 2014), reflecting urban-rural inequalities (Taleb et al., 2015). The diverse ethnic and religious groups in Syria have been subjected to political forces which have sought to highlight differences, sectarianism and conflict from the period of the French mandate (Provence, 2009) to the current regime (Van Dam, 2011). Even so, grassroots activists have hoped to promote peace, democratic systems (Yazbeck, 2012) and civil society (Abbas, 2014). While attitudes to mental health across the Arab world are diverse (Al-Krenawi, Graham, Al-Bedah, Kadri, & Sehwail, 2009), I hope that a general discussion of Arabic cultural norms can inform more in-depth locally defined approaches to understanding issues which may impact on the efficacy of psychosocial support for Syrians.

SOCIAL STRUCTURE, TRADITION AND THE COLLECTIVE

Arabic culture has been described as patriarchal and group oriented (Al Abdul Jabbar & Al-Issa, 2000; Pridmore & Pasha, 2004). Tradition is emphasised and change may be perceived as threatening to social harmony (Pridmore & Pasha, 2004). In her in-depth ethnographic account of life in Syria under Hafez Asaad, Lisa Wedeen demonstrates the ways in which the regime used state propaganda to, not only silence open political dissent, but also to induce complicity and regulate all aspects of behaviour (Wedeen, 2015). While she also highlights the many highly sophisticated ways that Syrians

undermined this system, we should not underestimate the extent to which many Syrians rightfully feared being informed upon.

In western democracies, rights and access to benefits in society are secured through the state. In contrast, in countries like Syria that live under autocratic governments, access to rights is generally achieved through social position. In the absence of institutional social services which promote universal access, citizens must rely on family connections in order to find employment, access to education or find a marriage partner (Dwairy, 2002). This is known as w*asta*, attaining social benefits (including legal and economic) through contacts (Starr, 2012). Due to the importance of family social position, families may be motivated to conceal stigmatised phenomena. For example, women's marriage prospects may be affected by psychiatric diagnoses, such as depression (Nasir & Al-Qutob, 2005). Since poor family functioning may be perceived as causing mental disorder (Youssef & Deane, 2006), a psychiatric diagnosis may impact the standing of the whole family. For this reason, sharing family information about mental illness or domestic violence with outsiders is generally censured (Hamdan, 2008).

In order to protect the group or family unit, suppression of personal concerns for the sake of others is highly valued. This may include concealing ones true feelings to save others from embarrassment , which may be considered a sign of maturity rather than a sign of emotional constriction (Al Abdul Jabbar & Al-Issa, 2000). Dwairy (2002) argues that in cultures where greater emphasis is placed on collective meanings, social norms are highly predictive of behaviour and personality needs to be viewed through an interpersonal lens. He lists interpersonal coping behaviours appropriate to "collective" Arabic culture. These include concealing one's true feelings in order to avoid interpersonal conflict (*mosayara)*; satisfying socially unacceptable desires in private (*Istighaba*) and using humour and exaggeration of one's achievements and abilities in order to avoid confronting aspects of the

social system (*fahlawia)*. Humility and modesty are considered virtues (Al-Issa, 2000b). For example, as argued by female Tunisian researchers (Douki, Zineb, Nacef, & Halbreich, 2007), despite the fact that Islam requires the consent of women for marriage, in practice, girls are traditionally expected not to express their wishes. As a result, they may have little say in arranged marriages, which are associated with higher levels of domestic abuse These comments may refer to a particular interpretation of Islamic texts and may differ in different settings.

The social structures outlined above are likely to impact the ways in which Syrians consider and describe emotional distress. If people are encouraged to consider the needs of others over their own, seeking help within a medical framework, which risks negatively impacting family members may not be socially acceptable. However, such factors are not wholly deterministic. Individuals still have agency to respond to their social worlds, and these social worlds are in constant flux, especially in times of upheaval. For this reason, there are likely people within the Syrian refugee community who would like to seek mental health support, despite these cultural barriers (as discussed in Chapter 7). Thus, services may need to be designed to specifically protect anonymity so that potential clients can feel secure that their, or their family's identities will not be revealed to the larger community. It may also be useful to place explicit focus on the interpersonal benefits of reducing distress. That is, rather than constructing therapy rationales that focus on individual benefit from symptom reduction, therapists may choose to highlight how reducing distress may prove beneficial for the family unit or improve the prospects of family members. I now explore in greater detail how these social structures may impact on concepts of self and identity.

CONCEPTS OF THE SELF

General arguments about the role of the self in "collectivist" societies need to be interpreted with caution, as they are in danger of becoming essentialist if applied across contexts. That is, an overly

simplistic dichotomy between western individualism and the 'other' as collective belies the complexity of lived experience and denies human agency in response to social structures. The contention that social norms may create expectations that self-concept is framed through interpersonal approaches does not rule out the possibility that individuals may examine their own intra-psychic processes and not express them, or even openly identify with individualistic conceptions of self-hood. Research in this area is limited and norms are subject to rapid change as globalisation accelerates.

With this in mind, it may also be helpful to explore how Arab writers have discussed the ways that the concept of the self in Arabic culture may focus more on the place a person occupies within social structures than on the self as a purely autonomous individual (Al Abdul Jabbar & Al-Issa, 2000). This may include the view that individual actions are governed by perceptions of others' needs in interpersonal contexts, rather than intra-psychic processes (Al-Issa, 2000b). In an ethnography of a "working-class" Christian family in Beirut, Lebanon, Joseph (Joseph, 2009) explores how brothers are taught to conceive of their sisters as extensions of themselves. As a result, brothers must regulate the social acts of sisters in order to retain their own personal dignity and honour. She suggests that constructions of love are enacted and expressed through an asymmetry of power, involving service for women and control for men. Thus gendered concepts of self-identity are defined in the context of important interpersonal relationships. Abdul-Haq (2008) raises the finding that authoritarian parenting practices have been associated with poorer outcomes for children in the United States. However, she argues that this parenting style in Arabic cultures has a different effect, since authoritarian practices are the norm and are not associated with negative attitudes towards the child.

TRADITIONAL PATRIARCHAL SYSTEMS

Education and intelligence among women is highly valued in many parts of Arabic society. For

example, the famous story of *Shahrazade* in the 1001 nights (*Arabian Nights)* folk tales, describes a women who overcomes brutality and male domination through narrative, using her vast knowledge, poetry and wit (Bouhdiba, 2009). Shahrazade is married to the despotic king, who murders his brides in the morning before marrying another. She evades execution by weaving fantastic stories each night until day break, leaving the story unfinished so that the king must keep her alive for another day. Women have good access to education within the secular Syrian state, participating in generally equal numbers in tertiary education, although levels vary according to urbanisation. Despite this, employment available to women is generally lower paying and women are rarely heads of household (Salamandra, 2009). Results from population studies (>1000) in Syria showed that boys were more likely than girls to be taken to see a doctor (Maziak, Mzayek, & Al Musherref, 1999) and women were more likely to report poor health (Ahmad, Ryan, Maziak, Pless-Mulloli, & White, 2013; Asfar et al., 2007). Similarly, women may be less likely than men to receive health education under the same circumstances (Nasir & Al-Qutob, 2008).

As in many parts of the world, women are disproportionally affected by mental health problems (Taleb et al., 2015). Douki and colleagues (Douki et al., 2007) argue that conditions of patriarchy in Arabic communities increase prevalence and limit care seeking for women. They identify a range factors which place women at a greater risk for psychological disorders, including education, employment and marriage issues (Asfar et al., 2007). For example, marital problems are associated with poorer mental health outcomes for women (Nasir & Al-Qutob, 2008). Despite the fact that erotic pleasure (for either gender) is not viewed as sinful in Islam (Bouhdiba, 2009), women's sexuality is generally viewed as taboo within Arabic communities (Douki et al., 2007). Consequently, a women's loss of virginity outside of marriage may rarely lead to suicide (Al Dawla, 2001) or homicide by family members (Zoepf, 2009) and unfaithful sexual behaviour may be viewed as a justification for physical abuse (Hamdan, 2008). In some forms of modern Islamic jurisprudence, contraception is not forbidden, although abortion is only permitted in cases of serious health complications (Nasir & Al-Qutob, 2008). Sexuality

remains a taboo topic in Arabic culture, in particular concerning people who identify as LGBTQ. With the exception of a few spaces in large cities such as Amman and Beirut, non-heterosexual identities must generally be concealed (McCormick, 2009).

VIOLENCE AGAINST WOMEN

Domestic violence is common in the region, as in all societies (Abu-Lughod, 2013). Two large randomly sampled population studies in Palestine (n = 2410 and 1334) revealed high annual incidences (52-54%) of physical violence against women in the home (Haj-Yahia, 2000). Among a sample of 411 low-income women randomly selected from primary health care centres in Aleppo, Syria, 23% reported current physical abuse (3 or more incidences in previous 12 months). Abuse was most strongly associated with lower education, and also with religion, age, economic hardship and mental distress (Maziak & Asfar, 2003). There are few practical opportunities for women who leave situations of domestic violence (Zoabi & Savaya, 2011) and, in many Arab countries, they may have limited rights to access their children if they do (Awwad et al., 2014). A qualitative content analysis of narratives describing typical instances of physical domestic violence among 60 low income women in Lebanon found that unmet gender role expectations, including a male family member's failure to provide financially, often precipitated violence (Keenan, El Hadad, & Balian, 1998).

Syrian law permits *crimes of passion* and does not penalise people who kill for an honourable motive. In the case of murder of female relatives who have participated in sexual acts outside of marriage (including rape), the family's attempt to expunge the *stain* on their reputation is often interpreted as honourable by the courts. This includes Article 548, which pardons someone for killing a woman after witnessing her committing an "immoral" act. Zoepf (2009) argues that the origins of these laws can be traced back to the traditions of the Bedioun (nomadic tribal peoples of the Levant and North Africa) and their enshrinement in legal codes during the period of the French mandate, rather than Islamic

law. In fact, one of Syria's highest Islamic scholars, Grand Mufti Ahmad Badr Eddin Hassoun has condemned the act of honour killing.

There is a bias in western literature to describe gender inequalities in the Muslim world, often describing them as natural outcomes of Islamic Ideology. There is a danger in equating religion and patriarchy, as this may give in to Western conceptions of the 'orient' which risk repeating paternalistic and oppressive practices of colonisation (Said, 1979) and prevent examination of social realities which maintain injustice. Some Muslim women question the application of a simplistic understanding of Islam to their place in society (Abu-Lughod, 2013). Many sections of the Koran and Hadith (sayings of the Prophet) exhort Muslims to respect women.

"The most perfect believers are the best in conduct. And the best of you are those who are best to their wives"

Shamaa-il of Imaam Abu 'Eesa Timidhi, Hadith, Sayings of the Prophet Mohammad.

Others argue that Islamic concepts can be employed to promote emancipation (Harmsen, 2009).

Islam and Concepts of Mental Health

Not all Syrians are Muslims, and not all Muslims share the same beliefs (e.g. Sunni, Shia, Sufi etc.). However, since the vast majority of Syrians are Muslim, the impact of Islamic thought will be discussed here. In Islamic culture, religion is rarely conceived as separable from other aspects of life (Pridmore & Pasha, 2004). Rather, social, daily, political, marital, family and legal interactions are conceived as enacting and embodying an Islamic way of life (Al Abdul Jabbar & Al-Issa, 2000).

Islamic thought has long grappled with concepts and taxonomies of mental distress. During the medieval period, Islamic scholarship made many novel contributions to medical science (Littlewood, 2007), preserving the medical knowledge of ancient Greece. This included a medical understanding of abnormal behaviour, treatment for mental disturbance and creation of psychiatric hospitals (Pridmore & Pasha, 2004). For example, Al-Razi (in the year 932) described symptoms of melancholia common to depression including sorrow, sadness, fear, irritability, social isolation and a subtype involving obsessions. He employed a form of cognitive re-evaluation of obsessions with past actions, and prescribed pleasurable activities as treatment (Al-Issa, 2000a).

"Oh you who believe! Seek help in patience and As-Salat (prayer). Truly Allah is with As-Sabirin (the patient ones)"

Al-Baquqrah, 153, cited in Al-Abdul-Jabbar (2000)

A central tenet of Islam is that submission to the will of God will result in inner peace (Pridmore & Pasha, 2004). Patience and duty are considered key Islamic virtues and a legitimate way of coping with life's stresses. Adversity, including illness, is viewed as a trial in traditional Islamic thought, which provides the individual with a form of martyrdom, providing access to paradise (Al-Issa, 2000a). Religious council of patience and forbearance may take the form of requiring individuals to face adversity without complaint, but also offer a framework for acceptance of loss and grief (Al Abdul Jabbar & Al-Issa, 2000). Harmsen (Harmsen, 2009) argues that, in the case of Islamic charities, the concept of patience may variously be used as a means of social control, in urging recipients to participate in education and cultural programmes, or as a way to question hierarchies, for example, in efforts to prevent domestic violence.

Many Arabs turn to traditional religious healers or rituals for mental health treatment (Gearing et al., 2013; Okasha et al., 2012a) as they believe the causes to be supernatural, although many hold the mental health system in high regard (Al-Krenawi & Graham, 2009). In health interventions in general,

patients may believe their recovery depends more on the will of God than on medical interventions (Hamdy & Nasir, 2008). Among Arabic speaking people living in Sydney, 86% reported that they believe mental health concerns (generally referring to psychosis) are caused by the Devil, with 43% reporting that they believe mental illness is incurable for this reason (Youssef & Deane, 2006). When comparing British Caucasians and Arabic people living the United Kingdom, Hamid and Furnham (Hamid & Furnham, 2013) found that people with Arabic background were more likely to report supernatural causal beliefs about mental illness, including belief in *Jinns* (possessing spirits) and the evil eye. Al-Krenawi (Al-Krenawi & Graham, 2009) explored the issue of belief in Jinn possession as an explanation for mental disorder among Palestinian Arabs living in the Negev. He described how various forms of symbolic healing, for example through Koranic healers, who prescribe specific Koranic recitations, to Dervishes, who perform ceremonies which address issues of possession. He argues that integration of traditional healing practices into western style health systems improves outcomes for people who view mental illness in this way.

The above discussion highlights how social, cultural and religious practices common in Syria differ from those in the cultures in which the medical model of distress has arisen. The Western medical model is contingent on a social system of liberalism, founded on mind-body dualism, in which the self, or ego, is socially constructed as a separate entity, through the processes of capitalism and colonialism which have produced modern neoliberal paradigms of individualism (ref, individualism books). In contrast, Levantine Arabic society, as described in the English language literature, places a greater emphasis on subverting one's own interests for the sake of family members, displaying patience in the face of adversity and conceptualising distress in the context of spiritual explanatory models. As a result, Syrians may be more likely to seek emotional support within these systems of family and religion, rather than in medical contexts. Although these possible impacts on care seeking practices may be noted, there is also considerable complexity and variation in how these issues may play out in context, so their consideration in planning services need to be taken in conjunction with consultation with local

staff and partners. The differential impact of identity markers, such as gender and sexuality, is also noted here, along with higher levels of social and mental health challenges for women. In Chapter 9, I will discuss the ways in which gender moderates the impact of displacement on wellbeing to demonstrate how the social and cultural constructs discussed here need to be considered in their unique contexts. I will now consider how social structures, conceptions of self and religious practice may shape expressions of distress within Levantine Arabic culture. The ways in which distress is expressed will have important implications for how psychosocial workers can engage with people who seek care.

Idioms of Distress

The ways in which idioms of distress (expressions of distress within a given culture) may play out in the development and maintenance of anxiety disorders is now discussed. For example, obsessional repetition of Islamic religious ablutions (*waswas*) due to doubts about appropriate performance of ablutions may be discussed with reference to the prescribed number of repetitions in Islamic teaching (Takriti & Ahmad, 2000). El Islam (1982) argues that in the collectivist Islamic context, shame (criticism from others) rather than guilt (self-criticism) is a primary tool of socialisation. While, similar to in western cultures, a strict upbringing will predispose to social anxiety, the symptom profile may reflect a greater concern with actual criticism from others, rather than self-criticism. In order to avoid misdiagnosis, the behavioural avoidance that accompanies agoraphobia will need to be differentiated from behaviour subject to cultural norms which require many women to remain at home unless accompanied by a male. Differentiating anxiety induced avoidance from culturally normative practice will also influence the type of behavioural interventions to be implemented with women. In the case of specific phobias, fear of cats and dogs may not necessarily represent a phobia, rather a normal reaction to animals which are considered dirty due to the fact that they are rarely domesticated (Takriti & Ahmad, 2000).

Reactions to potentially traumatic events (PTEs) is also shaped by cultural practices and the specific experiences of the Syrian conflict. As one Syrian doctor working in Lebanon has commented, his patients feel that they have no words to describe the events they have witnessed and survived (Bou Khalil, 2013). Given the novelty and intensity of the situation, many may express their distress through metaphors which do not translate literally. Table 2 lists some terms taken from texts describing current and historical meanings in a variety of contexts and countries. There may be considerable variation by region and dialect. As can be seen in Table 2, terms for psychological phenomena appear to describe distress in a mixture of bodily (*feeling pressure, pain*) and religious (*I should only complain to God*) and also behavioural (*crying most of the time)* terms. However, it is unclear whether the behavioural terms listed in the International Medical Corps (IMC) and United Nations High Commission for Refugees (UNHCR) (2013) are a product of the methodology used. That is, whether participants were restricted to describing behaviour. Of note is the manner in which hopelessness and sense of a foreshortened future are expressed through metaphors of sight (*By God, I can't see in front of me; The world is closing in front of my face*).

Table 2. Arabic Terms to Describe Distress

Term	Signs	Meaning	Reference
Waswas	Doubts about correct performance of rituals (e.g. ablutions); Excessive performance of rituals (repetitive washing)	May be interpreted as a correct response to the whispers of the devil.	(Al-Issa, 2000c)
Sadness (حزن)	Anger, love, rancour, fear, fear of death, defeat, melancholy	Spiritual loss or anguish (indicates correct intention to get closer to God (Sufism)); a burden to be carried with pride; an honourable reaction to loss; “endurance in times of poverty and deprivation” (pp. 60)	(Pamuk, 2009)
Al-ilaj Annafsani		When health professionals promote health through c*hanges of the soul*. Originally coined by Al-Razi. Refers to a form of psychotherapy.	(Al-Issa, 2000a)
Al-Ishq (عاشق)	Pain, unhappiness, madness, epilepsy	Excessive, passionate, romantic love	(Al-Issa, 2000a)
- meddayyek ketir hal fatra هههالفترة كتيير متضاييق - haassess haalii meddayyek حالي حاسس متضاييق	Rumination; Boredom; Fatigue; Pain; Blocked Constriction in the chest	To be Cramped or constricted	Syrian Refugees in Egypt Personal communication of Mekki-Berrada, A in (Hassan et al., 2014)
- ta3ban nafseyan تعباننأ نفسيي;- hassess halii ta3ban تعباننحالي حاسس; - halti ta3baneh حالتي	Undifferentiated anxiety and depression symptoms Tiredness; Fatigue	"fatigued self/soul"	

تعبانة			
- ma ader athammel ما اتحمل قاددرر; - el daght ‘alayy ketiir كتيير علي االضغط; - mou kaader rakkezz men el doghoutaat االضغط من رركز قاددرر مو	Extreme stress Extreme pressure	Can't bear anymore The pressure on me is too much Can't concentrate because of the pressure The pressures on me are increasing these days	
- wallah mou shayfii oddaamii قداامي شاييف مو لله وو	Stress Loss of options Foreshortened future	By God, I can't see in front of me	
- hases eddenia msakkra beoushi **مسكرة االدنييا حاسس بوشي**	Despair; hopelessness	The world is closing in front of my face	
sho baddi ‘ehki… el shakwa le gher allah mazalleh **, بدي شو االحكي** **مذلة لله لغيير االشكوة...**	Shame, despair	What am I supposed to say… it is humiliating to complain to someone other than God	
- maa ba‘ref shou beddi a‘ mel be halii. أأعمل بدي شو باعرف ما بحالي	General distress Helplessness	I don't know what I am going to do with myself	
Ekte’ab	sad, cries, no friends, doesn’t talk much	Depressed	Reported by displaced adolescents in Za’atari Camp in
Tawattor	doesn’t accept others’ words, hard to sleep, concentrate, not eating well	Tense	

Asabi	fires up so quickly, gets upset about little things, mad at small things	Nervous	(IMC & UNICEF, 2013)
Mashkalji	getting into problems, neighbours or friends complain about him/her	Trouble maker	
Hozzon	feeling sad and depressed over loss of friends in Syria, remembering them often, crying most of the time, withdrawing	Grieving	
Khof	having nightmares, scared about military action that would reach the camp	Fear	

It now becomes clear that the impact of culture and social structures on mental health experience, expression and care seeking cannot be considered in isolation. Social and cultural factors have implications for the most basic building blocks of identity (such as conceptions of self); religious expectations about how people should respond to adversity; gendered power relations influence who is most likely to receive care; and linguistic forms influence the metaphors used to describe distress. The purpose of understanding these factors is to help us to understand how their interaction may impact on care seeking. This can help us to plan services by uncovering what kinds of contexts Syrians are likely to disclose distress in, who they will seek help from, how they will describe distress and what kinds of responses are most likely to help people feel accepted and included. I will now turn to a more focused discussion of how attitudes to mental health care and availability of services in Syria prior to the conflict are likely to influence care seeking behaviour among Syrians living in displacement. Stigmatising attitudes to mental health concerns are commonly described as barriers to help seeking among Arabic speaking populations. In Chapter 7, I will discuss how these attitudes in the Syrian refugee community appear to be changing in response to the crisis and displacement. It is thus useful to understand how these attitudes operated in the region in general and in pre-conflict Syria, along with the context of mental health services.

The Impact of Culture on Help Seeking Behaviour

Access to care is limited by availability of services

Mental health services are not widely available in Levantine Arabic countries. For example, in 2012 there were less than 0.5 psychiatrists, less than 0.5 psychologists, and 0.5 psychiatric nurses per 100,000 population in Syria (Okasha, Karam, & Okasha, 2012). Psychiatric services are generally residential and are restricted to major cities (1200 beds in the country) (Abou-Saleh & Mobayed, 2013). During the Syrian conflict, health services have come under military attack and health workers have been forced to work under threat of torture or assassination (Hassan et al., 2014). Public health

systems in major cities in Syria are no longer functioning (Abou-Saleh & Mobayed, 2013; Kherallah, Alahfez, Sahloul, Eddin, & Jamil, 2015) and health systems in host countries are struggling to deal with increased numbers (Lancet Editorial, 2013; Murshidi et al., 2013). Services in host countries may also have limited resources devoted to mental health care. For example, Jordanian primary health care providers reported that appropriate therapies for depression, including antidepressants, are not generally available within the health system (Nasir & Al-Qutob, 2005).

STIGMA MAY FURTHER LIMIT ACCESS TO CARE

While research on stigmatising attitudes in Syria is limited, research within the region demonstrates a clear pattern of limiting access to care. A review of 22 publications of interventions adapted for Arab patients reported that a high number of papers identified beliefs about aetiology of disorder and fear of stigma as barriers to care (Gearing et al., 2013). Stigma occurs when individuals are excluded from social acceptance on the basis of an attribute which has negative cultural connotations (Brown et al., 2010). Negative reactions to individuals may result from perceived threat or stereotyped beliefs. Attributions that a person is responsible for their mental health symptoms will depend on explanatory models, and are likely to elicit anger and punishing actions (Link, Yang, Phelan, & Collins, 2004). Stigma may be internalised (negative beliefs about the self as a result of diagnosis, shame and low self-esteem) or externalised (negative societal attitudes about people with mental illness which impacts on people's ability to take advantage of social resources) (Corrigan, 2004). Stigmatizing responses may take the form of stereotyping attitudes, such as the belief that mentally ill people should be coerced or restricted, and overt discrimination, such as the making of false accusations or refusal to provide access to services or social benefits (Corrigan, 2006).

Externalised stigma may impact care seeking by creating increased barriers within a society (Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007). Participants within a study of Arabic speaking people

interviewed in Sydney, Australia, reported that having a heritable disease (such as schizophrenia) may be considered an appropriate grounds for divorce and 51% said that isolating people with mental health disorders was considered normal (Youssef & Deane, 2006). As a result, families may be motivated to restrict access to treatment, if they don't trust in confidentiality (Dow, Helena & Woolley, 2011; Youssef & Deane, 2006). Even within family units, individuals may be fearful of disclosing mental health concerns in case this places an extra burden on family members (Dow, 2011) and may not seek external help until the problem is severe (Dow, Helena & Woolley, 2011). The practice of only seeking external help when mental health problems are severe may also indicate that less severe forms of disturbed behaviour are generally accepted within families and not viewed as relevant to medical models (Al-Issa, 2000a). However, fear of social consequences may lead to disclosure of somatic symptoms only (Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001) and patients may be unlikely to attend dedicated mental health clinics for fear that they will be observed attending the clinic by community members. Provision of mental health services in the primary health care context may help to overcome this (Nasir & Al-Qutob, 2005).

Internalised stigma can lead to reduced help seeking over and above that related to fear of social consequences. For example, O'Connor and colleagues found that after taking external stigma into account, disparities in help seeking behaviour between African Americans and Caucasian Americans was explained by higher levels of internalised stigma among African Americans, which directly impacted on help seeking behaviour (Brown et al., 2010). For individuals who value self-perceptions of personal strength, a mental health diagnosis may undermine self-esteem (Interian et al., 2007). Explanations which ascribe the causes of mental illness to external events or entities are likely to lead to reduced feelings of shame and protect people from loss of status (Link et al., 2004).

Stigma has been identified as a significant barrier to care for people from Arabic speaking countries

by a range of authors (Gonçalves, Zidan, Issa, & Barah, 2012; Karam et al., 2006; Kilzieh, Rastam, Ward, & Maziak, 2010; Maziak, Asfar, Mzayek, Fouad, & Kilzieh, 2002) although few (e.g. Al-Krenawi et al., 2009) have measured it. Zoabi (Zoabi & Savaya, 2011) conducted qualitative interviews with social workers treating Arab clients in Israel, who reported that stigma is a large barrier to seeking care for mental health problems. In particular, sharing information with outsiders and having a mental illness were seen to harm a person's social standing in a hierarchical social system. Illness is described as shameful, particularly for women (al-Krenawi & Graham, 2000).

There is evidence that many individuals suffering from mental distress do not seek care. A World Health Organisation epidemiological study in a nationally representative sample (n= 2857) in Lebanon (Karam et al., 2006), found that exposure to two or more traumatic war events significantly elevated the odds of developing a mental disorder, yet only 10.9% of those who reported symptoms consistent with disorders sought care. Explanatory models, and the meaning attached to traumatic events determine attributions of responsibility for distress and influence stigma and help-seeking behaviour (Hamid & Furnham, 2013; Shidhaye & Kermode, 2013). Primary health providers in Jordan reported that many Jordanians believe that failure on the part of the family to appropriately bring up children, or personal weakness and failure are commonly believed to be the cause of depression in Jordanian society (Nasir & Al-Qutob, 2005). Most relevant to the population that is a focus of the current thesis, Syrian refugees in southern Turkey reported that reasons for not seeking care included only needing God, preferring to speak to family or friends and stating that their emotional reaction to the circumstance is normal, so they do not require specialised treatment (Jefee-Bahloul, 2014).

Stigma, shame and concerns regarding honour may limit access to health services for Syrians who have experience sexual violence (Hassan et al., 2014; Ouyang, 2013). In some cases, this may be related to fear of violent repercussions from family members if sexual humiliation is disclosed (Douki et al., 2007) as they may be held responsible for the abuse they have received (Hassan et al., 2014). A

report into violence against women during the conflict in Syria, in three large refugee camps in Jordan, found most women were too afraid to talk directly about their experiences, rather they spoke in the third person. Instances of gender based violence, including rape and sexual humiliation, were widely reported but women were generally not seeking help from services, where available. Women reported being fearful of the stigma associated with sexual violation. It was reported that some women were being rejected by their husbands upon returning from government detention, as violent sexual acts and humiliation are understood to be common torture techniques employed by the regime (International Federation for Human Rights (FIDH), 2012). Uptake of services may be improved if explicit disclosure is not required (Hassan et al., 2014).

A large body of evidence in Arabic speaking populations, including Levantine countries in particular, highlights the significant impact that stigmatising attitudes are likely to have on the ways in which Syrians seek support for distress. As discussed above, in relation to the importance of family and religious systems, Syrians are probably more likely to seek support within these arenas, rather than from mental health professionals in a medical context. This has important implications for how services to support Syrian refugees should be designed, as more people may be assisted by supporting existing social, cultural and religious systems to perform their existing functions of promoting social wellbeing. This focus on the provision of community and social supports is also consistent with international guidelines for humanitarian intervention in crisis settings both because it is more cost effective, and because it recognises that the majority of people exposed to PTEs require restoration of the resources required to support adaptation, rather than specialised mental health services (IASC, 2007). While this framework recognises the primacy of providing less intensive services to the majority of the population, there is also a need to ensure that specialised services are available to those who need them (Silove, Ekblad, & Mollica, 2000). In this context the roles of clinical psychologists may need to change. That is, psychologists may need to focus on finding ways to help the local community provide psychosocial support, rather than seeking to provide this support themselves.

This focus calls into question a model of humanitarian intervention which sees psychologists fly in and fly out to provide individualised psychological treatment. This is because individualised therapy may not be relevant to the needs of displaced people (Derek Summerfield, 1999b) and because local workers may be better placed to understand the cultural context of the people they are working with. In addition, there will also be a need for specialised interventions for the minority of people in the community who do develop psychological disorders (Silove et al., 2000). Thus, the role of international clinical psychologists becomes one of determining what intervention is needed to ensure that a full range of psychosocial services is available to those who need it and choose to use it. The next section discusses recommendations from the available literature about how mental health services may need to be adapted to promote their uptake in the Syrian refugee community.

MEASURES TO INCREASE UPTAKE OF SERVICES

Mental health systems in countries receiving refugees must adapt in order to work effectively with these populations, since healthcare workers' failures to understand the significance of symptoms has been highlighted as a barrier to effective treatment for Arabic populations (Al-Krenawi & Graham, 2009). Interventions need to be designed to help individuals solve problems which are relevant to them within their own cultural context (Al Abdul Jabbar & Al-Issa, 2000). Therapists need to be aware of their own cultural affiliations when working in a multicultural context. It is only from this perspective that one may "maintain a phenomenological stance to appreciate the meaning of client's distinctive ways of being in the world."(Gorman, 2001).

Refugees in new cultural contexts may experience the environment of mental health services as alien and a product of a dominant culture which they do not feel part of (Velde et al., 2009). Many may be suspicious of psychological therapy as secular and western (Raiya & Pargament, 2010; Jefee-Bahloul, 2014). Many youths with combined Western-Arab citizenship describe their identities as fractured and

in conflict (Fine et al., 2012). Refugees who have experienced human rights abuses (such as torture during detention) at the hands of authorities are likely to be especially mistrustful of government services which they associate with authority (Dow, 2011; Gorman, 2001). Participants from both Iraq and Syria rejected an internet based psychosocial therapy program, as they feared they would be monitored by the authorities (Jefee-Bahloul, 2014; Wagner, Schulz, & Knaevelsrud, 2012). Jafee-Bahloul and colleagues (Jefee-Bahloul, 2014) investigated the acceptability of telepsychiatry among Syrian refugees living in southern Turkey. While 42% reported elevated distress on the HAD Stress scale, 34% reported a need for psychiatric services. Of this 34%, 45% were open to receiving telepsychiatry. Women and people who reported higher stress scores were less likely to accept telepsychiatry.

People suffering from anxiety or depression are more likely to seek help in primary care than from a mental health professional (Khoury, Khoury, & Nasir, 2008) and many patients may prefer to have others present during psychiatric interviews. This may be due to the perception that mental difficulties are the responsibility of the family (Nasir & Abdul-Haq, 2008). Nasir and Abdul-Haq argue that self-report measures are unlikely to be well accepted by Arab patients, who may prefer face to face interviews, due to the value placed on human contact in Arabic culture (Nasir & Abdul-Haq, 2008).

EXPECTATIONS OF TREATMENT AND THERAPEUTIC RELATIONSHIPS

Although people within Arabic speaking communities may not often be familiar with a medicalised context for mental health care, they will likely be familiar with medical contexts. Thus, interactions with psychosocial workers in medical contexts may lead people to have similar expectations to those they would have of medical doctors. This may include expectations of a hierarchical relationship with medical staff in which staff are expected to provide ready answers and solutions to health problems. (ref from caring for arab patients book).

Therefore, people may view psychiatric care within a biomedical framework, expecting a quick fix (L S Nasir & Abdul-Haq, 2008), or view the role of treatment as simply to provide immediate symptom relief.

"I will spare you, Doctor, the details of how I packed the body parts of my family members who were all killed by the bombing that day, and would like to ask you to give me something that could help me sleep at night."

A Syrian refugee in Lebanon talking to his psychiatrist

(Bou Khalil, 2013*, pp. 1396.)*

Patients may reject psychological explanations of their illness, but be prevented from expressing this, as openly disagreeing with a health professional may be seen as improper (Nasir & Abdul-Haq, 2008). Expectations of hierarchy have implications for collaborative therapeutic interventions. Al-Abdul Jabbar and Al Issa (Jabbar & Al-Issa, 2000) argue that the likely perception of the therapist as an elder places the patient in a passive position which is not conducive to open-ended insight-oriented work. They recommend a more directive approach. It should be noted that this discussion is somewhat dated (2000) and is largely a reaction to the application of psychoanalytic techniques in Islamic contexts. However, these comments raise important questions about how to promote agency and collaboration in the therapeutic alliance.

CHAPTER 5:

PSYCHOSOCIAL INTERVENTION IN THE HUMANITARIAN CONTEXT: PROMOTING INDIVIDUAL AGENCY WITHIN UNEQUAL STRUCTURAL POWER RELATIONS: A LITERATURE REVIEW

CHAPTER 5: PSYCHOSOCIAL INTERVENTION IN THE HUMANITARIAN CONTEXT: PROMOTING INDIVIDUAL AGENCY WITHIN UNEQUAL STRUCTURAL POWER RELATIONS: A LITERATURE REVIEW

The importance of considering local culture when designing psychosocial interventions in humanitarian settings has been highlighted above. Attending to cultural differences is a necessary but not sufficient condition for supporting wellbeing in an ethical manner. Psychosocial services operate in the context of structural power relations which are not equally distributed. Given the history of colonisation, individuals and organisations intervening in humanitarian contexts do so with considerable advantages in resources, access to rights, mobility and privilege. Thus, interactions with refugee populations who often lack these advantages need to attend to these power differences. In addition, attention must also be paid to the history of colonisation and humanitarian action which have often intervened in ways that served to disempower and harm the people they were intended to help, despite benevolent motives. The next chapter will consider this history and consider the ethical implications of humanitarian interventions. Participatory research is discussed as a methodology which may help to ensure that programs serve the perceived needs of the community and enable community members to be involved in program design and implementation. This serves as a theoretical basis for the empirical work discussed in this thesis, which is designed to understand the perceived needs of the community and use participatory methodologies to address them.

A CHALLENGE TO THE PERCEIVED NEED TO INTERVENE IN PSYCHOLOGICAL ISSUES

“"Looking at this endless list of horrible stories from a psychiatrist’s perspective, I see only patients suffering from what my profession calls posttraumatic stress disorder... Looking at this same list from a human being’s perspective, I only see in the looks and attitudes of those patients… something that is beyond what contemporary evidence-based medicine can describe scientifically. In every one of these patients, I see intense, irreversible mistrust and a lack of belief in every principle or rule that is supposed to control our relationships with each other. I see question marks regarding the meaning of their whole existence as well as the meanings behind the most important concepts that seemed unquestionable to them in the past, such as religion, politics, work, family, and finally, last but not least, health. These patients manifest symptoms that justify the wide array of treatment modalities I offer to them, but I am left with a terrible feeling that this management is somehow wanting. All that has been shattered in these patients’ lives cannot be mended by the small treatment that we can offer.”

Lebanese Psychiatrist working in with Syrian Refugees in Beirut, Lebanon

(Bou Khalil, 2013*, pp 1397)*

ARE PSYCHOLOGICAL ISSUES PRIORITISED BY REFUGEES?

Derek Summerfield calls into question the application of trauma interventions in war-affected areas (Summerfield, 1999), drawing attention to the erroneous assumption that there is a one to one correspondence between trauma and pathology, and that therapy is required to solve this problem. An examination of United Nations (UN) field manuals from 1990s humanitarian projects revealed a staff attitude that sexual assault necessarily leads to pathology, and a lack of cultural awareness which prevented individuals reporting rights abuses (Atlani & Rousseau, 2000). Not everyone who experiences trauma develops psychological pathology (Siriwardhana et al., 2014) and the majority

recover from acute posttraumatic reactions (Ajdukovic et al., 2013). In fact, Many refugees prioritise social factors, such as schooling and family reunion, above mental health concerns (Summerfield, 2003). Summerfield argues that psychiatric categories are of limited concern to many people in post-conflict settings, as they are not relevant to the meaning and interpretations people have of the events they have experienced. These categories fail to describe the wider social and political context of mass violence (Porter & Haslam, 2005).

The work of Bolton and colleagues (Bolton & Ndogoni, 2000; Bolton & Tang, 2004) in post-genocide Rwanda (discussed in Chapter 3) demonstrates a rigorous, ethnographic approach to assessing the perceived needs of psychosocial aid recipients. Bolton and Tang (Bolton & Tang, 2004) present a prioritised list of problems identified by lay people in a free listing exercise, used to determine concepts for in-depth investigation. Examination of this list reveals that the six psychological issues identified were not generally placed high on the list. The highest placed item (Suspicion/mistrust with breakdown of neighbourly relation) appears to display a concern with social/ interpersonal difficulties, rather than with individual intra-psychic depressive symptoms. Similarly, psychosocial issues related to basic needs, the difficulties of widowhood and lack of justice would effectively be ignored in the building of a model which could be suitably mapped onto DSM categories of emotional disturbance. The medical model process locates 'disorder' within the individual, rather than within the social context (Kleinman, 1988). This work reveals that, even when attempting to address issues of cultural bias, it is very difficult to avoid framing problems within the paradigmatic world view of western psychiatric categories. This does not deny the likely practical benefits of this exercise. Rather, it calls attention to the need for reflexive techniques which can help address this bias.

Diagnosing individuals with PTSD may serve to depoliticise the context in which they were subjected to violence in the first place (van der Kolk, Mcfarlane, et al., 2012), avoiding confrontation of social realities which effect psychological outcomes (Kirmayer, 2006) and reframing rights abuses as intra-psychic processes. Research and intervention priorities may serve to obfuscate more damaging social realities. For example, Tol (Tol et al., 2013) examined research on gender based violence in areas of armed conflict and found that most research examined the impact of group based violence, despite that fact far more women suffer from the effects of intimate partner violence. In addition, humanitarian organisations tend to focus programs on stranger violence, despite increases in intimate partner violence during conflict periods (Stark & Ager, 2011). These programs fail to address the social realities which lead to the majority of violence against women. Summerfield calls for interventions which are "unique, indigenous and community based" as opposed to "generalised, technical and targeted" (Summerfield, 1999).

The foregoing discussion highlights the need to use qualitative methodologies to not only examine the cultural relevance of psychological constructs, but to ensure that programs address the perceived needs of the local community. There is little utility in understanding local idioms of distress if programs continue to apply a Western derived system which may be of little use to the people it is aimed to help. For this reason, this thesis aims to explore local conceptions of wellbeing within ecological context, including examining how culturally defined understandings of psychosocial health operate within the displacement environment. These considerations highlight the issue that researching cultural factors without reference to the context in which they play out may be problematic.

There is a danger in reifying local culture as a unified entity, as this may ignore the fact that various

forces vie for power on the local scale and certain cultural notions may serve to maintain unequal power relations. Blanket deference to local cultural norms may serve to entrench ongoing rights abuses (Atlani & Rousseau, 2000). Some argue that psychologists have a responsibility to address cultural norms which threaten certain groups, such as culturally sanctioned violence against women (Douki et al., 2007). Of course, the application of local concepts depends on interpretation. As Harmsen argues, in the case of Islamic charities, concepts of duty may be invoked to maintain the status quo, with reference to collectivist norms requiring foregoing of individual rights for the sake of social harmony, or as a tool to question hierarchies by requiring the full use of personal capacities to address social issues (Harmsen, 2009).

IMPERIALISM

Humanitarian action, in particular psychosocial programs, has a history which is implicated in global systems which can often serve the interests of people other than those they are intended to help (Hugman, Pittaway, & Bartolomei, 2011). Understanding this history may be key to avoiding repeating past injustices. The next section will examine some of this history.

The first torture and trauma treatment centre was opened in Denmark in 1982. Within 15 years the number of such organisations had grown to 173 (Gorman, 2001). Humanitarian intervention is a burgeoning business and research is necessarily located in a power system (Frisby, & Creese, 2011). PTSD is a socially constructed concept built out of the experience of western soldiers of the world wars and Vietnam (van der Kolk, Weisaeth, et al., 2012). Yet, the vast majority of studies conducted in humanitarian settings employ Western measurement instruments, calling into the question the validity of this research (Kirmayer, 2006; Summerfield, 2008). This focus helps to build a narrative which makes the work of humanitarian organisations attractive to western donors (Summerfield,

1999) and is the product of an international scientific system in which the power to produce knowledge is concentrated in more wealthy countries (Viswanathan et al., 2004).

Psychiatric interventions may reify western models and expertise while devaluing local understandings of distress and coping as lacking in awareness. Citing Foucault's analysis of the power of language and the inherently value laden nature of knowledge, Summerfield draws a link between the history of colonialism and current humanitarian interventions in which the 'developed' north patronises the 'developing, conflict ridden' south (Summerfield, 1999). The category of PTSD can be viewed as a normative description for how individuals 'should' respond to distress and rights infringements, which may not be appropriate in cross-cultural settings. However, there is no way to determine how a 'normal' person should respond to massive abuses, such as torture or genocide (Eisenbruch, 1991).

INTERVENTIONS HAVE THE POTENTIAL TO CAUSE HARM

Inappropriate interventions may do harm. For example, in the case of gender based violence targeting, pathologising or stigmatising of survivors, poor service quality and lack of recognition of the social structures which perpetuate violence against women have all been noted as potentially harmful (Garcia-Moreno & van Ommeren, 2012). In the absence of methodological rigour, the best of intentions can go awry. For example, White reports (White, 1998) on a 1995 program to train local psychologists and psychiatrists to use eye-movement desensitisation and reprocessing (EMDR) to treat trauma. Training was undertaken in 3 days, in groups of up to 40 with follow-up supervision via fax or email. The published report mentions no examination of local culture and systems, no consideration of the impact of current stressors on psychological health, no theoretical framework which placed PTSD within a context of a range of psychological reactions to trauma and no prior community consultation. Rather, the authors appear to have designed the project on the assumption

that the main challenge facing survivors would be the distress associated with specific traumatic memories of the war. They employed a treatment (EMDR) which attempts to modify reactions to a discrete traumatic event. The only evaluation of the training program was post-course evaluation forms. The author interprets the generally high ratings on these forms as demonstrating that participants benefitted from the training without discussing the potential for demand characteristics. There were no procedures to evaluate whether trainees understood or were competent in assessment and treatment application and no investigation of the effect on patient outcomes.

A study such as this is an example of a '*hit and run*' program (Summerfield, 1999) with the potential to cause harm by solely problematizing PTSD and assuming that reactions to discrete traumatic events are the primary causes of distress associated with conflict. Without consideration of the contextual factors mentioned above, trainees may exacerbate problems by applying PTSD treatments to inappropriate patients, in an incomplete manner and without consideration of the social factors which may be causing harm. Given that the majority of people exposed to mass violence recover of their own accord, blanket implementation of treatment is not justified (Silove et al., 2000).

PUTTING INTERVENTIONS IN CONTEXT

Given these historical limitations to psychosocial intervention in humanitarian settings, the focus of this thesis is to combine consideration of cultural adaptation with the use of qualitative methodologies to understand more about the social, political and cultural context in which interventions with Syrian refugees may be implemented. This includes research to understand community perceived needs (Chapter 6), explanatory models of distress (Chapter 7), engagement with local psychosocial actors to understand community readiness (Chapter 8) and integration of these findings into an ecological model (Chapter 9) which may help to guide program design and implementation. The next section

explores research which has examined how to consider local context in program design with displaced and post-conflict communities.

Interventions need to be designed with an understanding of the socio-political context in which refugees live. Silove (Silove, 2011) has proposed the ADAPT model. He postulates that posttraumatic reactions are an evolved psychophysiological mechanism which functions to promote survival in situations of continuing threat. Interventions which promote a sense of safety, security and predictability in the displaced person's new environment will help to reduce psychological distress (Silove, 2011; Silove et al., 2007). Silove and colleagues (Silove et al., 2007) sought to test this model in a prospective longitudinal study among 62 asylum seekers in Australia who did not differ on degree of past trauma or baseline depression and anxiety. They found that having refugee claims accepted and achieving certainty regarding residency status was associated with significant reductions in symptoms of anxiety and depression. These symptoms remained above clinical thresholds for those whose claims were rejected. They argue that, as predicted by the ADAPT model, this reduction in uncertainty about repatriation and access to health and employment rights may lead to significant reductions in psychological distress associated with past trauma and displacement.

BEYOND TRAUMA

Many refugees report that everyday stressors inherent in displacement are more distressing than discrete traumatic experiences (Wessells, 2009). Miller and Rasmussen (Miller & Rasmussen, 2010) argue that daily stressors partially mediate the relationship between war exposure and trauma related mental health disorders (Fernando, Miller, & Berger, 2010). This may be due to the salience of everyday phenomena, as well as their tendency to erode coping resources. They argue that addressing a broad range of psychosocial problems may be more effective in addressing needs (Miller & Rasmussen, 2010). This model is supported by examinations of the impact of daily stressors. Steel and

colleagues (Steel et al., 1999) found that the effect of some pre-migration traumas on posttraumatic symptoms is mediated by post-migration difficulties. They argue that this could indicate that trauma impairs individuals' abilities to cope with daily stressors or that people exposed to conflict related trauma are at greater risk of being faced with post-migration difficulties. Similarly, Porter and Haslam (Porter & Haslam, 2005) found that post-migration stressors, such as economic opportunity and repatriation, moderated the effect of pre-migration trauma on mental health outcomes among refugees.

There has been a relative shift towards research and interventions which take into account the challenges of the displacement environment (Murray & Davidson, 2010). Refugees living in camps may be forced to contend with ongoing living situations which cause considerable distress for decades following initial trauma exposure (Mollica et al., 1993). Refugees may face restrictions to employment and family unification in host countries (Silove et al., 2007). In an epidemiological survey, using random cluster sampling, in postwar Afghanistan (n=799), 62% of respondents reported experiencing at least 4 traumatic events over a decade of war. The most common of these were lack of food and water and shelter (Cardozo et al., 2004). Loss of social support structures can leave people without their previous coping mechanisms and make people more vulnerable to mental health concerns (Velde et al., 2009). Poor social support may be more strongly associated with depression than past trauma, and family reunion may be an effective means to address this (Gorst-Unsworth & Goldenberg, 1998). Social factors can influence the severity of both posttraumatic and depressive reactions to trauma (Gorst-Unsworth & Goldenberg, 1998; Steel et al., 1999) and depletion in economic and social resources can make it more difficult to recover from the effects of trauma (Ajdukovic et al., 2013). See Table 3 for factors affecting adjustment.

Table 3. Factors Affecting Adjustment in Displacement Contexts

Factors Negatively Affecting Adjustment	• Social roles, unemployment and finances, loss of social networks (Garcia-Moreno & van Ommeren, 2012; Murray & Davidson, 2010). • Low level of affective support, separation from children, lack of contact with political organisations, low number of social activities (Gorst-Unsworth & Goldenberg, 1998). • Economic factors, occupational opportunities and identification with social ideals (Hume & Summerfield, 1994) • Being dependent on others, feeling worthless and having a passive role, insecure residency status, (Ajdukovic et al., 2013). • Insecure residency status in host countries (Derrick Silove et al., 2007); • Living in institutional accommodation, limited economic opportunity, internally displaced, repatriated to countries previously fled, if conflict they fled was ongoing (Porter & Haslam, 2005). • Cultural change as a result of migration (Velde et al., 2009).
Factors which Promote Recovery	• Feeling understood, motivation and hope for children's futures, orientation to the future, making new friends, having reciprocal relationships, activity, sharing traumatic experiences with others, being open to new experiences, calming techniques, hope (Ajdukovic et al., 2013). • Sense of trust in the community and community cohesion (Hall et al., 2014). • Religious faith, commitment to a political cause (D Silove, 1999). • Permanent private accommodation (Porter & Haslam, 2005)

It should also be noted, that the impact of daily stressors is not one-directional. That is, while these stressors may negatively impact wellbeing, psychological health may also impact on individual capacities to cope with adversity. As Nickerson points out (Nickerson et al., 2011), there is evidence that participants who receive treatment may be more capable of marshalling resources to change their practical situation, such as migrating out of a refugee camp. Social causation posits that a loss of social resources leads to mental health difficulties, while social drift theories posit that mental health difficulties lead to impaired ability to marshal social resources (Hall, Tol, Jordans, Bass, & de Jong,

2014). Hobfoll (Hobfoll, 2011) argues that social resource losses following conflict causes mental health difficulties that can lead to decreased ability to take advantage of social resources.

TOWARDS INTEGRATED INTERVENTIONS

The concerns raised above highlight limitations in current humanitarian practice. This raises the question of how to best determine where to intervene in humanitarian settings. Some argue that, while valid, these theoretical issues have led to polarisations which risk obscuring practical realities for the severely mentally ill (Kirmayer, 2006; Silove et al., 2000). However mental disorder is classified, the fact remains that across cultures, a subset of people suffer marked functional and social impairment as a result of mental health difficulties (Kleinman, 1988), most notably among those with severe problems such as psychosis, neurological disorder and epilepsy (D Silove et al., 2000). The mentally ill may be at increased risk in these environments. Clearly, there is a difference between *hit and run* generalist approaches and work which seeks to gain a deeper understanding of local healing norms (e.g al-Krenawi & Graham, 2000; Hinton et al., 2009; Mollica et al., 1993). Humanitarian actors have sought to develop consensus on a stepped care approach to provide appropriate care to people with serious mental disorders, while guarding against pathologising whole populations. An example of this is the *The Inter-agency Standing Committee guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC) (IASC, 2007). These guidelines will be discussed in more detail in Chapter 6.

PARTICIPATORY ACTION TO PROMOTE ACTIVE ENGAGEMENT AS A PATH TO DIGNITY

The international consensus regarding psychosocial intervention in humanitarian settings (IASC, 2007) draws attention to the varied ways that individuals respond to crisis. The guidelines state that in a crisis, the majority of people will not develop psychological problems. Rather, the provision of basic rights and necessities is likely to address their needs. A subset of people are likely to experience

distress and would benefit from family and community based supports, while a minority of people will experience distress that leads to the need for specialised clinical intervention. This means that a primary focus for psychosocial intervention in these kinds of settings may involve the development of community based supports. Community based programs may be aided by the use of participatory action frameworks, which are specifically designed to engage community members in the design and implementation of programs to address their needs. Participatory engagement can help ensure that community needs are being addressed while they give community members the opportunity to be involved in delivery of programs. That is, participatory research can become a community intervention itself, by helping to address key stressors in displacement, which may include unemployment, social isolation and perceived loss of control.

"We believe that the Syrian dictator is only today's passing news, something temporary, but we are the "living document". We believe that our city, the "Beauty of the Euphrates", is a place for life and love, and that all this devastation and grief is only a fleeting accident in its eternal river. We do not believe in victimhood, and refuse to play this role. All we want is to speak the truth freely and own our own destinies. We want to be our own decision-makers"

Kartoneh, anonymous collective of activists and artists, Deir al-Zour, Syria, 2014 pp 65.

(Kartoneh, 2014)

PARTICIPATORY RESEARCH

Participatory research gives the community of interest the opportunity to be involved in the planning of activities and the creation of knowledge which affect them (Kemmis & McTaggart, 2003; Reason & Bradbury, 2001). Qualitative research can help build a knowledge base about local conceptions of mental health while promoting grass roots ownership (Summerfield, 2008) and promote access to health care (Wallerstein & Duran, 2006). Involving participants as actors in the process may overcome the observer-object distinction of traditional social research inquiry which can "reproduce power

inequalities" [15, pg58] (Foster, 2008). This is especially important when researcher-participant relationships involve large international organisations, which have historically depicted aid recipients as dependent (Wessells, 2009) victims (Chandler, 2001) and Arabic communities as alien (Said, 1979). Participation enables reciprocal knowledge and skills exchange (M Viswanathan et al., 2004), promotes autonomy and capacity building (Mackenzie, McDowell, & Pittaway, 2007) and is therefor more appropriate for use in humanitarian settings (Baird et al., 2015; Silove et al., 2000). Participatory research is increasingly being used to address health disparities (Wallerstein & Duran, 2006). Principles of participatory action include reciprocal sharing of knowledge and expertise, shared decision making and ownership of projects (Viswanathan et al., 2004). Through partnership and dialogue, participatory methods may help to convert insight into action and create links which promote understanding between communities (Baird et al., 2015). It is research *with* rather than *on* or *for* communities (Frisby & Creese, 2011).

REBUILDING COMMUNITY STRUCTURES

Silove and colleagues (Silove, 1999) identify how the breakdown of systems of social networks, justice and other support structures in post-conflict settings undermine community structures which might otherwise provide support to individuals. Programs which help to rebuild these structures can promote healing at the community and individual level. Greater trust in the community and a sense of community cohesion has been associated with better social support and declining mental health difficulties in a longitudinal study of displaced children in Burundi, indicating that programs which build a sense of community may help children to marshal social resources in order to improve health (Hall, Tol, Jordans, Bass, & de Jong, 2014).

Situations of dependency associated with living in refugee camps, or lack of recognition of previous roles and qualifications in resettlement countries leads to major disruptions to individuals' identity

(Silove, 1999). Involvement in meaningful action leading to recognition as a valuable member of the community has been identified by refugees as contributing to recovery from PTSD following conflict and displacement (Ajdukovic et al., 2013). In addition, the provision of alms and care to the needy is one of the five pillars of Islam and volunteering, especially among women, may be considered a social norm for all those who are able (Deeb, 2009). Van der Velde and colleagues (Velde et al., 2009) reported that refugee participants in a research study described the elements of project design which most effectively led to their own empowerment were "mutual respect and reciprocal information transfer among all members, the creation and control of the project by community members, and active involvement in a project designed for the betterment of their communities" (pp 1298, Velde et al., 2009).

IMPLEMENTATION

Participatory interventions are necessarily long term and involve working to create a forum through which local voices can be heard (Wallerstein & Duran, 2006). By engaging community members in recruitment, research design and dissemination, face validity and quick translation of outcomes may be improved (Viswanathan et al., 2004). Participants report feeling that their knowledge is validated and that they learn useful skills through the process. This also provides opportunities for community members to gain an understanding of western knowledge systems which can help them act as mediators between the community and larger international forces (Velde et al., 2009). Challenges to implementation may include substantial changes to research question and design following community input and difficulties forming trusting relationships with refugee groups (Higgins & O'Donnell, 2008). It remains important to continue to use reflexivity tools to address the potential for power imbalance in participatory research, especially when academics are driven by the need to publish outcomes (Legault, Claudette Vanderplaat, 2008). This process necessarily involves adopting multiple viewpoints, including how one's self may be perceived by the community (Wallerstein & Duran, 2006), and continued awareness that the researcher is not a detached observer (Foster, 2008).

This involves investigating for what purpose and within what frame of reference questions and knowledge claims are produced (Frisby & Creese, 2011).

This brief review provides a theoretical basis for the use of participatory engagement strategies in the empirical work discussed in this thesis and represents a starting point for this process of engagement. Chapter 8 provides a more detailed account of the specific methodology used, the Community Readiness Model, which is intended to help initiate relationships between researchers and community members to guide further action. As discussed above, participatory programs are often iterative and may end up somewhere different to where they are originally intended to. This is a strength of the methodology, which allows researchers to adapt their aims to community needs. Chapter 10 discusses the multiple journeys entered into through this iterative process. Finally, the desire for participatory engagement was expressed by Syrian participants in multiple settings described in the empirical chapters of this thesis. The next chapter highlights this issue in a qualitative synthesis of psychosocial needs reported by Syrian refugees in humanitarian organisation reports in Jordan.

CHAPTER 6:

PSYCHOSOCIAL CONCERNS REPORTED BY SYRIAN REFUGEES LIVING IN JORDAN: SYSTEMATIC REVIEW OF UNPUBLISHED NEEDS ASSESSMENTS

A primary aim of this thesis is to promote greater understanding of the specific ecological factors which affect wellbeing for Syrian refugees living in Jordan. A thorough understanding of the broad range of factors which shape the daily lives of Syrian refugees is key to designing programmes which can promote uptake and sustainable implementation. In particular, understanding needs relevant to community members will be best enhanced through the use of methodologies which allow community members to state their needs on their own terms and in which researchers use reflexivity to challenge their own assumptions. At the time of initiation of this review (March 2014) there was very limited peer reviewed academic literature describing psychosocial needs as described by Syrian refugees, in fact no reports published in academic journals satisfied the systematic search criteria of this review. However, in the early stages of a humanitarian crisis, it is standard practice for humanitarian organisations to conduct needs assessments to guide program implementation. During my first field trip to Jordan (December 2013 – January 2014) psychosocial workers I met introduced me to the UNHCR website designed to collate information and data about the regional refugee response (UNHCR, 2017b). There was a wealth of information about psychosocial needs as they had been reported by Syrian refugees to humanitarian organisations, so I determined to systematically search these sources and generate a qualitative synthesis of the findings. The resulting model is an attempt to present these findings in a way which privileges the views of Syrian refugee community members while considering their relation to priorities for action in humanitarian settings (IASC, 2007). The findings demonstrate the salience of everyday stressors over psychological diagnostic categories to community members. We also took the opportunity to assess the methodological quality of reports in order to make statements about the standards of general practice in this field.

CHAPTER 6: PSYCHOSOCIAL CONCERNS REPORTED BY SYRIAN REFUGEES LIVING IN JORDAN: SYSTEMATIC REVIEW OF UNPUBLISHED NEEDS ASSESSMENTS [2]

ABSTRACT

Background: Humanitarian organisations (HOs) supporting Syrian refugees in Jordan have conducted needs assessments to appropriately direct resources.

Aims: To present a model of psychosocial concerns reported by Syrian refugees and a peer review of research practices.

Methods: Academic and grey literature databases, the UN Syria Regional Response website, key HO websites and Google were searched for needs assessments with Syrian Refugees in Jordan between February 2011 and June 2015. Information directly reporting the views of Syrian refugees regarding psychosocial needs was extracted and a qualitative synthesis was conducted.

Results: Syrians report psychological distress is exacerbated by both environmental (financial, housing, employment) and psychosocial outcomes (loss of role and social support, inactivity) which are themselves stressors. Need for improvement in research methodology, participatory engagement and ethical reporting was evident.

Conclusions: Participatory engagement strategies may help to address identified psychosocial outcomes. More rigorous qualitative methodologies are required to ensure accuracy of findings.

Declaration of Interest: None.

[2] This chapter is a published manuscript: Wells, R., Steel, Z., Abo-Hilal, M., Hassan, A. H., & Lawsin, C. (2016). Psychosocial concerns reported by Syrian refugees living in Jordan: systematic review of unpublished needs assessments. *British Journal of Psychiatry, 209*(2), 99-106. doi:10.1192/bjp.bp.115.165084

INTRODUCTION

The United Nations (UN) has labelled the current Syrian conflict as the worst humanitarian crisis that has occurred within the first part of the 21st century (Lancet, 2014). It is estimated that there are in excess of 4 million displaced Syrian refugees in the Middle East and over 629,000 that have been displaced to Jordan (UNHCR, 2015), the focus of the current review. While many displaced Syrians live in refugee camps, the largest being Za'atari camp, which is home to over 120,000 people, the vast majority live in the host community (Murshidi, Hijjawi, Jeriesat & Eltom, 2013). In Jordan, Syrian's have limited access to work permits often being required to work in the informal sector to secure livelihood. Syrian's registered with the UN are eligible to access some cash assistance and food vouchers and education and health systems (SNAP, 2013), although the health system has struggled to keep up with demand (Murshidi et al., 2013).

Stressors inherent in forced displacement (Wessells, 2009) combined with exposure to potentially traumatic events (PTEs) during conflict (Steel et al., 2009) are likely to contribute to the development of heightened mental health difficulties (Miller & Rasmussen, 2010) in such humanitarian settings. Over recent years Humanitarian Organisations (HOs) have increasingly undertaken psychosocial needs assessments to inform the development of aid programs. These assessments are of critical importance, in that they not only inform policy development but provide early snapshots of the problems experienced by populations subject to forced displacement. This literature has largely remained unreported in peer review setting, however examination of this literature is important as first line evidence of psychosocial needs in emerging crises (Quosh, Eloul & Ajlani, 2013; Tol et al., 2011) as well as providing an opportunity for review of the methodological rigour of such assessments (Ager et al., 2014; Tol et al., 2014).

International consensus research has identified the most pressing psychosocial research questions within emerging humanitarian settings is the identification of stressors faced by displaced persons, and how refugee populations perceive and describe their psychosocial concerns (WHO, 2012; IASC, 2012; UNHCR, 2006; Tol et al., 2011). A large number of needs assessments of mental health concerns among Syrian refugees in Jordan have now been undertaken in response to the refugee and humanitarian crisis in that country. A critical factor in reviewing HO needs assessments is assessing the quality of the reports, both in relation to methodological rigour and consideration of ethical research principles (Evans & Pearson, 2001; Braun & Clarke, 2006; Blaxter, 1996). Adherence to qualitative research standards and ethical practice is necessary despite the practical challenges of achieving this in humanitarian situations (IASC, 2014), with deviation from this likely to undermine the value of the research and potentially undermine relationships between researchers and participants.

This systematic review draws together existing reports of needs assessments undertaken between February 2011 and June 2015 in Jordan which is as a leading country of first asylum for Syrian refugees. In reviewing these assessments we aim to create a model of psychosocial concerns identified by Syrian refugees and to subject the design of conducted needs assessments to independent review.

METHODS

SEARCHING

We under took a combined search of peer reviewed academic abstracting databases (Psychinfo; Medline; Scopus; PILOTS; Science Direct; Proquest), grey literature databases (Grey Literature Report (Myohanen, Taylor & Keith, 2005); Open grey (Schopfel & Prost, 2009); National Repository of Grey Literature (National Technical Library, 2014)), HO websites as well as internet searches using the Google search engine (see supplemental table S1 for list of search terms and databases). Searches were conducted in two waves (May 2014 and June 2015). The searches aimed to identify English

language needs assessments which included the terms *Syria*, *refugee* and *needs assessment* between February 2011 and June 2015. Search terms were broad and were varied according to database indexing system and information source. Where available, database subject indexing terms were used to identify relevant articles. Where subject heading results were limited, additional text key word searches were conducted. Grey literature databases that index documents not published in peer reviewed journals, such as **technical or research reports, doctoral dissertations and conference papers, were also searched.** The United Nations Syria refugee response inter-agency information sharing portal (UNHCR 2015) also lists documents shared by UN partner organisations. All documents from this list, limited to reports conducted in Jordan and written in English, were downloaded. Relevant HO websites were text searched with key words detailed in supplemental table S1, using the Google search engine to limit results to specific websites and portable document format (pdf) documents. For indexed databases, abstracts were downloaded. In all other cases, the full text of identified reports were downloaded and individual references created for each document and imported into Endnote in order to remove duplicates. Searches were conducted by the first author.

This process identified 1821 articles published or released between February 2011 and June 2015, the period reviewed following the mass displacement of Syrian refugees.

SELECTION

Titles and abstracts (if available) of articles were systematically searched for:

(1) Reports of assessments of need, using qualitative or mixed qualitative and quantitative methods, among Syrians of any age, living in Jordan, displaced by the current crisis.

(2) Identified needs assessments were examined by two authors (RW and CL) to determine if they included psychosocial concerns as reported by Syrian refugees in Jordan and agreement reached. For the purpose of this review, psychosocial concerns include: distress and

symptoms of low mood or anxiety; reported issues resulting from known risk factors for mental health impairment, including gender based violence, lack of social support, loss of role, conflict related PTEs; community desires to build capacity to address psychosocial displacement challenges.

Reports based only on data from stakeholders or service providers were not included in the analysis, unless the informants were explicitly stated to be Syrian refugees. For non-published reports, full reports were text searched for words containing *psych, social, support, mental, MHP (abbreviation of MHPSS),* or *distress*. The context of identified words was inspected and reports which directly discussed psychosocial needs identified by Syrian refugees were included. The full text was also visually scanned for sections referring to psychosocial outcomes.

EVALUATION OF METHODOLOGICAL QUALITY OF STUDIES

The Inter-agency Standing Committee guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC) (IASC, 2007; UNHCR, 2013) establish best practice models for responding to psychosocial needs in humanitarian crises. The guidelines recommend that humanitarian service provision is based on ongoing assessment of the psychosocial concerns of the community (WHO, 2011) and recognises that externally driven programs will not be sustainable (Wessells, 2009). The IASC guidelines highlight the need to ensure ethical practice, including informed consent and non-expectation of reward for research participation and participatory engagement and capacity building practices (here after referred to as participatory engagement), which include community stakeholders and training of local staff and volunteers, to facilitate community ownership of programs (IASC, 2007) and help ensure interventions are ethical (Wessells, 2009) and culturally appropriate (Taleb et al., 2015).

We drew on the Cochrane guidelines for inclusion of qualitative research in systematic reviews (Hannes, 2011) with assessment quality in four domains: credibility, transferability, dependability and confirmability. Credibility refers to methods, such as member checking (review of emergent themes by research participants or relevant community members), peer debriefing and independent rating, which help ensure that results reflect the views of the participants. Credibility may be enhanced by partnership and engagement. Transferability refers to whether findings can be applied or generalized to other contexts, which is enabled by provision of detailed information about participants and their context. Dependability can be promoted through peer review, debriefing, connection to existing literature, the use of accepted analysis methods and triangulation of data sources. Confirmability may be enhanced by reflexivity regarding the researcher's role, bias, school of thought and impact on the participants and outcomes.

In order to evaluate the methodology of the psychosocial needs assessments we applied existing rating scales (Evans & Pearson, 2001) including items from criteria outlined by Popay and colleagues (Popay, Rogers & Williams, 1998) and Blaxter (Blaxter, 1996) with the addition of an item relating to ethical procedures. Reports were scored as low, medium or high (0,1 and 2 respectively) on each checklist item. Supplemental table S2 outlines the checklist items and the criteria used to score reports at each level. For each methodological domain an average quality score out of 2 was calculated from all scores on items within that domain, and graded as does not satisfy minimum criteria (< 1), satisfies minimum criteria (≥1) or high quality adherence (> 1.5). Study quality indicators for each domain and total score were compared between search 1 and search 2 using independent means *t* test. Significance level was set at $p < 0.05$.

QUALITATIVE SYNTHESIS OF EXTRACTED DATA

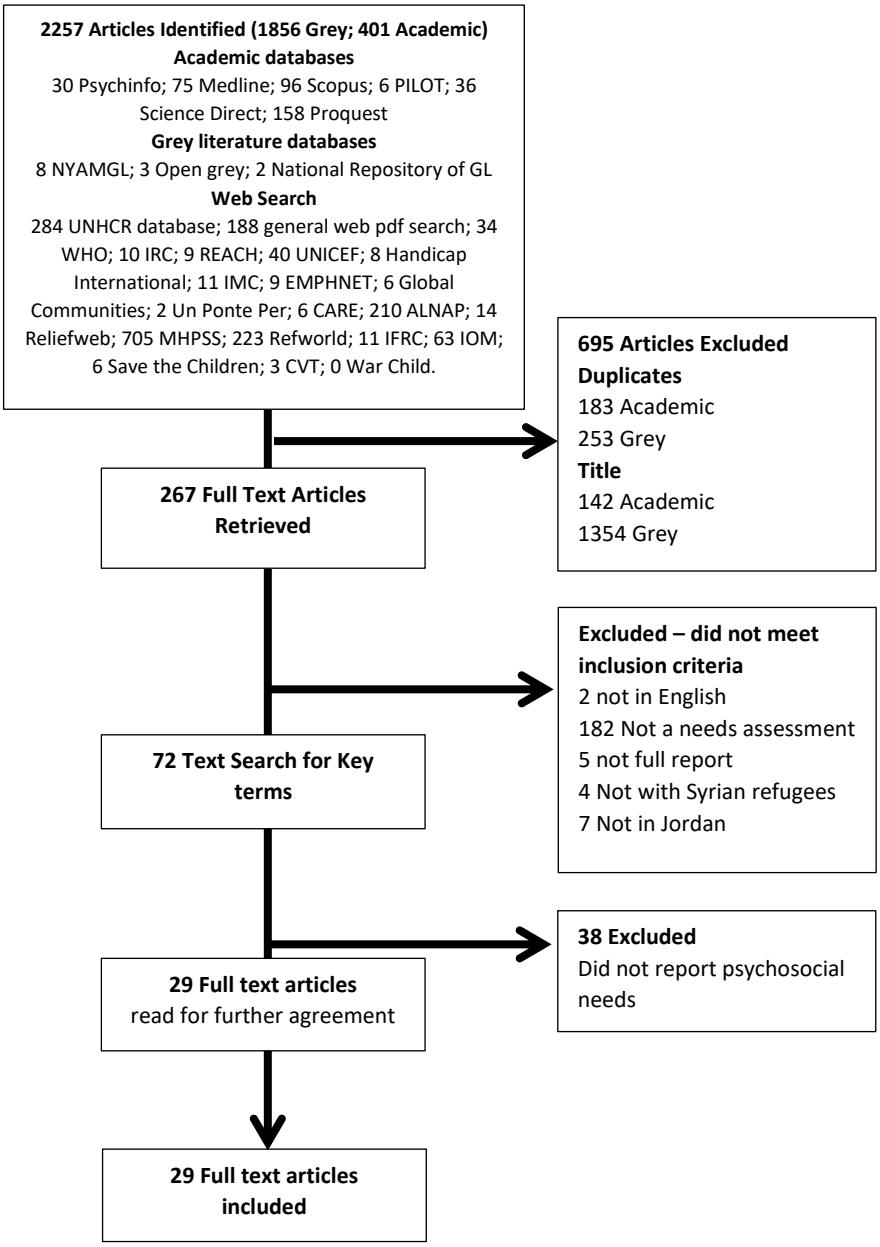
In developing a synthesis of needs across assessments, we employed thematic analysis (Braun & Clarke, 2006) for integrating perceived needs of refugees. Reports were coded into key themes, which were cross coded and iteratively revised to identify core themes. In order to ensure findings reflected relevant community attitudes, emerging themes were presented to two Syrian psychiatrists currently treating Syrian refugee in Jordan (AHH and MAH) and were revised accordingly. When describing themes emerging in at least 6 articles (21%), percentage of assessments reporting the theme were reported in text with references provided in Table 1, otherwise individual citations were provided in text. As the majority of studies employed open questioning and often did not provide copies of the questions asked of respondents, it was not possible to list prevalence of studies reporting an issue as a percentage of studies which examined the issue. In line with recommendations for psychosocial interventions in post-conflict (SIlove, 2011) and mass trauma (Hobfoll et al., 2007) settings, we distinguished between *environmental stressors*, objective (Ryan, Dooley & Benson, 2008) factors which impact on access to basic necessities, such as housing, food, safety, security and rights and *psychosocial impacts*, subjectively mediated impacts of environmental stressors which may, themselves, become stressors and lead to cycles of resource loss (Hobfoll, 2001).

RESULTS

Searches identified 2257 articles. Following removal of 1932 duplicates and exclusions by title, 267 articles were retrieved with 29 meeting inclusion criteria (see Figure 1). Demographic information and study characteristics for the 29 studies that met inclusion criteria are presented in supplemental table S3. Studies reported results from a total sample of 15720 refugees in 13 regions in Jordan, including those in refugee camps or host communities, between May 2012 and June 2015. Respondents ranged in age from below 6 years to 85 years and originated from six regions in Syria, most predominantly Deraa, Homs and Damascus. Supplemental figure S2 shows the locations of studies, with most being concentrated in the north of Jordan, and the sample size for each study at each location.

The scope of reports varied, with some focusing on specific issues and some only assessed psychosocial issues as part of a larger logistic and operations review. Population wide psychosocial needs were the primary focus of 17% of the reports. The remainder of reported that also included a needs assessments were intended to determine current general needs (31%), basic needs (e.g. housing, food), educational needs (14%), health needs (10%) or the psychosocial needs of specific subgroups (e.g. women, Youth) (28%) in order to guide immediate aid implementation across a range of domains. See supplemental table S3 for assessment type of each study.

Figure 1. Flow Chart of Article Selection Process.



QUALITATIVE SYNTHESIS OF PSYCHOSOCIAL NEEDS DISCUSSED BY SYRIAN REFUGEES

ENVIRONMENTAL STRESSORS

Insecure housing and lack of income to pay rent was rated as a concern in all studies which assessed this issue (18 studies; 62%), (see Table 1 for references to individual studies, references in this results section refer to the list of included reports in this review). Rent prices were reported to be excessive and increasing (Care Jordan, 2013), with some households selling food rations to pay rent Care Jordan, 2013; Questscope, 2013; IRC, 2013; UNHCR, 2012; Serrato, 2014). Refugees reported living in overcrowded conditions in 9 studies (31%) (see Table 1), for example, up to 18 people in a single home were cited (Save the Children, 2015). Refugees linked cramped living conditions to their psychological health (IMC, 2012) and family conflict (UK Aid, 2014).

Refugees reported work exploitation (13 studies; 45%), including child labour leading to missing school (Serrato, 2014; Save the Children, 2015; Mercy Corps, 2012; UNHCR, 2014; Care Jordan, 2012) and employment restrictions leading to work in the informal sector (Serrato, 2014; Mercy Corps, 2014; IRC, 2014) where they were subject to long hours (Care Jordan, 2012; Care Jordan, 2013; Doedens et al., 2013); low pay, and abuse and harassment Mercy Corps, 2014; IRC, 2014). Difficulties associated with complicated registration processes were reported to limit access to healthcare UNHCR, 2014, education (JENA, 2015) and services (Serrato, 2014; Un Ponte Per, 2012). Women reported sexual harassment (17 studies; 59%), including pressure to accept unwanted marriage proposals (Mercy Corps, 2014; IRC, 2014) or being asked for sexual favours (UNHCR, 2014; IRC, 2014) in exchange for financial aid with fear of the host community (Care Jordan, 2014; Serrato, 2014; IRC, 2014; UNHCR, 2014; MoH, 2014) and movement restrictions (6 studies, 21%) being reported by women as a result. Eight studies (28%) reported that discrimination limited access to health care (Serrato, 2014; UNHCR, 2014) and housing ((UNHCR, 2014; MoH, 2014). Thirteen studies (45%) reported verbal abuse and

insults in public, while 9 studies (31%) reported physical abuse in the street, including at school for children, resulting in many children dropping out of school (Serrato, 2014; UK Aid, 2014; Mercy Corps, 2014; JENA, 2015; JENA, 2014). Approximately half of Syrian children were identified as not attending school (Save the Children, 2015; Mercy Corps, 2014; Jena, 2014). In counterbalance, two studies reported positive interactions with the host community (UNHCR, 2014; MoH, 2014).

PSYCHOSOCIAL IMPACTS

Syrian refugees reported that environmental stressors led to psychosocial impacts which themselves created an additional level of stress in 23 studies (79%). This included loss of social and occupational role (11 studies; 38%) and having nothing to do (7 studies; 24%) which was identified as contributing to increases in domestic conflict (6 studies; 21%). Syrians reported social isolation due to loss of contact with social support structures and fear of abuse outside the home in 15 studies (52%). Isolation was reported to be worse in the host community (Save the Children, 2015; UK Aid, 2014), with limited spaces for social engagement (IMC, 2012; Un Ponte Per, 2012; Handicap International, 2014). Many could not afford hospitality and feared being a burden on others if they visited them (Care Jordan, 2012; 2013).

SYMPTOMS OF DISTRESS

Being worried or distressed by practical circumstances and uncertainty was commonly reported (24 studies; 83%). In 15 reports (52%), Syrian refugees identified that PTEs (e.g. war and displacement related) has led to symptoms of distress (Mercy Corps, 2014; IRC, 2014; UNHCR, 2014; MoH, 2014), including anger (Mercy Corps, 2014; MoH, 2014; WHO 2015) and increased general fear (UK Aid, 2014; JENA, 2014). Refugees reported being frightened by reminders of PTE's, including the sounds of planes, guns or firecrackers (7 studies; 39%) and avoiding them (WHO, 2015). Parents and children

reported distress and fear about family separation (7 studies; 24%). Children reported fears of burning, being arrested, being shot or kidnapped (IMC, 2012).

Symptoms of depression and low mood were also commonly reported by refugees (20 studies; 69%), including, symptoms of sadness (Serrato, 2014; Save the Children, 2015; IRC, 2014; JENA, 2015; MoH, 2014; WHO, 2015), hopelessness (Mercy Corps, 2014; Care Jordan 2013; MoH, 2014; JENA, 2014; WHO, 2015), lethargy (Handicap International, 2014), loss of interest (UNHCR, 2014; WHO, 2015; UNHCR, 2013), insomnia (Questscopre, 2013; IRC, 2013; Care Jordan, 2012; Care Jordan, 2013; MoH, 2014), impaired concentration (Care Jordan, 2013; MoH, 2014; JENA, 2014; Handicap International, 2014; WHO, 2015), suicidal ideation (IRC, 2013; Care Jordan, 2013; JHAS, 2012; IMC, 2013) and self-harm (UK Aid, 2014). One study noted deterioration in psychological symptoms in surveys that spanned multiple time assessments (Care Jordan, 2014).

STRESSORS, IMPACTS AND SYMPTOMS INTERACT TO INCREASE DISTRESS

Refugees reported that psychological symptoms interacted with the other displacement stressors and often led to anger (10 studies; 34%), further exacerbating familial distress (Questscope, 2013). Inactivity, loss of role and psychological symptoms were perceived to be leading to aggressive behaviours among young men in the camp setting (8 studies; 27%). Adults linked children's aggressive behaviour to psychological problems (UK Aid, 2014; MoH, 2014; JENA, 2013). Violence within the refugee community was another reason for children not attending school (Care Jordan, 2014; JENA, 2013; WRC, 2014). The stresses of life in displacement, especially inactivity (Care Jordan, 2014; UNHCR, 2013), were seen as leading to family conflict and domestic violence in 14 studies (48%), which was reported to be common (Save the Children, 2015; UK Aid, 2014; JENA 2015; WHO, 2015) and increasing (IRC, 2014; Care Jordan, 2013; Doedens et al., 2013; MoH, 2014; IRC, 2012). In one study, 38% of Syrians reported child abuse in the family (IMC, 2013).

PSYCHOSOCIAL SUPPORT SERVICES

Groups in 11 reports (38%) asked for increases in psychosocial support services and community activities to relieve stress. Many highlighted satisfaction with range of activities available at informal education centres, preferring them to schools (JENA, 2015; JENA, 2014) while others commented that there are many activities for girls, but not for boys (IRC, 2013; UNHCR, 2013).

Victims of conflict-related and familial gender based violence (GBV) were reported to be prevented from seeking physical or psychological care due to stigma and safety fears (IRC, 2013; UNHCR, 2012; Serrato, 2014; Doedens et al., 2013) or lack of information (UHCR, 2014). There was recognition of the problem of GBV across reports (IRC, 2013; UNHCR, 2012; UNHCR, 2014; IRC, 2014; Doedens et al., 2013; JENA, 2013) with young men requesting awareness sessions to reduce domestic violence (UNHCR, 2013). Young women also requested awareness sessions regarding early marriage (UNHCR, 2012) and there was social action by groups of women participating in public performances exploring this issue (WRC, 2014).

Refugees displayed a desire to be involved in the process of community support, or activities which can mobilise social resources (11 reports; 38%) and requested skills development (6 reports; 21%) including psychosocial care skills (JENA, 2015) and legal procedures (Serrato, 2014). Many highlighted the benefits of informal community supports (UNHCR, 2014) and self-directed participatory engagement in community life (IRC, 2014; JENA, 2014), including kin caring for children separated from their parents (Save the Children, 2015) and children requesting the chance to help others (World Vision, 2014). Refugees also reported that their offers to volunteer or feedback were ignored by HOs (Serrato, 2014; IMC, 2012; Doedens et al., 2013). Syrian volunteer teachers expressed frustration at

not being permitted a greater role in the education of children in Za'atari camp (JENA, 2013), while children said they preferred Syrian teachers (JENA, 2014).

Table 1. Exemplars of Themes from Qualitative Analysis of Reports

Theme		Exemplar	References
Basic needs and discrimination	Basic needs first	*""Rent is the most important thing for us, if we don't have a roof over our heads we will have to go back to Syria …. If you are going to give us anything give us rent first and then blankets!"* Father of 6, Hai Nazzal*"* **5**, pg 30."*We are psychologically tired because we lost everything and had to migrate. We have no money"* **19** pg 42	1, 4, 5, 6, 7, 9, 10,16,17,19, 20,21,22,23,24,25,26,27,28,29
	Overcrowding	*"There is no privacy any more, with the large number of people in every room. We no longer feel comfortable or at peace."* **13,** pg 5.	3, 6, 7, 12, 13, 16,24,28,29
	Work Exploitation	*""If you can and are willing to work, it is not difficult to find work here. The difficulties come with being paid almost nothing and the long hours. For me it is still better than sitting at home waiting to see if someone will help us!"* Father of 5, Hai Nazza*""* **5,** pg 30. "Syrian girls spoke of verbal abuse and harassment during work, and said they feared beatings if they complained about their conditions" **21**, pg 12.	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29
	Sexual harrassment and economically necessitated marriage	"Abu Ahmad fell down the stairs and broke his leg... Someone offered the family help... but the support was conditional: Nour, Abu Ahmad's 19-year-old daughter, must enter a marriage set up by the person who offered support." **17,** pg 53	2, 4, 5, 6, 7, 9, 12, 16, 18, 17, 20, 21, 22, 23, 24,25,26,28
		"When I walk down the street I hear the comments men make. When I take public transportation to pick up aid or do the shopping, men always ask me if I am Syrian. I feel immediately objectified. In Syria, I would go out at night, even without a male escort. I enjoyed being a hostess and we were a very social family. But here, I isolate myself." **25** pg 6	
	Discrimination	*"Many focus group respondents perceived this poor treatment by healthcare staff as prejudice against Syrian refugees and spent a good deal of time discussing the discrimination they felt played an important and highly detrimental role in their healthcare experiences in Jordan"* **20** pg 20*"They alleged one community member was denied child delivery assistance and out of desperation travelled to Amman to give birth"* **28** pg 26	3, 6, 10, 13, 19, 20,21,22,23,26,28,29
Loss of role and social networks	Loss of role	"the incapability of providing for the family made them very frustrated and depressed. They would like to be able to go further than the basic needs and buy toys for their children, for instance." Adult Male FGD, **16,** pg 35 "Ninety-four per cent of the women interviewed felt their responsibilities had shifted since becoming the head of household, with a small number of the opinion that this was empowering and positive. But most – 95 per cent – indicated that the role change was a negative one" **22** pg 45	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29

	Inactivity worsens stress	"One focus group participant acknowledged that she was sure her hypertension and health was made worse by drinking coffee and watching television all day but complained she had nothing else to do." **5**, pg 33	5, 9, 14, 15, 16, 12, 23
	Inactivity leads to conflict	"*I hate having my father and her eldest brother staying in the caravan the whole day, they start interfering in everything and this is making my life impossible. It would be much better if they had a work so they would be busy with other things*" female youth not attending to school" **16,** pg 32	3, 4, 16, 18, , 25, 28
	Social isolation	""*During my first days in Jordan, I was just walking through the street crying, because I felt lost and did not know anybody.*" Female FGD participant from Amman" **17,** pg 40 "Harassment on the streets, long work hours, and domestic duties further inhibit socializing and increase isolation for many adolescents" **21** pg 8	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29
	Verbal and physical abuse	""*We, the displaced Syrian children, are suffering from violence in the streets. We're getting beaten up and cursed…Verbal abuse hurts us deep inside. Humiliating words such as 'When will you go back to your country?' and 'When will we get rid of you?' resound in our minds, hurting us*." **14,** pg 11 The primary school boys also reported having stones thrown at them... [they] were particularly fearful of this violence, particularly after their experiences in Syria; "although we escaped from bombing... now some boys organise gangs and beat us" (primary school boy) **27** pg 68	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29

Refugees report symptoms of distress	Fear of stimuli associated with conflict	"Images and sounds of the war are still alive in their minds they said, affecting their psychological state" **2**, pg 11 "War-related concerns (fear of airplanes, bombs, sadness about family in Syria, nightmares, fears of war) and education concerns were listed as high priorities." **29** pg 3	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29
	PTEs leads to distress	"According to one informant, the ongoing emotional and mental discomfort of having witnessed and/or experienced such violence *"feels like having a two-sided blade in your mouth – you can't swallow it and you can't take it out."* **12,** pg 24	2, 3, 5, 11, 14, 15, 12,16,20, 21, 23, 25, 27, 29
	Worried or stressed by circumstances	Worry and concern over the situation and relatives in Syria was the most commonly expressed problem by the respondents representing 29.5% (39 responses) **19** pg 41 "Most FGD participants summarised the consequence of displacement as making them feel constantly anxious and stressed" **28** pg 38	2, 5. 6, 8,12,16, 19, 21, 28, 29
	Symptoms of low mood and hopelessness	""*I was very frustrated and angry, and one day I found that I lost my faith in what I do, then I quit (school), since then I don't have interest in anything around me*"" female youth out of school." **16,** Pg 21 "*I am depressed, I hate everything and I can't sense anything around me"* (12-17 Girl) ? "*Everything ended ...home country, education and future."* (12-17 Girl)" **27** pg 40	2, 3, 4, 5, 7, 9, 12, 14, 15, 16, 18 , 19, 21, 23, 24, 25, 26, 27, 28, 29
	Anger	*"I'm depressed; I'm short-tempered—I never was before. But here…I beat my daughters—this one I beat every two to three days; this other all the time. I don't want to; I just—I'm angry all the time*."—Nour, 38, Jordan" **25** pg 10	2, 5, 11, 12, 19, 21, 23,24, 25, 28

Violence resulting from psychological problems puts refugees at greater risk	Youth aggressive behaviours in camps	"*the teens are now disrespectful, defiant, and rudely talking like I'm a sibling, not parent. This is no way to raise a kid in a camp. They don't respect or listen to us anymore- only listen if we beat them*." – Focus group of fathers of adolescent Syrians in Za'atari." **14,** pg 19	3, 9, 10, 11, 14, 16, 18, 17,
	Stress leads to family violence	"This group believed that domestic violence was somehow a consequence of this lack of privacy and space, as well as the high psychological pressure put on families that is leading to bad behaviours" Adult female 'with male support' FGD, **16,** pg 11 " Some women attribute this "yelling and beating" as men's way of coping with the stress of trauma and of being a refugee" **25** pg 9	4, 7, 13, 10, 16, 18, 19, 22, 23 24,25,26, 28, 29
	Violence towards children	"*If my friend tried to talk to him, [his father] would hit and abuse him because of the psychological burdens inflicted on the family*." **13,** pg7 "" One woman said: "*When his pockets are empty, yes, I am beaten by my husband. I handle it by taking it out on the kids"*—Raniya, 28, Jordan. In some instances, women confided that they had beaten their children as a way to relieve the stress and anger they felt after being beaten themselves" **25,** pg 10 "Parents described themselves as short-tempered and frequently feeling that the only solution left to discipline children was to hit them. Underpinning this is the stress of not knowing what the future will hold" **28,** pg 6	6, 14, 18, 25, 28
Refugees request psychosocial support and participation	Stigma limits access to services	"Cultural norms often limit women from accessing medical or mental health services related to rape, sexual violence or domestic violence. Identifying oneself as a survivor can bring great shame upon a family; women are encouraged to keep silent or risk loss of reputation or further violence (or even death)" **12,** pg 20	6, 10, 12, 16,17, 28
	Requesting psychosocial support and awareness raising	"Last week we attended an awareness session on early marriage and how it affects women health. I love it and I think it really opened our eyes to things we have never thought of it." **6,** pg 29 - A woman in Mafraq (UNHCR 2012) "I feel better having spoken my frustrations out loud and feeling like someone was listening to me." **12,** pg 24	2, 4, 7, 5, 10, 12,20,21,24,25,26,28,29
	Requesting skills development	"They added that in order to avoid dependency on assistance they would like to receive trainings, including language and computer courses, to prepare them to assume functions and jobs both here and when go back to Syria." **16,** pg 33 "A skill for a woman is a weapon. It allows her to stay independent, to protect herself and her family. —Yana, AGE 65" **25** pg 15	6, 11, 12, 16, 26, 28
	Requesting participation	"*We would love to take part in relief efforts and help other Syrian refugees and friends to help wipe away their tears and the pain of being away from their country. We would love to draw a smile on their faces*" **13,** pg 17	3, 10, 11, 13, 16, 23, 29, 22, 25, 27, 28

Note. Example quotes contributing to themes are provided for each theme and sub-theme. References refer to numbered items on list of included studies (see references).

EVALUATION OF STUDY QUALITY

Table 2 outlines the findings of the methodology review for the 29 psychosocial assessments. For each of the 5 domains, a quality score out of 2 was derived. This represents an average across all 29 studies for each of the domains. A score for a domain of less than 1.0 indicates the studies do not satisfy minimum criteria for that domain (< 1); a score between 1.0 and 1.5 meets minimal criteria (medium quality); and a score above 1.5 indicates that the majority of studies have met the majority of criteria for that domain (high quality). For each checklist item, the percentage of studies employing a minimum level of rigour are defined as those that meet either medium or high quality concordance ratings across each of the quality checklist items. We also present the percentage of studies meeting the highest quality ranking for each quality checklist item in brackets. A copy of the individual scores for each needs assessment included in the current review is available from the authors.

On average, dependability scores (see definition above) satisfied minimum criteria (average 1.1/2 across studies and criteria). 90% of reports reviewed relevant literature (59% high) with 93% of studies also using some form of triangulation of multiple data sources (62% high); 72% of studies used trained staff or provided training to staff (24% high) and 72% of reports described data collection and analysis procedures (45% high). However only 41% of studies described the qualitative data analysis techniques applied (31% high) while only 45% used supervision or debriefing procedures (24% high).

On average, transferability scores satisfied minimum criteria (average score across studies and criteria 1.4/2.0). 90% placed the findings reported in the relevant context (55% high); 90% of reports provided

adequate description of research setting (55% high); 76% of reports gave clear accounts of sampling (55% high) and 66% used purposive sampling to target specific groups (55% high).

On average, confirmability scores satisfied minimum criteria (average 1). 48% of reports included researcher reflexivity (28% high). 76% of studies discussed the impact of tools employed (41% high) 66% of studies reported adapting research tools to the local context (41% high).

On average, credibility, partnership and engagement scores across the studies did not meet minimum criteria (average 0.8). While 86% of reports privileged the knowledge of refugees over other sources within qualitative analysis (59% high) only a third of needs assessments (34%) used some form of participatory engagement to ensure the inclusion of refugees within research design and implementation (24% high) and only 28% of studies used member checking procedures to confirm findings (17% high). In terms of ethical practices, on average studies did not meet minimum criteria (average 0.9), 52% of reports described ethical procedures (44% high). There was considerable improvement from the first systematic search (2014) to the second (2015) wave of review that identified more recent assessments, with significant differences between searches in dependability ($t(27) = 2,2$, $p = 0.04$), confirmability ($t(27) = 2.2$, $p = 0.04$) and total quality score ($t(27) = 2,4$, $p = 0.03$).

Table 2. Methodological Quality Ratings Across Studies.

Criteria	Mean (0-2)	% ≥ 1	% ≥ 1.5
Dependability	1.1	34	24
Review of literature	1.5	31	59
Clear accounts of data collection and analysis?	1.2	28	45
Training provided or trained staff?	1	48	24
Supervision or peer debriefing?	0.7	21	24
Qualitative analysis procedures	0.7	10	31
Triangulation	1.6	31	62
Transferability	1.4	34	45
Clear accounts of sampling	1.3	21	55
Purposive sampling	1.2	10	55
Adequate description	1.5	28	62
Data is contextualised	1.4	34	55
Confirmability	1.0	31	24
Adapt design to context	1.07	24	41
Discussion of tools	1.17	34	41
Reflexivity or bias	0.76	21	28
Credibility	0.8	28	14
Member checking	0.4	10	17
Privileges knowledge of respondents	1.4	28	59
Participatory	0.6	10	24
Ethics	1	0	0
Ethics statement	1	7	45

Note. Quality ratings for each checklist item (in rows). Reports were scored as low, medium or high (0,1 and 2 respectively) on each checklist item. A total quality score, out of 2, is presented for each domain as an average of scores within that domain. Average quality scores (out of 2) are graded as does not satisfy minimum criteria (< 1), satisfies minimum criteria (>1) or excellent (> 1.5). Average quality scores across the studies are presented in the first column, followed by the percentage of studies >1 and the percentage of studies > 1.5.

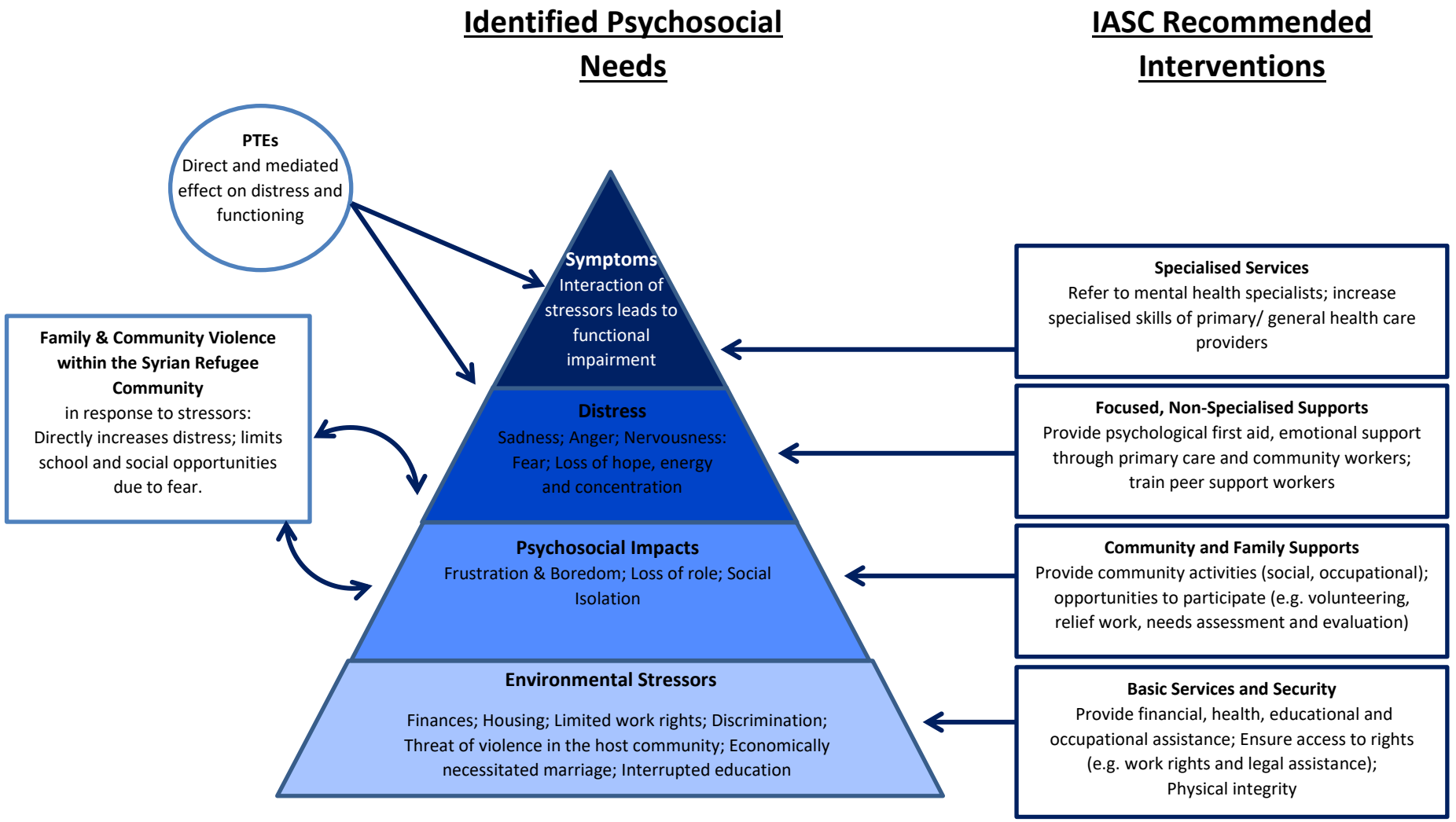
DISCUSSION

Across the surveys reviewed, Syrian refugees living in Jordan report distress as a direct result of both PTEs and stressors inherent in the displacement setting. These factors interact to exacerbate distress. Despite the stigma associated with mental health care seeking documented amongst Syrian populations (Quosh et al., 2013; Maziak, Asfar, Mzayek, Fouad & Kilzieh, 2002) substantial numbers of displaced Syrian refugees in Jordan identified the impact of stressors on mental health difficulties within the community across the majority of the need assessments undertaken, and a proportion requested access to psychosocial support. It is unclear if this represents a cultural shift in attitudes to mental health care seeking or has spontaneously arisen from the experiences of the refugees, especially considering that only 17% of the needs assessment reports were explicitly focused on assessing psychosocial needs.

Figure 2 depicts a model derived from the current findings. Consistent with Miller and Rasmussen (2010), this model describes how PTEs during conflict and/or displacement exert a direct effect on psychological symptoms, while displacement stressors mediate the effect of PTEs on psychological symptoms. In addition, as previously demonstrated in other post-conflict settings (Brooks, Silove, Steel Z,Steel, CB & Rees, 2011), the importance of anger responses arising from PTEs and socio-economic stressors is also highlighted. Previous research has demonstrated that exposure to PTEs has a direct effect on anxiety and mood symptoms (Steel et al., 2009). The interaction of environmental stressors and psychosocial outcomes worsens psychological symptoms (Miller & Rasmussen, 2010), and daily functioning (Quosh et al., 2013), making it harder to work (Al-Hamzawi et al., 2014). Environmental stressors, such as lack of work rights (Quosh, 2013), impact mental health outcomes (Silove et al., 2007) and produce psychosocial outcomes, which themselves become stressors, such as social isolation (Hobfoll, 2001). Loss of social support increases feelings of loneliness, worsening symptoms

of depression (Cummings, Sull, Davis & Worley, 2011), further isolating those most in need of help. Finally, reactions to PTEs and displacement stressors leads to increased anger and aggression (Quosh et al., 2013; Brooks et al., 2011).

Figure 2. Model of Psychosocial Concerns Raised by Syrians



The interaction of PTEs, environmental and psychosocial outcomes creates continuous feedback, reinforcing mental health impairment in the absence of protective factors. In line with best practice models for psychosocial interventions in humanitarian settings (IASC, 2007; Silove 2011; Hobfoll et al., 2007), interventions which may alleviate this burden and the stage at which they may have the most effect are also depicted in the model. The importance of basic needs provision is evident in that such essential services directly alleviate environmental stressors. Specialist and non-focused mental health services may ameliorate psychological symptoms, but these effects are unlikely to be fully effective or to meet the broader needs of the refugees in the absence of psychosocial (or social (Van Ommeren, Saxena & Saraceno, 2005)) programs to target psychosocial stressors or limited resources to reduce environmental stressors (IASC, 2007; Bou Khalil, 2013). The two types of psychosocial interventions requested by refugees, community group programs and participatory engagement in the relief effort, are well suited to addressing identified psychosocial impacts (Hobfoll et al., 2007), can be made available to large numbers of people and can promote sustainability (Silove, 2011; Quosh, 2013; Van Ommeren, Saxena & Saraceno, 2005).

Silove (2011) argues that challenges to identity and role as well as bonds and networks in displacement, including discrimination and social isolation, contribute to poor mental health outcomes and links this with family difficulties. He calls for programmes which promote access to education, employment and community participation. An increased role for refugees in the administration of social and community programs (i.e. participatory engagement) could promote social networks, sustainability and community ownership of projects (Wessells, 2009; Quosh, 2013) while enabling activity, forging new social roles, skills sharing and acquisition (Taleb et al., 2015). Increased refugee involvement in the design and implementation of psychosocial programmes may address many of the key psychosocial outcomes identified from the current review (Hobfoll et al., 2007) and was noted as a key strength of the psychosocial needs assessments that utilised

participatory engagement with refugee communities. It appears that HOs can make improvements in the area of participatory engagement by involving local stakeholders as organisers and research or program partners (Ager et al., 2014). Attention to the manner in which services are provided, through consultation and active engagement, can help address these needs while maintaining a focus on basic services and security (Iasc, 2007). Considering the potential for participatory engagement to help overcome the effects of structural power inequalities on human dignity and agency, and the fact that it is being requested, an increase in these strategies is strongly advised (Quosh, 2013). Limited work rights for Syrians in Jordan make it difficult for HOs to formally involve grassroots Syrian organisations in project planning, yet there is growing evidence that refugees in urban settings can make positive contributions to local economies while supporting their own livelihoods (Jacobsen, 2006). International HOs may be in a position to promote this.

In contrast, the implementation of needs assessments reviewed here demonstrated a general lack of engagement with participatory research methods in the international HO field. The absence of strategies to include community members as key members of research teams limits opportunities for them to build the knowledge which influences what happens to them. There were some notable exceptions to this within the current review. For example, a World Vision report (World Vision, 2014) was written entirely by Syrian refugee children. Integration of participatory models may also assist with addressing key weakness in the methodology of the cohort of needs assessment reviewed herein by building member checking procedures into the research process.

STUDY QUALITY

As noted in other contexts (Quosh et al., 2013), the use of methodologies to improve the validity of psychosocial needs assessments was mixed with adherence to some methodological standards, such as the inclusion of literature reviews, privileging of refugee respondents, and the use of triangulation

of qualitative data but generally poor adherence to the many other quality indicators. The danger of such deviation from quality standards is that reports may not provide the accurate information needed for effective program planning and resource allocation (Blaxter, 0996). For example, a considerable number of reports used the word trauma to refer to PTEs, often in the third person. It not clear whether this term accurately reflects the views expressed by respondents or the orienting framework adopted by the HOs. Greater reflexivity may have helped to clarify this issue. Credibility or refugee engagement scores did not meet minimum criteria, in particular because member checking and participatory techniques were rarely employed as noted above. Greater inclusion of first person exemplars would aid understanding of refugee perspectives and contexts more fully. Transferability scores satisfied minimum criteria, indicating that most assessment teams considered the impact of sampling and the need to provide relevant contextual information. Convenience sampling may have biased results towards care seeking refugees. In addition, many reports focused on the needs of specific *vulnerable* groups (e.g. women), resulting in limited information on the views of other groups (e.g. men), preventing a wholistic or systemic approach to social problems (Wessells, 2009) (e.g. GBV) being achieved.

Confirmability scores only marginally satisfied minimum criteria, while many HOs adapted and discussed research tools, there is room for improvement in the areas of researcher reflexivity and engagement with methods to address potential sources of bias. The perspectives of research organisations must be taken into account when interpreting qualitative results (Wessells, 2009). For example, many international HOs adopt an official stance of neutrality which may impact on reporting of and questioning about sensitive political issues, despite their likely relevance to psychosocial stress. Considering that most of the participants were recipients of aid from the organisations conducting the research, the way that researcher-participant power dynamics influence responses, and how this issue may be mitigated, should be important topics for consideration. The impact of questions asked should also be reviewed. For example, terms such as *psychosocial* may not translate well into Arabic, so direct

questions relating to these concerns may result in less reporting than free-listing (IMC, 2012; Un Ponte {er, 2012). Dependability scores satisfied minimum criteria. Although many assessment teams used triangulation of multiple data sources, qualitative analysis techniques were generally not described. These are all basic qualitative methods which should be reported and included as standard procedure to enhance rigour (Blaxter, 1996; Hannes, 2011; Popay et al., 1998; CASP; 2013; Bearman & Dawson, 2013).

The low engagement with ethical reporting issues in assessments indicates that there is limited expectation in the field for organisations to be transparent and accountable regarding the potential for ethical and rights violations during research practice, despite clear recommendations laid out in the IASC guidelines. Considering the lack of legal protection and information provision available to refugees in humanitarian contexts, it is important that these guidelines are adhered to in the absence of peer review and human research ethics approval processes. Consistent with IASC guidelines (IASC, 2007) agencies should report on procedures for informed consent, ensuring participants understand confidentiality, do not expect rewards for participation and the voluntary nature of participation in research as a minimum requirement (Wessells, 2009; Mackenzie, McDowell & Pittaway, 2007). There are ample open source tools and guidelines available to organisations (IASC, 2007; WHO, 2011) to aid with appropriate ethical adherence and reporting. The expectation of clear ethical procedures in the humanitarian context report should help to ensure their use in the field.

LIMITATIONS

The search terms used to identify studies were intentionally broad. However, since most unpublished literature sources are not indexed, requiring basic text searches, and unpublished studies did not have abstracts describing relevant inclusion or exclusion criteria, some potentially relevant studies may have been excluded or not identified. As only English language reports were included, some reports in other languages (e.g. Arabic) may have been excluded. However, only 2 non-English reports were

excluded during the search. Percentages listed should not be taken to indicate the prevalence of opinions or themes in the community, as refugees were not systematically asked questions relating to themes across studies. As reports were not peer reviewed and are intended for immediate program implementation, authors may not have deemed it necessary to include details of methodologies used within reports. Lastly, the perspective of the first author should be acknowledged. The first author has run both research and psychosocial group programs with Syrian refugees in Jordan, both of which involved large participatory elements. During these programs, the large capacity and desire of community members to direct program implementation was evident. This may have resulted in bias when interpreting the reports.

CONCLUDING COMMENTS

The findings of this review identify an urgent need for humanitarian organisations that undertake needs assessments with displaced refugees to improve use of rigorous qualitative research and ethical best practice guidelines in order to ensure the perspectives of potential aid recipients are more clearly represented. Despite these limitations the collective findings of the 29 reports reviewed indicate that many displaced Syrians living in Jordan identify the interacting impact of displacement stressors and mental health impairment and indicate a willingness to participate in programs aimed at addressing such mental health issues. Psychosocial impacts, such as loss of role and social support, are key areas for which HOs can employ participatory engagement strategies to improve relevance and sustainability (IASC, 2007).

List of Reports Included in the Analysis

1 Un Ponte Per. Comprehensive Assessment on Syrian Refugees Residing in the Community in Northern Jordan. 2012.

2 International Medical Corps. Displaced Syrians in Za'atari Camp : Rapid Mental Health and Psychosocial Support Assessment Analysis and Interpretations of Findings. 2012.

3 Care Jordan. Syrian refugees in Urban Jordan. Baseline Assessment of Community-Identified Vulnerabilities among Syrian Refugees living in Irbid, Madaba, Mufraq, and Zarqa. 2013.

4 UNHCR the UN Refugee Agency. Report of the Participatory Assessment UNHCR , Amman December 2012. Amman: 2012.

5 Jordan Health Aid Society. Displaced Syrians in Jordan: A Mental Health and Psychosocial Information Gathering Exercise. Analysis and Interpretations of Findings. Amman: 2012.

6 Care Jordan. Baseline Assessment of Community Identified Vulnerabilities among Syrian Refugees living in Amman. Rapid Participatory Community Assessment. 2012.

7 Doedens W, Giga N, Krause S, et al. Reproductive Health Services for Syrian Refugees in Zaatri Refugee Camp and Irbid City , Jordan An Evaluation of the Minimum Initial Service Package. 2013.

8 Global Communities. Tension in Jordanian Communities : Rapid Assessment. 2013.

9 The Joint Education Needs Assessment (JENA) Task Force. Education Sector Working Group. Joint Education Needs Assessment. Za'atari Refugee Camp. 2013.

10 International Rescue Committee. Assessment Report Cash Transfer Program to Syrian Refugees in Jordan. 2012.

11 UNHCR the UN Refugee Agency. Participatory Needs Assessment EJC Refugee Camp November 2013. 2013.

12 IRC. Jordan Country Program Cross-Sectoral Assessment of Syrian Refugees in Urban Areas of South and Central Jordan. 2013.

13 Questscope. Participatory Reflection and Action (PRA) Report. "Factors Affecting the Education Situation of Syrian Refugees in Jordan. 2013.

14 World Vision. Children's Report. Stand with Me. Our Uncertain Future. 2014.

15 IMC, UNICEF. Mental Health/Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za ' atari Refugee Camp , Jordan July 2013. 2013.

16 Handicap International, HelpAge International. Hidden victims of the Syrian crisis: diasbled, injured and older refugees. 2014.

17 Women's Refugee Commission. Unpacking Gender The Humanitarian Response to the Syrian Refugee Crisis in Jordan. 2014.

18 Care Jordan. Lives Unseen: Urban Syrian Refugees and Jordanian Host Communities Three Years into the Syrian Crisis. 2014.

19 WHO, IMC, Jordanian Ministry of Health, *et al.* Assessment of Mental Health and Psychosocial Support Needs of Displaced Syrians in Jordan. 2015.

20 UNHCR, UNFPA, International Medical Corps. Population-Based Health Access Assessment for Syrian Refugees in Non-Camp Settings Throughout Jordan: With Sub-Investigation on Non-Communicable Disease Management. A Qualitative Cross-Sectional Cluster Survey. 2014.

21 Mercy Corps. Syrian Adolescents: Their Tomorrow Begins Today. 2014.

22 UNHCR. Woman Alone. The fight for survival by Syria's refugee women. 2014.

23 The Ministry of Health Jordan, Aide Medicale Internationale. Hashemite Kingdom of Jordan Syrian Crisis Health Needs Assessment. Report to the Ministry of Health. 2014.

24 Save the Children, King Hussein Foundation Information and Research Centre. Kinship Care Report. Syrian Refugee Children in Jordan. 2015.

25 IRC. Are We Listening? Acting on Our Commitments to Women and Girls Affected by the Syrian Conflic. 2014.

26 Education Sector Working Group. Access to Education for Syrian Refugee Children and Youth in Jordan Host Communities. Joint Education Needs Assessment Report. 2015.

27 The Joint Education Needs Assessment (JENA) Education Sector Working Group. Access to Education for Syrian Refugee Children in Zaatari Camp, Jordan. 2014.

28 Oxfam, Serrato BC. Refugee Perceptions Study. Za'atari Camp and Host Communities in Jordan. 2014.

29 UK aid, UNICEF, IMC. Mental Health Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan. 2014

CHAPTER 7:

A QUALITATIVE STUDY OF EXPLANATIONS OF AND ATTITUDES TO MENTAL HEALTH CONCERNS AMONG SYRIAN REFUGEES LIVING IN JORDAN

The findings from the above systematic review (Chapter 6) confirm the importance of attending to everyday stressors rather than western defined categories of psychological disorder in addressing the needs of displaced people, as discussed in Chapter 5. Given the importance of basic needs, rights and family and community functioning discussed in Chapter 6, the next chapter uses grounded theory techniques to explore the ways that Syrian refugees in Jordan describe and explain distress in more detail. In a series of 20 interviews Syrian and Jordanian psychosocial actors were key informants regarding explanations of and attitudes to mental health concerns in the Syrian refugee community in Jordan. The findings highlight the ways that community attitudes to mental health concerns have changed in response to the conflict in Syria. Participants described the situation as a crisis, which included the impacts of conflict, flight and the stresses of living in displacement. Many characterised the effect of the crisis as leading to a build up for pressure which leads to both individual distress and disruption to family functioning. Participants explained that many in the community saw the crisis as the reason that people in the community may experience mental health concerns and believed that most people were suffering in this situation. This represented a shift in explanatory model from one which led to stigmatisation of mental health concerns, because they were viewed as being caused by family failure or supernatural causes, to one which recognised that suffering was a result of injustice. These findings highlight how community attitudes and culture are not fixed entities, rather they change in response to changing circumstances. For this reason, it is necessary to study culture in ecological context to understand how cultural practices perform their functions within social systems.

CHAPTER 7: A QUALITATIVE STUDY OF EXPLANATIONS OF AND ATTITUDES TO MENTAL HEALTH CONCERNS AMONG SYRIAN REFUGEES LIVING IN JORDAN [3]

INTRODUCTION

The current war in Syria has led to the displacement of almost half of the population of that country since 2011 (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016).Over 4.8 million registered refugees have fled to neighbouring countries (UNHCR, 2016), the majority living in the host community (Murshidi, Hijjawi, Jeriesat, & Eltom, 2013). In addition to experiencing potentially traumatic events (PTEs), many have difficulty addressing their most basic needs (Taleb et al., 2015). Such experiences are associated with increased risk of psychopathology (Steel, Chey, Marnane, Bryant, & Ommeren, 2009), yet little is understood about the mental health impacts of the Syrian crisis. In order to appropriately design interventions, we must first understand how Syrians perceive and describe distress (Wells, Wells, & Lawsin, 2015). Reactions to PTEs are the result of an individual's interpretation of the meaning of the event (Ajdukovic et al., 2013) and are shaped by culture and individual coping patterns (Gorman, 2001). Culturally specific idioms of distress and explanatory models of illness and health are crucial to understanding this process of meaning making (Kleinman, 1988), as are considerations of social context and power structures (Kirmayer, 2006). Individuals and clinicians must co-construct a shared understanding of the issue requiring treatment. As a result, an understanding of explanatory models and idioms of distress, in the Syrian context, may help mental health practitioners, especially those from non-Syrian backgrounds, develop therapeutic relationships and design interventions which promote recovery. This paper draws on interviews with Syrian and Jordanian mental health workers in Jordon to examine these explanations and idioms and present a

[3] Wells, R., Wells, D., Steel, Z., Hunt, C., Alachkar, M., & Lawsin, C. (2016b). A Qualitative Study of Explanations of and Attitudes to Mental Health Concerns among Syrian Refugees Living in Jordan. In S.J. Villaseñor Bayardo, (Eds.) *Book Global Challenges and Cultural Psychiatry (Proceedings of the Puerto Vallarta World Congress).* (pp. 165-176) Zapopan, Jalisco, México: Universidad de Guadalajara; Centro Universitario de Ciencias de la Salud; World Association of cultural Psychiatry and Grupo Latinoamericano de Estudios Transculturales.

model of how the impact of the crisis has led to shifts in attitudes to, and explanations of, mental health difficulties.

THE IMPACT OF CONFLICT ON MENTAL HEALTH

The evidence base for understanding refugee mental health needs and models for intervention is inconsistent (Tol, Barbui, et al., 2011) and is often hampered by poor methodology (Tol & van Ommeren, 2012; Steel et al., 2009). It is clear that common refugee experiences, such as torture, loss and displacement, compound one another (Nickerson & Bryant, 2014) and are associated with increased distress (Bou Khalil, 2013; Porter & Haslam, 2005). However, most research has focused on quantifying the presence of western defined disorders, such as PTSD, with little attention paid to the conceptual validity of these categories (Summerfield, 1999; Wells et al., 2015). Many refugees display great resilience (Hijazi et al., 2014) in the face of enormous hardship. Recent research has called for a greater focus on understanding the impact of everyday stressors, and community perceptions and descriptions of distress (Tol et al., 2011). A deeper understanding of Syrian refugee attitudes to mental health care and conceptualisations of the causes of distress, will aid in identifying the psychosocial needs they prioritise.

The impact of PTEs and everyday stressors in the displacement context combine to increase distress (Miller & Rasmussen, 2010). Our qualitative synthesis of psychosocial needs reported directly by Syrian refugees in Jordan, demonstrated how the impact of PTEs is potentiated by displacement stressors (Wells, Steel, Abo-hilal, Hassan, & Lawsin, 2016). Inability to satisfy basic needs (such as housing) interacts with psychosocial impacts (such as loss of role) to increase symptoms of distress (such as anger) and fuel family and community violence. These findings make clear the challenges involved in generating effective psychological interventions in the context of crisis, highlighting the need to integrate such interventions into a referral system which addresses a range of needs.

THE IMPACT OF CULTURE ON ATTITUDES TO MENTAL HEALTH CARE

Syria's population of approximately 22 million (Taleb et al., 2015) is characterised by religiously and ethnically diverse groups (Hassan et al., 2015), which have been subject to political forces highlighting difference, sectarianism and conflict (Van Dam, 2011). Still, others within society have sought to forge a Syrian identity focused on peace (Yazbeck, 2012) and civil society (Abbas, 2014). When discussing Syrian culture, it should be noted that culture is a dynamic system of meaning and practices (Kirmayer, 2006) which responds to changing environments (Atlani & Rousseau, 2000), and we can expect to see shifts in Syrian culture in response to the current crisis.

MENTAL HEALTH STIGMA.

Psychological therapies are relatively unknown in Syria and access to mental health services has been restricted by lack of availability and the rudimentary nature of services (Abou-Saleh & Mobayed, 2013). Epidemiological research in Lebanon (Karam et al., 2006) demonstrated that only a small percentage (10.9%) of people reporting symptoms consistent with psychological disorders actually sought care, possibly because emotional distress may be perceived as a normal part of life, rather than as psychological disorder (Youssef & Deane, 2006). Research among Syrians has cited stigma as a barrier to care (Gonçalves, Zidan, Issa, & Barah, 2012; Maziak, Asfar, Mzayek, Fouad, & Kilzieh, 2002) but it has not been directly measured. In particular, being the victim of sexual violence is especially stigmatising, often as people fear social or violent repercussions (Ouyang, 2013).

Religion plays an important role in how people frame their experience and seek assistance. Many religious leaders recommend patience and forbearance in the face of adversity (Al Abdul Jabbar & Al-Issa, 2000). Many Arabs may turn to religious leaders or healers (Gearing et al., 2013; Okasha, Karam, & Okasha, 2012) due to explanations of distress which may include belief in *Jinns* (spirits) and the evil

eye (Al-Krenawi & Graham, 2009). However, the atrocities of war can cause individuals to look for new ways to understand their experience. As one Syrian doctor has commented, his patients feel that they have no words to describe the events they have witnessed (Bou Khalil, 2013). Many may express their distress through metaphors which do not translate literally. These idioms may include one's whole life or self being tired (hassess halii ta3ban حاسس حالي تعبان), stress expressed as an unbearable sense of pressure (el daght 'alayy ketiirاالضغط علي كتير), and despair described as the world closing in front of one's face (hases eddenia msakkra beoushi **حاسس االدنيا مسكرة بوشي**)(Hassan et al., 2015).

Within a cultural context of stigma and low exposure to psychological services, it is reasonable to expect that Syrians are more likely to seek to address their basic needs than to seek professional mental health care. This presents a challenge to mental health practitioners seeking to identify and assist the minority (IASC, 2007) of people in the community in need of mental health care. As this process may be aided by an understanding of idioms of distress and explanatory models, this paper seeks to address the following research questions.

1. How do Syrian refugees explain distress in the current context? What concepts and metaphors are important in linking their circumstances to the subjective experience of distress?
2. How has the crisis impacted on explanations of and attitudes to mental health difficulties?

METHODS

SETTING

Interviews were conducted in Amman, Jordan, in December 2013 and January 2014, when Jordan was hosting approximately 600,000 registered Syrian refugees, with over 80% living in the host community (UNHCR, 2013) and others living in refugee camps.

PARTICIPANTS

Twenty interviews were conducted with key informants, individuals considered knowledgeable about an issue within the community (Thurman, Vernon, & Plested, 2007). Eligible key informants were Syrians or Jordanians, working in psychosocial services within the Syrian refugee community for a minimum of six months who were knowledgeable about local cultural values and norms. Informants were recruited by a staff member of a local grassroots psychosocial organisation and a doctor of psychology at a local university. Theoretical sampling (Charmaz, 2014) was used to ensure individuals from a range of professions and roles were interviewed. The study was approved by the Sydney University Human Research Ethics Committee (Project No. 2013/803) and all participants provided informed consent.

SEMI-STRUCTURED INTERVIEWS

Data was collected as part of a larger study which aimed to: 1) to explore explanatory models of distress and attitudes to mental health care; 2) to assess community readiness to address mental health concerns; 3) to explore barriers to uptake and implementation of mental health care services. This paper focuses on the first aim, with the results of the other aims to be reported elsewhere. The first half of Interviews employed the semi-structured Community Readiness Model (CRM) (Plested, Jumper-thurman, & Edwards, 2009), a participatory research interview which explores community readiness to address a specific health issue. The CRM questions explored community knowledge of mental health services; community members' attitudes towards and knowledge of mental health concerns; and available community resources. Following this, open ended questions explored community perceptions of the causes of mental health difficulties, barriers to care and attitudes to mental health. As a result, questions where not systematically applied to all interviews. Questions included "*how might someone in the community explain the causes of a mental health difficulty to a family member or friend?"* and *"If someone is showing signs of mental health difficulties, how might a*

typical family respond?" Interviews lasted 45-80 minutes and were conducted in English or Arabic, depending on informant preference, with a qualified Arabic-English interpreter where necessary.

DATA ANALYSIS

Thematic analysis

Thematic analysis (Braun & Clarke, 2006), with key techniques from grounded theory (Strauss & Corbin, 1998), was undertaken by RW, DW and CL. RW is a psychologist who has conducted multiple research projects in Jordan, for up to 6 months at a time, working closely with local psychologists to implement culturally appropriate treatment protocols; DW is an anthropologist with experience conducting community based qualitative research; CL is a clinical psychologist with extensive qualitative research experience as well as designing and implementing cross-cultural health systems and has conducted psychological trainings in Jordan. Interviews were transcribed verbatim and coded using *QSR nvivo* (version 11) qualitative analysis software. All analysts open coded a subset of interviews individually and then met to agree on an initial coding system. Following cross coding, RW conducted axial coding, using sensitising questions (Charmaz, 2014) to consider alternative explanations and hypotheses. A model was developed and discussed with the other authors during model development. An iterative process was employed to review data, using constant comparison to compare the model to raw data. Member checking was conducted by asking two informants for feedback on the emergent model, with relevant suggestions incorporated into the results.

Content Coding

During coding, the theme of 'pressure' emerged. This theme was further explored by a content analysis in which words related to the theme of psychological pressure (*pressure, stress, explode, release, relief, hold, contain*) were identified in context and sorted into sub themes. The percentage of informants who mentioned a specific term is presented below.

RESULTS

A total of 22 key informants were interviewed in 20 interviews. Table 1 contains the demographic information for informants.

Table 1.

Key Informants Interviewed

1	M	Syrian	Relief Worker (volunteer)
2	M	Syrian	Psychologist
3	F	Syrian	Psychologist
4	F	Syrian	Manager psychosocial organisation
5	F	Jordanian	Psychologist
6	M	Syrian	Psychologist
7	M	Jordanian	Psychologist
8	F	Syrian	Teacher
9	M	Syrian	Relief Worker (volunteer)
10	M	Syrian	Psychologist
11	F	Syrian	Psychologist
12	M	Syrian	Religious leader
13	M	Jordanian	Psychologist / religious scholar
14	M	Syrian	Psychologist
15	M	Syrian	Activist (psychosocial volunteer)
16	M	Syrian	Manager psychosocial organisation
17	M	Syrian	Relief Worker (volunteer)
18	F	Syrian	Activist (psychosocial volunteer)
19	F	Jordanian	Psychologist
20	M	Syrian	Medical Doctor
21	M	Syrian	Psychologist
22	M	Syrian	Psychologist

INFORMANTS

Over 80% of the informants were Syrian, with all but two arriving as refugees since 2011. As professionals educated in a western influenced discipline, they were positioned as both insiders and outsiders of the community. This position may have affected a narrative of change emerging from the interviews, representing the community as moving from low-awareness to awareness of western

mental health concepts. The following model is an exploration of this narrative, which may not be transferable to the community as a whole.

CONTENT ANALYSIS:

SUFFERING IS DESCRIBED AS A BUILD-UP OF PRESSURE

The metaphor of pressure was often used to explain distress. A content analysis of words related to the concept of psychological pressure as a result of stress was conducted. The psychological processes informants linked to concepts of pressure are presented below, with percentage of informants using these descriptions provided in brackets. Informants were not asked to explicitly list metaphors used to describe distress, so percentages should not be taken as indicative of prevalence of this opinion among informants. Words translated as pressure were used to describe psychological effects of PTEs and displacement stress (47%). Actions intended to alleviate psychological difficulties were described as discharging, relieving or releasing pressure (32%). A subjective sense of pressure was linked to stresses in the external environment (e.g. the regime, displacement) (21%). Pressure was described as a psychological process which builds up over time, in some cases until it cannot be contained (42%). Pressure was described as being associated with mental health difficulties (31%).

Examination of the searched terms in context revealed that images and metaphors of pressure were commonly used to explain the causes of mental health difficulties. Pressure was linked to the subjective experience of distress and to its amelioration.

The experience of living under an authoritarian regime, and the stresses of living in displacement, were linked to a sense that living in a chaotic context leads to interpersonal conflict and disharmony.

> "*And we are like [the rest of the] Arab world, because we have a pressure regime.*"

> *"The pressure of these three stages. That of living inside Syria, of living in the refugee community and the move between them."*

The suffering engendered by the interaction of multiple stressors was described as leading to a build-up of pressure, until coping resources are overwhelmed. Suffering was described as something which cannot be held or contained, until the pressure finally leads to an explosion.

> *"Yes, this is because they've experienced too many traumas in their lives, and now they're under social and economic pressure. Now another trauma, it could take his life. Maybe he'd die if he had to deal with another problem."*

> *"For the man, difficulty in how he will feed his family. When he thinks about this, he feels like his head is going to explode from the all these he has to deal with."*

The effects of pressure were used to explain mental health difficulties. Trauma was described as leading to pressure, and this pressure contributing to family difficulties, causing further suffering.

> *"Children need psychological support, children have seen killing and torture and have been under an enormous kind of psychological pressure."*

> *"When he comes back to the family he wants to relieve himself of this pressure. So he makes pressure on his wife and on the children. Then all the family will be depressed, all of the family will be stressed."*

The sensation of pressure was often described as being housed in the body. Many described the potential benefit of psychological assistance or social contact as helping to release pressure and relieve distress.

> *"I have felt stress in my chest …I want to explode the whole world."*

> *"[the people in the community] need to change, they need to release their feelings, it's very important to release your feelings."*

THEMATIC ANALYSIS

THE CRISIS LEADS TO SUFFERING

The war, the process of displacement, and the stresses of living as a refugee were often described by the term "the crisis". This was ongoing and continuous, and the main source of suffering. The interactions between the various elements of the crisis and pre-existing emotional difficulties was described as leading to ongoing psychological problems.

> *"They know the trauma changed them and sometimes not the trauma itself, sometimes being a refugee, the suffering that they face daily how they…feed themselves, how they will eat… this has changed them a lot."*

Informants described how the crisis has led to changes in personal identity and a sense that personal difficulties cannot be ameliorated without an end to the crisis. As a result, many feel changed by the situation, for it is not possible to remain 'normal' in such extraordinary circumstances. This continuous source of suffering was likened to a spring, pouring forth adversities, which leads to a build-up of pressure if underlying problems are not addressed.

> *"Because the crisis is continuous, it's not stop, for this reason, you can't make a good job in treatment if the crisis is continuous…We don't need organisation to face this crisis, we need our country."*

> "*It's like when you have the spring, the water, so this is the main source of the water... If you solve the problem in the filter it's not for the whole problem, it's a part of the problem, but go to the spring itself, the source, so this is like mental health."*

EVERYONE IS AFFECTED BY THE CRISIS

Informants described a sense of shared suffering because most people have experienced loss. As a result, having emotional difficulties has become relatively normalised, leading to a reduction in stigma

and increased help seeking and disclosure of distress. The community's definition of normal behaviour is changed by the abnormal and unnatural situation. It is normal to be changed by such circumstances. In addition, the presence of services, as well as word of mouth within the community, has led to increased exposure to others with mental health difficulties, leading to further normalisation. As a result, many more are willing to seek help from psychological services.

> *"Actually, this is the same for all Syrian refugees… most of them have experienced rape or have been beaten or have been to prison. So the problems are common for all. So they get rid of this feeling of stigma, because the problem is the same for all."*

> *"They know that this person is not as before, that he is normal, he is not crazy, but he is not as before."*

> *"Those people who have depression, now they are the natural people. But those who don't have depression, now they are unnatural. "You don't have depression? No? Ha Ha, you must go see a doctor. Are you Syrian? Yeah?""*

GREATER EXPOSURE TO MENTAL HEALTH DIFFICULTIES LEADS TO INCREASED AWARENESS AND DIFFERENTIATION

Informants described how attitudes to mental health difficulties have changed as a result of the crisis. Before the crisis, many would have associated psychological difficulties with someone being 'crazy', disabled or having a brain disorder. Conceptions of mental health were described as "narrow", but slowly becoming more nuanced as a result of increased awareness. Greater differentiation in what was perceived of as a mental health concern were associated with changes in perception of the emotional impact of trauma, and describing family relationship difficulties as related to psychological health. However, stigma is still a major barrier to care, especially with regards to sensitive issues, such as gender-based violence.

“Before the crisis and the events in Syria and other Arab countries, mental health was totally about a person who’s insane or a crazy person, that’s all.”

“Before the crisis, very, very few people would go to a specialist. And if they went it was very secret, very secret… they felt shy or ashamed.”

"Also, the main problem is for women who have experienced rape or torture, and some of them have lost their husbands and children. They are afraid of their husbands or their big brother hearing that they’re coming to a psychologist."

A CAUSAL LINK BETWEEN THE CRISIS AND MENTAL HEALTH DIFFICULTIES

Informants described how, as people in the community become more exposed to a range of mental health concerns, they see the causal links between experiences of trauma or stress as a result of the crisis, and emotional states.

“In the past they saw that person with a mental health disorder as a weak person. But since the crisis or the war in Syria, it's the war which they see as the main reason. It's not because I am a weak person, no. It is because of the war. I have lost my husband, I have lost my family and I have lost my house. So all of these factors make this problem for me.”

The impact of the crisis is self-evident, given that people feel they have been changed by it. Many parents notice changes in their children’s behaviour due to the crisis, rather than perceiving the causes as inherent weakness in the child or family functioning. As a result, causal explanations of mental health difficulties are also changing. Where, in the past, such difficulties may have been perceived as a result of weakness, or ascribed to magical causes, such as *Jinn*, people are more likely to perceive the crisis as the reason for problems.

"The mother is able to say, this behaviour has changed because now we are in an unnatural situation. Because she is also in this. The whole situation is not normal, as before. So any disorder or behaviours, the parents can explain this as a mental health disorder."

"They think that the men are causes of their problems (Laughs). Now they believe it is not because of supernatural situations. Because they have seen it, this is in reality."

CHANGE IN EXPLANATORY MODELS AND NORMALISATION LEAD TO CHANGES IN ATTITUDE TO MENTAL HEALTH

As a result of this change in explanation, mental health difficulties are no longer viewed as something to be afraid of (if caused magical forces) or to be avoided (for fear of being seen as weak). Instead, many in the community perceive emotional distress as a normal reaction to an abnormal situation. With a shared sense of suffering, capacity for empathy may become more common. In addition, the enormity of the crisis may dwarf the social concerns of stigma.

"I think [stigma] is reduced in the camp. There is something more important than thinking about stigmatising somebody. There is a big issue. There are too many people living with grief, who have lost their families, who have lost everything. So thinking about stigma now, it's not proper for anybody."

It is important to note that, although informants reported changes in attitude in the community, these changes were limited in scope and to groups who had had exposure to mental health services. In particular, key informants identified that men were more likely to deny any need for assistance, describing themselves as strong and, therefore, not requiring help from others. One respondent (religious leader) described how being patient and having the strength to withstand pressure is a key Islamic virtue.

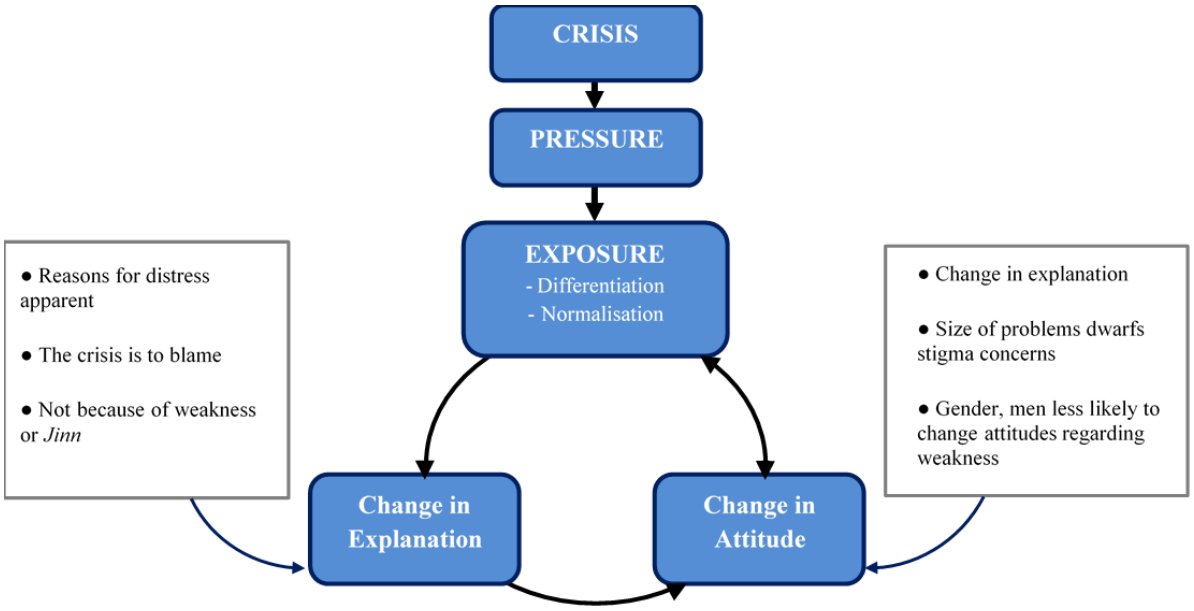
"This has happened because men have a belief that if they speak about their problems, they are weak."

"It's like when you play an instrument. Each string has a sound, and each rule has a sound within your faith. It's like being patient. Be patient because you will have a reward from Allah. Or being strong. Be very strong to face these hard things that have happened."

DISCUSSION

Informants described how the impact of the crisis has led to changes in attitude to, and explanations of, mental health difficulties. This is presented as a model of the qualitative data in Figure 1. From the perspectives of these informants, the crisis has led to practical and emotional challenges for most people, leading to a build-up of pressure. When this pressure can no longer be contained, people are forced to disclose their difficulties. As a result, people in the community are exposed to a wider range of mental health difficulties. This promotes awareness that mental health problems may be about more than severe presentations (such as psychosis) or 'craziness'. As everyone's suffering becomes apparent, a shared sense of suffering leads to normalisation. Because the reasons for these difficulties are apparent (i.e. the crisis has created an unnatural or abnormal situation), explanatory models of distress begin to change. Strange behaviours, which may have previously been explained by weakness or *Jinn*, can now be explained by the actions of humans. This change in explanation, along with normalisation and the sheer size of the crisis, contributes to changes in attitude to mental health concerns, resulting in reduced stigma. It should be noted that these changes in attitude may proceed in a dialogic fashion, within the minds of individuals as well as across the community.

Figure 1. A model of the Impact of the Syrian Crisis on Explanations of and Attitudes to Distress within the Syrian Community



THE PERSPECTIVES OF INFORMANTS

Given that many highlighted a sense that the crisis has changed people, it is important to reflect on the personal meaning this may hold for the Syrian informants. As both insiders and outsiders in the Syrian refugee community, their unique position raises some interesting issues. Firstly, they may be particularly resilient members of the community with access to psychosocial resources which enable them to face the challenges of displacement from a perspective of helping others. If this role supports their own resilience, it may influence this narrative of change from "low-awareness" to "awareness" of the concept of mental health. However, apparent changes in explanation within the community could result from community members learning a language and narrative structure which facilitates communication with health specialists, from a perspective of awareness of suffering within their own cultural frame.

How have these informants, themselves, been affected by the crisis? Before the crisis, challenging the

authority of the Syrian government was largely inconceivable (Yazbeck, 2012), yet now Syrians have seen open expression of dissent and have been uprooted from the contexts in which many social controls were exercised. In the context of loss, displacement offers opportunities for the development of new identities. Informants may have seen their answers as personal testimonies about the quality of work they are doing. Many spoke about being motivated by principles of justice. Narratives which emphasise the capacity of psychosocial services to restore justice within the community would likely help these individuals to draw strength from and cope with the difficult work they do, despite the challenges and losses they face as refugees themselves. In addition, informants may have focused on positive social changes in the community from a desire to present the community in the best light to a western researcher. The first author (RW) has developed relationships with members of the Syrian community through the course of participatory action based research and has, herself, become party to the construction of this narrative. There are likely many within the community who would not identify with such a narrative and, as such, care should be taken in generalising these results to others in the community and across contexts.

THE IMPACT OF THE CRISIS

The emergent theme of the crisis as the source of suffering, agrees with previous research demonstrating the impact of both PTEs and displacement stressors on mental health outcomes (Miller & Rasmussen, 2010; Steel et al., 2009), and with our systematic review of reported psychosocial needs among Syrians in Jordan, which found that dealing with the everyday stressors of life in displacement was perceived by many as a key source of emotional difficulties (Wells et al., 2016). This highlights the need for mental health practitioners to place an emphasis on listening to and addressing practical concerns. If we consider longer term implications, qualitative research from Palestine demonstrates how lack of access to basic rights, while living as a refugee, continues to be a major determinant of quality of life and personal functioning (Barber et al., 2014). This highlights the central role of justice in creating the necessary conditions for psychosocial health (Silove, 2013). Addressing practical

concerns is likely to be important in making treatment relevant to the lives of refugee patients. For example, structured problem solving approaches may help people to manage ongoing stressors and have been successfully implemented by trained non-specialised, local staff in low- middle income countries (Dawson et al., 2015).

EXTERNAL ATTRIBUTIONS FOR THE CAUSES OF DISTRESS

Explanatory models, and the meaning attached to traumatic events, determine attributions of responsibility for distress and influence stigma and help-seeking behaviour (Hamid & Furnham, 2013). In many Arabic speaking cultures, mental health difficulties are commonly attributed to personal weakness and failure (Nasir & Al-Qutob, 2005) or poor family functioning (Youssef & Deane, 2006), impacting the standing of the whole family. Explanations which ascribe the causes of mental illness to external events or entities are likely to lead to reduced feelings of shame and protect people from loss of status (Link, Yang, Phelan, & Collins, 2004). The theme of the crisis as the source of suffering observed in this study appears to place the responsibility for distress on external circumstances. This may allow some to overcome stigma to talk about their difficulties. Conversely, the negative impact of an external locus of control on both individuals and therapists requires consideration, especially in situations of protracted conflict, which may undermine hope.

This has important implications for treatment planning. Firstly, group programs can promote social contact and shared experience, normalising distress (Corrigan et al., 2001). Second, psychoeducation about the impact of both PTEs and displacement stressors on mental health outcomes may provide patients with an opportunity to discuss how these external factors have affected them. Third, the characterisation of distress as externally caused may help to create a conversation focused on socially sanctioned themes of patience and strength (Al Abdul Jabbar & Al-Issa, 2000). A strengths based approach, focusing on the impact of external stressors, can highlight positive coping capacities displayed in response to adversity. Therapists can build on this by enquiring into the nature of cultural

and religious themes of patience and strength, and working together with local religious leaders or healers (Al-Krenawi & Graham, 2009). Thus, the normalisation of distress may not only lead to increased help seeking because of reductions in fears of external stigma (social exclusion by others), but may also increase personal empowerment by addressing causes of self-stigma (internalised prejudiced attitudes against the self) (Corrigan, 2004). It is important for practitioners to be aware that changes in attitude do not apply to all community members or issues. For example, gender based violence continues to be stigmatised (FIDH, 2012) and may be associated with violence against survivors (Zoepf, 2009).

A STRENGTHS-BASED APPROACH TO MEANING MAKING

Changes to personal identity emerged as a key theme in this study. This is consistent with frameworks for understanding psychological outcomes in situations of ongoing stress and human rights violations. Silove (Silove, 2013) argues that, in the context of conflict, PTEs may impact on a range of adaptive systems, including safety, attachment, identity, justice and existential meaning. Characterisations of complex trauma also highlight the impact of ongoing stress to identity (Herman, 1992) and existential meaning (Gorst-Unsworth, Van Velsen, & Turner, 1993). A therapeutic focus on highlighting instances of personal strength and coping in order to redefine identity is consistent with Narrative exposure therapy (NET), which has a strong evidence base for treating PTSD among refugees (Neuner et al., 2008; Nickerson et al., 2011), including among Iraqi refugees (Hijazi et al., 2014). NET encourages the patient to integrate the meaning of a traumatic event into their whole life story, promoting new conceptions of personal identity. It builds on narrative therapy approaches (Carr, 1998), which focus on externalising distress and highlighting instances of past coping. These strategies may help Syrians consider the meaning of their role within their experience and frame the past in a way which promotes future resilience.

THERAPY EXPECTATIONS

The characterisation of distress as pressure has interesting implications for expectations of therapy. Firstly, recommended low-intensity interventions, such as psychological first aid (IASC, 2007) involving empathic listening and social support (WHO, 2011a), may help provide a relief to this build-up of pressure. However, a minority may require therapies which address the psychological causal and maintaining factors of distress. In this case, psychoeducation may help to orient community members to the idea that, rather than simply acting as a temporary pressure valve, focused interventions can address underlying, internal causes which potentiate distress. For example, while being sensitive to the individuals challenging environment a cognitive behavioural therapy (CBT) approach would also seek to address cognitions (such as elevated threat perception and negative automatic thoughts) and unhelpful coping strategies (such as substance use; social withdrawal or conflict with family members) with the aim of reducing symptoms (Nickerson et al., 2011). While external causal attributions may help some cope, others may find internal causal attributions helpful, if they can identify causal factors which are within their power to change (Sayre, 2000). Given that Arabic speaking patients are reported to prefer treatment in a medically focused, directive therapeutic relationship (Nasir & Al-Qutob, 2005), the psychoeducational and 'technical' framework of CBT therapies may be more amenable to treatment expectations than open ended 'talk therapies'.

LIMITATIONS AND FUTURE RESEARCH

A limitation of this study is a lack of definition of what informants meant by mental health difficulties. That is, many spoke about reductions in stigma, but it was not clear whether this referred only to issues such as anxiety and depression, or also to difficulties which are associated with more unusual behaviours, such as compulsive disorders, psychosis and self-harming behaviour. Future research may explore how stigma affects attitudes to specific disorders. As psychosocial actors, the community members informants came into contact with were likely to be care seeking individuals, inflating their

perception that stigma is reduced. In addition, the interviews also focused on assessing community readiness and barriers to care. The themes presented here were not systematically addressed with each informant, rather issues raised by informants during the semi-structured section of the interview were explored in more depth. As a result, proportions of informants discussing specific issues are not indicative of the prevalence of these concerns as discussions were influenced by differing interview questions. Future research may explore whether similar narratives of change emerge among Syrians living in other countries of asylum or within Syria itself. Are the social changes noted here a direct result of exile? Are there changes in attitude to mental health occurring inside Syria? How are these changes affected by access to services? Would those working in other kinds of relief efforts construct similar narratives of change? Finally, will the ongoing nature of the crisis make narratives of hope more difficult to maintain?

CONCLUSION

The views expressed by key informants working with Syrian refugees living in Jordan offer valuable information for mental health practitioners intending to work with this population. A focus on the impacts of war, displacement and living as refugees, may help practitioners to engage with community members and ensure that the psychosocial needs they prioritise are addressed. The social upheavals caused by the crisis have led to changes in explanations of distress and attitudes to mental health concerns, issues which may be explored in therapeutic encounters while maintaining sensitivity to ongoing issues of stigma and safety concerns. Finally, such a focus may enable practitioners to work together with community members to explore themes of justice and co-construct meaning and narratives which help individuals draw on their personal strengths for the future.

CHAPTER 8:

COMMUNITY READINESS IN THE SYRIAN REFUGEE COMMUNITY IN JORDAN: A RAPID ECOLOGICAL ASSESSMENT TOOL TO BUILD PSYCHOSOCIAL SERVICE CAPACITY

The findings reported in Chapter 7 are important for understanding how people in the Syrian refugee community may perceive and understand distress. This information may be useful for psychologists and psychosocial workers from outside this community who are looking to culturally tailor their practice. However, this may be of little use if practitioners do not understand the broader context in which community members seek support? What kinds of services are available to these people, how might they access them, what are the community attitudes to services, what resources are available? These kinds of questions require a community level analysis. The Community Readiness Model is a tool to answer these questions and assess the readiness of a community to address a social issue. Through a semi-structured interview and scoring method, researchers may assess how prepared a community is to address mental health concerns across a range of dimensions. This assessment then becomes the first step in engaged participatory action to support the community to initiate, maintain or improve available services. We used the Community Readiness Model to understand what the service context was for mental health services (Dec 2013- Jan 2014). On a subsequent research trip, we used the findings to consult with local stakeholders to design a program to address a need for training in psychological therapy skills. This program was delivered in November 2015. This chapter reports on the main participatory action component of this thesis, which helped to form the personal relationships and theoretical basis for the subsequent work.

CHAPTER 8: COMMUNITY READINESS IN THE SYRIAN REFUGEE COMMUNITY IN JORDAN: A RAPID ECOLOGICAL ASSESSMENT TOOL TO BUILD PSYCHOSOCIAL SERVICE CAPACITY [4]

ABSTRACT

Background: The knowledge of Syrian psychosocial activists in displaced communities is an invaluable resource for developing an ecological understanding of community needs and attitudes. This may elucidate the structural challenges of displacement to be addressed in psychosocial interventions. **Methods:** *Phase 1:* We employed the Community Readiness Model, a tool to assess community climate; needs; and resources, to determine community capacity building needs. Eight Syrian key informants were interviewed in Amman, Jordan (Dec 2013 - Jan 2014). Community readiness scores were calculated. Thematic analysis explored community identified needs. *Phase 2:* A focus group was conducted with 11 local psychosocial workers in Amman (Sep 2016) employing phase 1 findings to develop a local capacity building intervention. **Results:** *Phase 1*: Community attitudes to mental health were reported to be rapidly changing. However, continued stigma, lack of knowledge of service availability and insufficient number of services were noted as barriers to care. Sense of civic engagement and cultural knowledge of local psychosocial actors were noted as significant strengths. However, lack of access to work rights and technical supervision were identified as contributing to burnout, undermining the sustainability of local, grassroots initiatives. A need for training in clinical interventions, along with ongoing supervision was identified. *Phase 2*: Local psychologists elected to receive training in culturally adapted cognitive behaviour therapy and operational capacity building. **Conclusions**: The cultural and contextual knowledge of Syrian community members are invaluable. Unfortunately, failure to provide these professionals with basic work rights and technical support have undermined the sustainability of their endeavours.

[4]This Chapter has been submitted for publication as: Wells, R., Abo Hilal, M., Hasan, M., Said Youssef, R., Steel, Z., Hunt, C., Lawsin, C. (2018). Community Readiness: A Rapid Ecological Assessment Tool to Build Psychosocial Service Capacity in the Syrian Refugee Community in Jordan. *American Journal of Orthopsychiatry.* Submitted for publication.

BACKGROUND

Over 4.5 million registered Syrian refugees have been displaced to surrounding countries. More than 657,628 currently live in Jordan (UNHCR, 2017), the majority in the host community (Murshidi, Hijjawi, Jeriesat, & Eltom, 2013). Many have been subjected to conflict related potentially traumatic events (PTEs), such as bombings, death of family and friends, destruction of property, exposure to combat, torture and displacement (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). The impact of these events is further compounded by ongoing adversity and insecurity in the host country of displacement, all of which further intensify distress and social problems (Miller & Rasmussen, 2010; Steel, Chey, Marnane, Bryant, & Ommeren, 2009; R. Wells, Steel, Abo-Hilal, Hassan, & Lawsin, 2016). Mental health, daily functioning and family cohesion associated with these adversities may benefit from the provision of psychosocial support interventions, yet evidence regarding their implementation among refugee populations remains limited (Nickerson, Bryant, Silove, & Steel, 2011; Tol et al., 2011), among Syrians in particular (McKenzie, Spiegel, Khalifa, & Mateen, 2015; R. Wells, Wells, & Lawsin, 2015). In considering the implementation of care services which foster local agency, an ecological approach may promote culturally appropriate care (Ager, Strang, & Abebe, 2005), including a greater understanding of Syrian refugees' perceptions of mental health (Tol et al., 2011) and how prepared the Syrian refugee and Jordanian host communities are to respond to these health needs (Thurman, Vernon, & Plested, 2007). While humanitarian organsiations routinely conduct psychosocial needs assessments (Wells, Steel, et al., 2016), an ecological assessment goes further, to examine the context in which services to address these needs may be accessed (Wells et al., 2018).

The Community Readiness Model

Promotion of culturally appropriate care requires an understanding of the social, cultural and biological factors which shape individual and collective meaning making (Kirmayer, 2006). A recently developed approach that may prove valuable as a method for better engaging with a community

around mental health service provision is the Community Readiness Model (CRM). The CRM can give a snapshot of how people in the community relate to issues surrounding mental health. For example, what are people's beliefs about mental health? How do people access help? Who can support change? Then the community can choose interventions which fit with community values. CRM draws on individual theories of change suggesting that psychological readiness impacts motivation and ability to conceive of, initiate and implement behavioural change (Prochaska, DiClemente, & Norcross, 1992). The CRM adapts these concepts to communities, further identifying the need for community leadership and consensus regarding problem recognition (Edwards, Jumper-thurman,, Plested, Oetting, & Swanson, 2000).

The CRM provides a rapid method for assessing a community's attitudes and capacity to address a social issue to promote change (Thurman et al., 2007). CRM employs the knowledge of local key informants to identify community implementation barriers, taking local culture, resources and existing social structures into account (Thurman et al., 2007). It is research embedded in a process of action, engaging local stakeholders in determining and strengthening the nature of services which will affect their communities. The CRM assumes that communities differ in their readiness to address an issue; that there are multiple stages of readiness communities move through as they conceive of, realize, maintain and enhance intervention programs; and that interventions must be appropriate to the community readiness stage, in order to be effective and sustainable (Edwards, Jumper-thurman,, Plested, Oetting, & Swanson, 2000). Assessment of community readiness may also help identify necessary resources and gaps that need to be addressed during an intervention implementation process (Thurman et al., 2007).

Nine community stages of change are assessed using the CRM. Early stages focus on problem recognition in the local context. Then the focus shifts to information gathering for implementation and training local staff. Once programs are in place, sustainability strategies are required. The CRM offers suggestions for intervention at each stage, for example, raising community awareness during

early stages and then training professionals once services are in place. See Supplementary Table 1 for descriptions of stages and the CRM recommended interventions. While the stages aim to capture community preparedness, communities are not homogenous and readiness may differ across different sectors so CRM also describes the community in terms of six dimensions of readiness (see Table 1) including the resources (leadership, resources, knowledge, services) and climate (community attitudes and knowledge) required for implementation. The model acknowledges that community acceptance and leadership are essential for mobilisation of resources and that readiness will not be homogenous. The aim is to enable researchers and community members to build links which can promote effective participatory action (Jumper-Thurman, Plested, & Edwards, 2003; Thurman et al., 2007). The CRM has been applied towards a variety of health concerns ranging from HIV (Thurman et al., 2007) and cancer prevention (Lawsin et al., 2007) to intimate partner violence (Brackley et al., 2003) in effort to work with communities to better address these issues. The model is not intended to assess community readiness against an external benchmark, or to decide who is most 'ready' for a program. Rather, it is a tool to help researchers and community activists co-develop an understanding of how a social issue affects the community, across a range of dimensions, so that research may support community driven solutions. We are asking 'where is the whole community at in terms of addressing this local problem?'"

INSERT TABLE 1 ABOUT HERE

The Context for Mental Health Care among Syrians

Syria is a lower middle-income country (Abou-Saleh & Mobayed, 2013), with a diverse array of ethnic, linguistic and religious groups, but with a majority of the population being Sunni Muslim Arabs (Hassan et al., 2016). Levantine countries have a considerably limited mental health service

infrastructure and access to psychiatric services (Okasha, Karam, & Okasha, 2012). Health services in neighbouring countries hosting refugees are struggling to keep up with demand (Murshidi et al., 2013). Individuals may be more accustomed to seeking help from family members or religious healers due to spiritual explanations of mental distress (R. Wells, Wells, et al., 2016). In Syria, only a small percentage of individuals who report psychological distress seek care, this may be due to the social costs of stigma (Goncalves, Zidan, Issa, & Barah, 2012; Maziak, Asfar, Mzayek, Fouad, & Kilzieh, 2002) or because psychological treatment may not prioritise issues relevant to the community (Summerfield, 2003). Given the potential political and social implications of diagnosing individuals who have experienced human rights violations with a psychological disorder (Kirmayer, 2006), such as social exclusion, stigma and disempowerment, psychosocial interventions must be grounded in the perspectives of the local community (Silove, 2013). However, a key challenge is defining a community which is rapidly changing, is ethnically, politically and religiously diverse and is geographically scattered (Hassan et al., 2016). Nonetheless, many Syrian refugees in Jordan face similar challenges, such as limited educational and occupational opportunities (Wells, Steel, et al., 2016).

We assessed the readiness of the Syrian refugee community in Amman and Irbid cities and Za'atari refugee camp in Jordan to address the psychosocial outcomes of war and displacement. We aimed to understand how resource availability, community perceptions, knowledge and leadership impact on access to psychosocial interventions for Syrians living in Jordan. The findings were used to collaboratively design a training intervention to build the capacity of local psychologists to address the psychosocial needs of the Syrians they work with.

METHODS

Participants

We applied a multi-stage participant engagement and assessment approach to assess levels of community readiness. In the first step interviews were undertaken with key informants to determine indicators of community readiness. This was followed by a focus group undertaken with service providers to develop strategies for the third stage, which involved building capacity to address mental health concerns through existing grassroots programs.

Interviews: Eight key informants were interviewed. Key informants are community members holding key positions, who are knowledgeable about an issue, for example, school teachers, health professionals or religious leaders (Thurman et al., 2007). Given the need for the CRM to provide a feasible and rapid method of assessing key stakeholders' knowledge of local systems and attitudes, a sample size of four to five key informants has been used in other CRM studies (Edwards, Jumper-thurman, Plested, Oetting, & Swanson, 2000). Due to the diverse nature of this community, we purposively sampled eight key informants. Community stakeholders assisted in selecting key informants who were knowledgeable about Syrian refugee community attitudes to psychosocial health. Eligible participants included Syrian mental health care providers, community or religious leaders, who had directly worked with Syrian refugees (> 6 months) in the previous two years, with knowledge of Syrian cultural values and norms.

Focus Group: As phase one engagement resulted in significant relationships with *Syria Bright Future (SBF),* subsequent phases were conducted in collaboration with this organisation, a Syrian-Jordanian grassroots psychosocial organisation founded in 2011 by Syrian refugee mental health professionals. SBF employed both Syrian and Jordanian staff in Amman, Irbid, and Za'atari refugee camp and offered community outreach, group interventions, individual psychological therapy and psychiatric treatment. Ten staff from *SBF* (psychologists, social workers and administrative) participated in a focus group to design a training intervention.

Training Program: Eleven psychologists from a range of local and international organisations providing psychosocial support to Syrian refugees in Jordan, participated in the clinical skills training

workshops. Five staff (psychologists, psychiatrist and executive director) collaborated in operational capacity building.

All participants provided informed consent and ethical approval was obtained through University of Sydney Human Research Ethics Committee, approval number HREC 2013/803 and HREC 2015/148.

Measures

CRM semi-structured open-ended interview questions were adapted to the local context. See Supplementary Table S2. Interviews began with both parties defining mental health to prevent misunderstanding. Key informants answered the questions in terms of their knowledge of attitudes and perceptions within the Syrian refugee community in Jordan.

Procedures

Interviews: The interviews were conducted in Amman, the capital city of Jordan (December 2013 - January 2014), in the offices of local stakeholder organisations. Local stake holders approached key informants through their professional networks. Purposive sampling ensured they represented a range of professions and organizations. Depending on preference, interviews (45-80 minutes) were conducted in either English or Arabic, with a qualified Syrian Arabic-English translator.

Focus Group: Findings were presented to *Syria Bright Future* staff in August 2015. The focus group served to ensure the continued relevance of the findings and generate a focus for intervention. The recommended interventions for the readiness stages were presented to the group, who brainstormed ideas for intervention strategies. Through group discussion, a suitable focus for a capacity building training program was identified.

Workshops: A three-day training workshop in clinical psychology skills, was provided in December 2015. This was followed by 4 follow-up sessions to consolidate skills, and six months of fortnightly group clinical supervision via video link. Training was provided by Author 1, an Australian psychologist with clinical experience working with refugee populations, and Author 8, an American

clinical psychologist with extensive experience in health psychology. In addition, a collaborative operational capacity building program was designed to assist *SBF* to address key operational issues, involving data collection during routine clinical procedures to streamline referral procedures and provide data for future funding proposals.

Data Analysis

We applied two parallel coding systems to analyse the findings of the key informant interviews and focus group planning session. The first approach involved the application of the community readiness coding system and the second involved thematic analysis using qualitative data analytic techniques. Using the conceptual framework of the CRM dimensions of change, we have organised emerging themes within these dimensions to provide a broader interpretive context for findings of the rapid CRM procedure for use in displacement settings.

Community Readiness Analysis:

Interviews and the focus group were audio recorded and transcribed. The CRM provides a nine-point anchored rating scale, a numbered series of statements for each dimension, to assist in determining readiness stage (see online Supplementary Table S3 for an outline of the coding scheme that was applied to assess participant interviews. The CRM manual can obtained from www.nccr.colostate.edu/order/. Coders read the whole interview and determined the anchored statement which best described the community's readiness level, as described by the key informant. Coders then met to reach consensus for each interview. Author 1 and Author 7 scored all interviews, while Author 2 (a psychiatrist and member of the Syrian refugee community) coded interviews of community members who were not known to him, to ensure confidentiality. The resulting community readiness scores were averaged across key informants to generate the community calculated score (Lawsin, Borrayo, Edwards, & Belloso, 2007; Plested, Jumper-Thurman, & Edwards, 2009).

Outcomes of the focus group were theme coded by Author 1 and Author 7. Resulting key themes resulted in two intervention arms (operational and clinical skills) for which parallel training programs were developed in collaboration with senior *Syria Bright Future* staff.

Thematic Analysis:

In order to cross-validate and provide additional context for understanding the findings from CRM scoring procedures, thematic analysis (Braun & Clarke, 2006) with key techniques from grounded theory (Strauss & Corbin, 1998), was undertaken by Author 1 and Author 7. Interviews and focus group were transcribed verbatim and analysed in *QSR Nvivo* (version 11). Following open coding and cross coding, sensitising questions (Charmaz, 2014) and constant comparison (Strauss & Corbin, 1998) were used during axial coding to test emerging hypotheses. Data was collected by Author 1 as part of a larger participatory research program (2013-2017) and phenomenological analysis of Syrian refugee attitudes to mental health. Following the stages of coding described above, themes emerging from the interviews which pertained to the dimensions of the CRM were extracted and organised under the headings of the dimensions of change conceptualised in the CRM. With these themes in mind, the interviews were then recoded to test for exceptions and inconsistencies and the themes were modified accordingly. Authors 2 and 6 (local community members) provided ongoing consultation on contextual and cultural issues affecting data analysis. Themes emerging from the analysis were hypothesis tested during ongoing participatory fieldwork in Jordan by Author 1 and Author 7. During the process of this work, Author 1 developed close working relationships with multiple psychosocial activists within the Syrian refugee community. This has influenced the analysis by promoting a focus on community capacity building and a need to promote access to human rights for displaced Syrians.

RESULTS

All eight key informants (5 male) were Syrians, and six had arrived in Jordan within the previous three years of the study commencing in December 2013. All of the recently arrived respondents

were working on a voluntary basis, because of work restrictions due to their visa status, with the 3 longer term Syrian residents in Jordan having paid service roles. See Table 2 for details of respondents.

INSERT TABLE 2 ABOUT HERE

Community Readiness

Figure 1 displays the range of readiness scores across informants for each dimension. All informants agreed that efforts to address mental health had been implemented. While some community members had heard about services, community knowledge of these efforts was believed to be very limited. Only one informant reported that leadership recognised a need to support mental health services. Descriptions of community climate ranged between no interest and modest interest in addressing the issue of mental health, while knowledge about mental health disorder was described as basic. Most informants described availability of community resources.

INSERT FIGURE 1 ABOUT HERE

The average readiness stage for each dimension is presented in Table 3. Interventions, as recommended in the CRM (Plested et al., 2009), are presented for each dimension (See Supplementary Table S1 for more detail on staged interventions). Most dimensions were rated stages two to four so the majority of recommendations were for interventions to raise awareness. Thematic analysis for each dimension is presented below (quotes numbered by informants in Table

2). Themes are organised within each of the CRM dimensions, which were used to sensitise analysis to issues relevant to community change.

INSERT TABLE 3 ABOUT HERE

Community Efforts: Community efforts include services put in place to address mental health. Key informants indicated that the parts of the community participating in psychosocial activism were at the *initiation* stage, as psychosocial services had already been implemented and had been progressively scaled up, mostly by international NGOs, since 2011. In addition, there were a number of Syrian-run, recently started and ongoing initiatives.

"The nature of the Syrian refugees here in Jordan, due to their large number, started to force us to have specialized bodies… and this is how the mental health… organizations started to be present in our country" 7

Community Knowledge of Efforts: This dimension included community awareness about services and what they could offer. Key informants indicated that community knowledge of available services was at the stage of *vague awareness*.

Lack of information about available services

Although a few in the community had heard about mental health services, most people did not know how to access psychosocial services, or what they offered.

"No, they don't know. Even I am specialised in supporting the community, but I don't know where is the centre of these services is in Amman." 1

Soft entry points to inform community about services

Many organisations increased awareness of psychosocial programs by making contact through basic needs provision or home visits, explaining about available services. Two informants recommended the creation of a pamphlet listing available services.

"If you ask about how they cooperate? By knowing and mingling with the families, we start to know about their problems, their issues, the house, the rent…we start to know the family itself and the needs. If there is any psychological need to be addressed, they will refer to some specialist." 7

Leadership: This dimension assessed to what degree leadership recognised mental health as an issue to be addressed.

Leadership lacking

Three respondents indicated that leadership was lacking in the community. Most people had been uprooted from their previous social worlds, and there were very few established community leaders available.

"I don't know who may do this [lead the community]. Generally, awareness within the community will play the main role, more than the social leaders... Actually this is the main problem. The community being split. And this is a reason behind why they don't have a simplified character or a leader within the community." 8

Leaders have other priorities

The three informants who discussed leaders (religious, political and tribal) reported that leaders prioritised basic needs provision over psychosocial services.

"He [the leader] would say, "I'm sorry, I don't have money for that. Ok, I have to pay for relief process, ok, parcels, food… or we have surgeries…for the FSA [Free Syrian Army] and others...It's not a priority for them." 1

Community Climate: Community climate included cultural attitudes to mental health difficulties and services, as well as whether community members perceived mental health as an issue that needed to be addressed. Although service availability was identified by key informants as being at the stage of *initiation* (stage 6), community climate was considered to be at the level of *preplanning* (stage 4). This reflects a disparity between service implementation and the attitudes of the community to mental health concerns.

Stigma about mental health

Although there were some in the community who recognised mental health concerns as a problem, seven informants reported that many community members stigmatised mental health difficulties, and five said this was because people associated these difficulties with "craziness", preventing people from accessing services.

> *"Because nobody accepts to say that he has problems with his mind ... because it's a kind of a weaknesses... If I go to the doctor, then I have problems, then how can I say that I am strong? ... It is about how the community looks at me, if I go to the doctor… they will view such a person as having an imperfect mind ... they go to the doctor secretly, they don't tell anybody."* 5

Mental health is not a priority

Five informants reported that community members did not perceive mental health care as relevant because concerns would normally be dealt with in the family or community, or because they prioritised the satisfying of basic needs.

> *"Why do you think such a speciality was not present in Syria?... Because we have the relations and the links within the family, the strong bonds and ties within the family. When someone is in a problem, we find everyone there for him, to support him*." 6

"*Most people believe the disorder they have, mental disorder they have, is because of economic issues. So when they have the main things satisfied, or when they get a job, then everything will be OK.*" 8

Attitudes are changing

All informants reported that attitudes within the community were changing rapidly due to the impact of the crisis on people's mental health and as people sought assistance from humanitarian organisations. This was most commonly the case with women, who were more likely to seek assistance. As a result, disparities in attitudes between family members were beginning to emerge.

"Before the crisis and the events now, in Syria and the Arab countries, mental health is totally about a person [who's] insane or a crazy person, that's all… But now it's the contrary. That's because the spirit of the crisis affects the whole people." 8

"Because in our culture, as a man, it will be insulting to go and receive relief… If a man would go, "It's me, from that known family and I cannot just go and lower myself… like a beggar." As for women, it is different." 6

"Yes and a lot of them [women], they want to go back to study and they started to study high school here… [but men are] not engaging… Yes, it's a big problem! Because if a woman goes and learns new things and she comes home, she develops in her life and he stays in the same place" 3

Building community trust

Informants emphasised the importance of psychosocial workers introducing themselves and their organisations to the community, through meetings or home visits, to promote trust and access to services. Four informants indicated that many community members preferred to interact with Syrian staff, as they felt they could best understand the difficulties they had faced and this can build

community capacity. Three informants reported community mistrust of services due to fears about confidentiality or mistrusting the agendas of organisations.

> *"One of the strengths here in the team, is that all of us are also refugees. So this point gives us more strength to do this work. So we work here as a family... Do you know what, I am here alone, all my family was or are in Syria and the team [here] are my family. Because with them I feel very strong, so I can do many, many things. But alone, I say no."* 5

> *"Because we as Syrians, we feel afraid to speak about anything… because most of them in Syria, they have faced detention or violence from the regime or the intelligence… They have no confidence with anybody, that any word or anything or information they are going to provide, will go immediately to the regime... So it is very difficult to deal with such people."* 4

Community Knowledge about Mental Health: This dimension assessed community knowledge about understandings of mental health from a western perspective, since most services adopt this perspective.

> *Limited exposure to Western mental health concepts*

Six informants indicated that knowledge of western psychological classifications of mental health was very limited, including limited recognition of signs and symptoms of disorders.

> *"This is why a person, a Syrian, could face some problems, suffer from mental illness without being treated, because they would not recognise it, and they would not go to a psychiatrist or a psychologist unless they suffer from something serious... The concept itself [mental health care] was not known largely in Syria."* 6

> *Explanatory models influence help-seeking*

Community explanatory models for mental health concerns and recovery included religious explanations, such as perceiving difficulties as a test from God and an opportunity to develop

strength through patience, and the belief that mental illness is caused by weakness or *Jinn* (non-physical beings). Three informants said that people would seek help from a sheik before a psychologist.

> *"They find it easier to go to a Sheik before they go to the doctor."* 5

> *“And if someone survived torture and he started to have real mental issues, they wouldn’t take him to the psychologist. They would say “You’re a man, be tough. If you take this [pressure], you will go to heaven. Don’t be like a child, like a chicken, or you will go to hell”* 6

Explanatory models changing

Four respondents also indicated that these explanations were changing rapidly as a consequence of the crisis, stating that a growing number of community members perceived an impact of PTEs and displacement stressors on their mental health, and were increasingly willing to seek psychological help as a result. Five respondents spoke about how awareness raising about mental health concepts had increased engagement.

> *"I receive from 25-30 women for awareness sessions. After we finish the interview… the Syrian refugees in the host community, they say, “We need more”. We need individual counselling."* 2

Resources: This dimension assessed whether both material and social resources were available to address mental health.

Community activism and volunteers

In some ways, the community was rich in resources, as there were many community members, including professionals, who were willing to donate their time and skills to supporting others in the community. Six of the informants were volunteering their skills.

*"It is my attitude to share my knowledge with others, I'm still a volunteer in this community."*1

"When our profit Abraham was about to be burnt in fire, there were two animals, the frog and the lizard. The frog was trying to play the good part, and bring water in order to put out the fire, although it was almost impossible, but he tried to play his part. The lizard, that was the bad person, he tried to blow on the fire so that it increases. So both would not affect the outcome, but at least they both tried. I'm trying to be the frog here." 7

Barriers to participation

Limitations on work rights in Jordan were raised as an issue by six informants. Syrians could not be paid for their time, which limited sustainability and presented barriers to organisations hiring Syrian community members. Informants gave varying accounts of laws regarding their right to work, indicating a lack of clear information on this issue in the community. In addition, many of these workers did not have access to appropriate support structures, such as clinical supervision or peer debriefing, and would therefore be potentially at risk of becoming burnt out and overwhelmed by the clinical work without appropriate institutional support mechanisms.

"You know it's not allowed for Syrians to work here... That creates another crisis in the community here, and, I think, pushes the people to work more in the black market." 1

"There is no support for the workers in the field. Ok, for instance, I'm burning out, I need support. I need another expert, more so than me, ok?" 1

*"You can't make a good job in treatment if the crisis is continuous. For this reason, I worked for 6 months in the clinic and then I stopped, because I will burn out... And remember that we are Syrian and we feel, sometimes, the same feeling or the same suffering as what we hear."*3

Barriers to implementation

Despite these community strengths and considerable external aid, five respondents reported that the sheer numbers of refugees made it impossible to address the needs of all but a small percentage. Two informants spoke about how international funding priorities curtailed program design and limited sustainability, with one informant questioning monitoring and evaluation standards which focus on number of recipients, rather than program efficacy. Five informants recommended grass roots group programs as a way to reach more people in culturally appropriate ways and to build a sense of community involvement. Five informants stressed the importance of providing funds for transportation to programs to enable access.

> *"The main issue is that the lack of trained staff for doing within this community a very huge number of refugees here in Amman, it is the biggest community. This is the main problem."* 8

> *"The evaluation is done as the following: How many visitors we have, how many visitors who received medications, but there is no column for those who were cured… I worked in some [projects] that are renewed every month. Can you imagine how life would be here?... Forget about people, whether it would be effective. Only think about the psychology of the person who worked on that project to help others. He is not secure, so how can he provide security to others?" 6*

<u>Focus Group</u>

The CRM involves feeding back the results of interviews to community members to guide further collaboration. The above findings and the two main interventions recommended by the CRM (raising awareness and training professionals, see Table 3) were discussed. Training was discussed with reference to both clinical skills and operational capacity building. Thematic analysis of the focus group discussion (FGD) determined five key themes for training: 1) Awareness raising, e.g. regarding community concerns about psychiatric medications and stigma about discussing emotions; 2) Cognitive behavioural therapy (CBT) skills, in particular specific therapy techniques and examples;

"I need practical skills for how to use CBT with PTSD [posttraumatic stress disorder] or depression patients. I need it to be practical. How to deal the hard patients or the …atypical patients." FGD participant, psychologist.

3) Interpersonal skills related to family cohesion, including communication skills, stress management, family violence and finance issues.

"If there is something not good between father and mother …it affects the relationship or communication with the children, that affects the family's problems." FGD participant, social worker.

4) The need for cultural adaptation of Western therapy techniques.

"Culture plays a big role in therapy." FGD, manager

5) How to use clinical data to improve operations and funding proposals.

"It's very good to evaluate and modify our way of doing things, to renew another project with new experience. To know this information is the basic thing, so we can make more proposals." FGD, manager.

Syria Bright Future had been running community awareness raising programs since 2011. The CRM also recommended training professionals and local mental health professionals were a key community resource. Upon presenting these findings to the focus group, psychologists and social workers in the organisation identified that their highest need was for specific, practical skills in psychological interventions as university psychology training Jordan had equipped them with theoretical but not practical skills for therapy. Some had been able to access 2-3 day training sessions in specific therapy modalities, but this was not ongoing and they did not receive supervision. The majority requested practical training in cognitive behaviour therapy (CBT) including learning about specific strategies from trained professionals with feedback on their implementation.

Given that the two authors directly involved in implementation had received doctoral level clinical psychology training in CBT in Australia and the United States, it was decided that skills sharing in this area, with Jordanian and Syrian psychologists providing expertise in cultural adaptation and local implementation, would be of most use in increasing community readiness to address psychosocial concerns. Participants came to a consensus that a practical skills training program, which focused on basic CBT skills and strategies to assist with emotion regulation, would be helpful. In response to the need for ongoing supervision identified in both the focus group and the interviews, a plan for 6 months of ongoing supervision by Skype was included.

Operational Capacity Building: Senior management identified over-referral of clients from outreach programs to psychiatric assessment and requested assistance in designing assessment procedures which could streamline the referral procedure. A method was co-designed to provide clear objectives to outreach workers and validate a rapid distress screen to ensure appropriate referral within a stepped-care structure.

DISCUSSION

The CRM is a rapid assessment tool for examining the ecological systems that contribute to health problems and determining the kinds of interventions which will be most effective in supporting local initiatives. Putting the current findings into an ecological framework, we can examine the nested ecological systems involved as Syrians adapt to their new environment (Drozdek, 2015; Silove, 2013). At the individual level, this study highlights a community identified increase in distress compared to pre-conflict affected lives, similar to research in other post-conflict and displacement settings (Steel et al., 2009). At the level of family and peer relationships, loss of role due to displacement, shifting social conditions (such as women's greater direct access to resources through humanitarian organisations) cause changes to interpersonal support networks (Silove, 2013). At the societal level, access to health services is sometimes blocked by lack of knowledge or availability of services (Lawsin et al., 2007) while displacement has led to a lack of leadership to address challenges.

Financial resources may be limited, yet social resources, such as desire to contribute, appear to be high, as previously observed (Wells, Steel, et al., 2016). Finally, at the cultural level, access to support is mediated by cultural attitudes to mental health disturbance and help seeking (Okasha et al., 2012). While stigmatising attitudes may limit access for some, displacement can lead to rapid changes in community attitudes which provide some with opportunities to access support within a medical framework (R. Wells, Wells, et al., 2016). This analysis presents opportunities for supporting community resilience and recovery by identifying community needs. For example, practitioners can build on social resources to increase community participation in programming and should be aware that cultural attitudes to mental health are not fixed or homogenous with the community.

With a small number of interviews and a structured approach, an understanding of the individual, interpersonal, social and cultural impacts of conflict (Miller & Rasmussen, 2010) can be used to determine a focus for capacity building interventions. We used the CRM to understand what kind of support was needed, taking into account existing strengths, and provided technical and operational training and supervision. To our knowledge, this is the first study to apply the CRM to a refugee community. We hope the research will provide a clear framework for practitioners to rapidly assess community level concerns while building collaborative partnerships around these. The Syrian refugee community in Jordan displayed readiness ranging from *denial/ resistance* to *initiation* of programs. This divergent range of response patterns appears to be driven by the sudden, violent nature of the conflict, producing rapid increases in distress, and international implementation of psychosocial interventions rarely seen amongst Syrians before. As a result, community awareness of available services, and knowledge about the western bio-medical explanatory models they employ is lacking, yet there is a commensurate rapidly growing perceived need amongst an increasing number of community members.

The ongoing collaboration initiated by the interview phase enabled consultation with stakeholders, identifying community needs already being targeted, as well as gaps. The finding that community

attitudes towards psychosocial services is at the *denial/ resistance* stage is not surprising given low levels of exposure to western psychological concepts and low reporting of psychiatric disorders among Syrians (Goncalves et al., 2012). For example, among Syrian refugees in southern Turkey, reported reasons for not seeking care included only needing God, preferring to speak to family or friends, and a perception that specialized treatment is not required when one's emotional reaction to circumstances is normal (Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014). That is, many may have alternative coping methods. We hope these findings support practitioners to include local community approaches to healing and recovery where possible.

Participants in the focus group overwhelmingly called for training in CBT. This contrasts with concerns noted in the field that reliance on such approaches risks advancing a western cultural construct that may not be applicable in cross cultural settings (Summerfield, 2003). There may be no simple resolution to these issues and yet there was a strong expectation amongst the community workers and volunteers interviewed for greater access to training in western treatment modalities. In terms of awareness raising, SBF and other local organisations already had programs running to initiate community discussion about the psychological consequences of war and displacement. In addition, the MHGap program being rolled out internationally by the World Health Organisation, specifically targets community awareness by educating primary care physicians to identify mental health problems and training lay psychosocial workers, to enable referral for low intensity interventions. This is a large and well-funded initiative to increase access across low and middle income countries (WHO, 2010).

The current findings confirm the need for awareness raising, yet they also highlight the rapidly changing nature of attitudes to mental health in response to displacement indicating this is a dynamic process and not just a top down awareness raising model. Recent research has explored the nature of explanatory models and change in community attitudes to mental health in the Syrian refugee community (R. Wells, Wells, et al., 2016). This included a model whereby increased exposure

to mental health disturbance in the community led to normalisation and differentiation in understanding of symptoms. Explanatory models have shifted to include the impacts of the crisis as causes of mental health problems, as opposed to personal weakness or familial failure, leading to reduced stigma and increased accessing of services. Understanding these explanatory models can aid in the design of interventions which address the perceived needs of the community. Equipping local staff to provide care can help ensure that these explanatory models are explored, if staff are sensitised to the need for cultural formulation. These findings can encourage practitioners to have the curiosity to go beyond generalising statements about community attitudes and to wonder for who, and in what situations, people's attitudes may change or remain the same.

Communities are not homogenous, hence a dimensional analysis can uncover discrepancies and bring to light the ethical challenges of intervention in conflict settings. According to the CRM model (Edwards, Jumper-thurman, Plested, Oetting, & Swanson, 2000), community awareness raising programs are required for dimensions at earlier stages of readiness, while technical training and support is required for already initiated interventions. There are many indigenous healing systems which Syrians may prefer to access for help. However, given widespread exposure to human rights violations known to lead to serious distress among a minority (Steel et al., 2009), evidence based psychological interventions should be made available for those who chose to access them (Silove, 2013). Given this dilemma, we based our ongoing capacity building on what our collaborators were asking for, technical training. While awareness raising is clearly required, it is of little use if services lack the technical capacities to address newly identified needs. Training large numbers of community health workers may be effective at the population level (Silove, Ventevogel, & Rees, 2017), in practice, as community founded programs unfold in a crisis setting, staff may be asked to deal with highly complex cases without the training to help them feel competent and effective.

The community worker assessment and training model aims to take advantage of the cultural knowledge of local staff and enable scalability of programs in low resources settings (Silove et al.,

2017). By training local staff, the aim is to engender sustainable programs which will keep running once the immediate crisis is over and international humanitarian organisations move on. However, these findings present an important caution to such work. Programs need to offer adequate levels of training, ongoing supervision and strategies for staff self-care (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000). Our resulting training program addressed this by providing weekly supervision via video link for a period of six months. Strategies to improve organisational policies for staff self-care are also required. Lack of access to funding and limited work rights impact on the implementation of sustainable interventions. Many of the community workers and volunteers interviewed in this project have since moved on to other countries due to such structural barriers in Jordan. Psychosocial actors such as these perform the adaptive response of the community to a toxic environment, even as they cope with the same stresses as the people they help (Othman, Steel, Lawsin, & Wells, 2018). Advocating for political rights and economic opportunities is necessary to promote a community context in which psychosocial interventions can be sustainable and effective. These findings can provide evidence for practitioners to advocate to management and funders for organisational policies that support health, wellbeing and opportunities for local staff.

Limitations

More than three years have passed since this research was initiated, and the focus of community concerns may have changed, as longer periods of living in displacement may have caused the proximal causes of distress to shift from conflict related PTEs to daily living stressors. In particular, the impact of lack of work rights may be compounded over time, as financial, social and personal resource loss can accelerate, due to a cycle of losses (Hobfoll, 2001). We chose to present these findings in the context of our ongoing capacity building work, to demonstrate the utility of the community readiness approach in supporting ongoing participatory relationships. Interviews were conducted with a translator, which may have impacted our interpretation of informants' answers. While the sample size in this study is well above that found to be effective in previous CRM research,

these psychosocial workers represent the perspectives of a particular part of Syrian society, affected by social, economic and political status. Their perception of help seeking behaviour may have been affected by their exposure to help seeking individuals in psychosocial settings.

Conclusion

In conclusion, we demonstrate how a rapid assessment of community context is a useful strategy for determining an appropriate focus of intervention, building community relationships and designing a tailored capacity building program. CRM assessment highlighted the need for community awareness raising, as well as skills training. Some aspects of these findings relating to general cultural attitudes to mental health may be applicable to Syrian refugees in different settings, such as Lebanon or Turkey. However, different contextual factors will need to be taken into account, such as access to resources and rights, different ethnic and religious demography and service availability. The relationships built during the first phase of research (interviews), including participation by community members in analysis of these results, provided a foundation for implementation of capacity building. The second phase of community feedback (focus group) and training enabled us to take into account the strength of existing awareness raising programs, as well as the wishes of local staff, to further focus the area of intervention into a specific training program. We hope this structured approach provides a framework for practitioners in conflict settings to rapidly engage with community concerns to leverage community resources for change, while advocating for the rights of community activists.

Table 1. Stages and Dimensions of Community Readiness

Stages of Community Readiness
1 No awareness / recognition 2 Denial / resistance 3 Vague awareness 4 Preplanning 5 Preparation 6 Initiation 7 Stabilization 8 Confirmation/ expansion 9 High level of community ownership
Dimensions of Readiness
Community efforts to address the problem Community knowledge of efforts Leadership Community climate Community knowledge about the issue Resources related to the issue

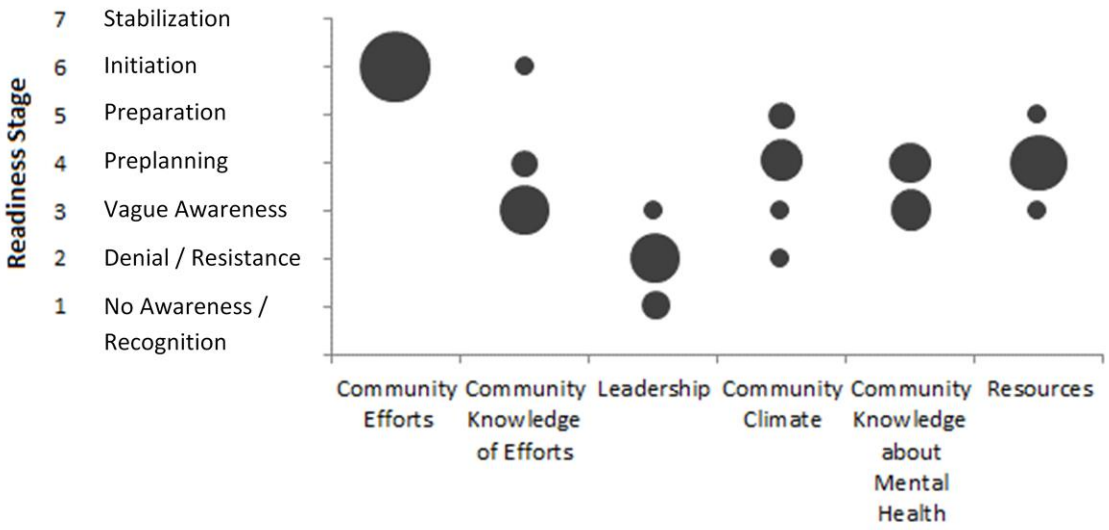
Table 2. CRM Interview Respondents.

	Nationality	Gender	Occupation	Organisation
1	Syrian	Male	Relief Work	Individual
2	Syrian	Male	Psychologist	International NGO
3	Syrian	Female	Psychologist	Grass Roots Syrian NGO
4	Syrian	Female	Manager	Grass Roots Syrian NGO
5	Syrian	Female	School Teacher	Grass Roots Syrian NGO
6	Syrian	Male	Relief Work	Individual
7	Syrian	Male	Relief Work	Religious Organisation
8	Syrian	Male	Medical Doctor	Grass Roots Syrian NGO

Table 3. Community Readiness Stage for each Dimension of Readiness

	Summary of Stakeholder ratings		**CRM Recommended Intervention**
Dimension	Readiness Stage	Stage Descriptor	
Community Efforts	**6**	Initiation	Train Professionals
Community Knowledge of Efforts	**3**	Vague Awareness	Raise awareness of programs
Leadership	**2**	Denial/Resistance	Raise awareness about mental health
Community Climate	**4**	Preplanning	Raise awareness about specific interventions
Community Knowledge about Mental Health	**3**	Vague Awareness	Raise awareness about mental health
Resources	**4**	Preplanning	Identify community resources

Figure 1. Range of Community Readiness Scores for each Dimension



Note: Range of informant descriptions of readiness stage. Larger circles represent a greater number of informants describing this readiness stage.

CHAPTER 9:

AN ECOLOGICAL MODEL OF PSYCHOSOCIAL ADAPTATION OF DISPLACED PEOPLE

This final chapter represents a culmination of the theoretical and empirical outcomes of this PhD. After considering the theoretical rationales for cultural adaptation of psychological therapies and gaining experience through engagement in participatory action using the Community Readiness Model, I have come to a more nuanced view about the possible roles of clinical psychologists who seek to work with displaced populations. Understanding cultural context is not a worthwhile enterprise unless practitioners seek to understand a broader range of contextual factors. This includes how beliefs, behaviours and practices interact across the levels of individual, family, society and culture. We need to ask what role these beliefs, behaviours and practices play in helping people adapt to their environments. The refugee experience is defined by a sudden change in environment which has implications for social, economic, personal and cultural resources. An analysis of the impact of this experience will be incomplete if it does not address these issues, along with how people marshal power and resources in challenging situations. I have thus taken an ecological approach, which uses concepts from ecology to develop a framework for looking at this issue from the perspective of the relationship between people and their environment. This model is then applied to the case of Syrian refugees living in Jordan and draws on further analysis of the interviews discussed in Chapters 7 and 8.

CHAPTER 9: AN ECOLOGICAL MODEL OF PSYCHOSOCIAL ADAPTATION OF DISPLACED PEOPLE [5]

ABSTRACT

Background: There is a need for ecological approaches to guide global mental health programs that can appropriately address the personal, family, social and cultural needs of displaced populations. A transactional ecological model of adaptation to displacement was developed and applied to the case of Syrian refugees living in Jordan. **Methods:** Syrian and Jordanian psychosocial workers (n=29) supporting the Syrian refugee community in Jordan were interviewed in three waves (2013-2016). A grounded-theory approach was used to develop a model of key local concepts of distress. Emergent themes were compared with the ecological model, including the five ADAPT pillars identified by Silove (2013). **Results:** The application of the ecological concept of niche construction demonstrated how the adaptive functions of a culturally significant concept of dignity (*karama*) are moderated by gender and displacement. This transactional concept brought to light the adaptive capacities of many Syrian women while highlighting the ways that stigma may restrict culturally sanctioned opportunities for others, in particular men. By examining responses to potentially traumatic events at the levels of individual, family/peers, society and culture, adaptive responses to environmental change can be included in formulation of distress. The five ADAPT pillars showed congruence with the psychosocial needs reported in the community. **Conclusions:** The transactional concepts in this model can help clinicians working with displaced people to consider and formulate a broader range of causal factors than is commonly included in individualistic therapy approaches. Researchers may use this model to develop testable hypotheses.

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More than half a million people have lost their lives in the current Syrian conflict (SOHR, 2018) and more than 11 million have been displaced (UNHCR, 2018). There are over 600,000 Syrian refugees living in Jordan (UNHCR, 2018) mostly in the host community, where services to address their needs may be limited (Murshidi et al., 2013). Many have been subjected to an array of potentially traumatic events (PTES) (Hassan et al., 2016) known to elevate risk of mental health problems (Steel et al., 2009), while the stresses of living in displacement have been demonstrated to intensify these issues (Wells et al., 2016a). We hope that an ecological approach to understanding distress within local meaning systems, and in response to local challenges, may help mental health practitioners respond to this crisis in ways that can support existing coping mechanisms.

Our recent systematic review of psychosocial concerns reported by Syrian refugees living in Jordan (Wells et al., 2016a) highlighted how threats to safety, (such as physical or sexual abuse, inadequate housing, exploitation and financial strain) were commonly reported, along with discrimination and perceived injustice. These environmental stressors lead to psychosocial stressors, such as loss of role, forced changes to identity and loss of social support. These combined with the impact of potentially traumatic events (PTEs) and distress symptoms to increase family violence, further disrupting interpersonal functioning. In the model derived from this systematic review, we describe the impact of displacement stressors as cumulative and interactive and recommend that psychosocial interventions focus on addressing the psychosocial impacts of environmental stressors by promoting access to resources, such as volunteering, employment, social support or skills acquisition, which is in line with international norms for psychosocial programming in crisis settings (IASC, 2007). That is, as outlined by Silove in the ADAPT model, providing opportunities to develop new roles, identities, existential meaning, bonds or justice (Silove, 2013) can support individual and community resilience.

Theoretical models sensitise researchers and clinicians to focus on specific issues. In this paper we highlight the contribution of political, social and ecological forces which shape adaptation and wellbeing in displacement (Hess, 2005) and argue for a theoretical perspective which analyses how individuals and communities adapt to new ecological contexts (Miller and Rasco, 2004). Our aim is to advance an ecological

model which examines the reciprocal relationships between individual psychological functioning and environmental factors pre-, during and post-displacement. In the last two decades, a greater emphasis on the social and cultural causes of distress (Hobfoll, 2001, Summerfield, 1999) and cultural adaptation (Bolton, 2001, Bolton and Tang, 2004) have contributed to international practice guidelines which are more attentive to the perceived needs and social and economic circumstances of communities affected by crisis (Lund et al., 2012, IASC, 2007). Often it is the daily stressors experienced in displacement that are the most salient concerns for affected communities (Wells et al., 2016a, Wells et al., 2016b) and mediate distress caused by PTEs (Miller and Rasmussen, 2010). We require theoretical and methodological tools to explore how intersecting environmental factors impact on adaptive functioning (Miller and Rasmussen, 2014).

Ecological understandings of distress: Social resources for adaptation

An ecological/ transactional model can highlight an individual's role in responding to environmental challenges commonly described as risk factors (e.g., human rights violations). Such models can explore how the structural properties of the displacement environment produce different adaptive role functions (Kelly, 1966). Bronfenbrenner (Bronfenbrenner, 1979) proposed an ecological theory of human development which conceptualised individuals as nested within multiple interacting systems. This includes intra-individual, interpersonal and larger social systems, with subsequent adaptations (Earls and Carlson, 2001, Tol et al., 2008). Drozdek, in applying these systems to refugee mental health, described the nested layers as intra-individual; family / peers; society; and culture (Drozdek, 2015).

Ecological systems are transactional in the sense that individuals can influence the nature of their social contexts, while also being subject to social constraints (Joyce, 2002). By describing individual human agency in response to social systems (Altorki, 2015), transactional models are useful for describing how people may use resources for resilience in the face of adversity (Cicchetti, 2010, Kohrt et al., 2015). Niche construction (Kendal et al., 2011) is a transactional concept which describes how changes we make to our environment can change how the environment influences us. We develop a niche (i.e. access to resources), promoting adaptation and providing ecological inheritance, often in the form of culture. Kelly (Kelly, 1966) argued that more random

environments, where resource availability is unpredictable, will lead to a broader niche (i.e., flexibility to adapt to diverse environments). Ethnographic research in Syria in the 1990s demonstrated how Syrians developed a set of conversational norms that allowed them to speak relatively freely within everyday discourse without putting themselves in danger of arrest in an autocratic system (Wedeen, 2015). These conversational norms may be seen as resources employed for adaptation.

The way we interact with resources is a key component of adaptation and resilience. Resources relevant to displaced people may include, financial savings, personal resilience, family cohesion, qualifications, language skills and an ability to act within the cultural norms of the host society. Ryan and colleagues (Ryan et al., 2008) argue that resources should be considered at pre-, during, and post-migration phases. Resources may be coerced (e.g. paying money to flee conflict) or under-utilised, (e.g. unable to work in the host country). Some resources may not be lost, rather their value changes with a change in environment (e.g. qualifications not recognised in new countries). In addition, people's ability to take advantage of resources may be undermined by the nature of traumatic experience. Human rights violations and PTEs are commonly associated with depression (Mollica et al., 1993); anger (Brooks et al., 2011); and interpersonal and emotion regulation difficulties (Nickerson et al., 2014) as well as PTSD (Steel et al., 2009) and resilience (Hijazi et al., 2014). The ADAPT model (Silove, 2013) takes this into account, along with the breakdown in social systems, to consider adaptive functioning across five adaptive systems. These include safety and security; bonds and networks, justice; roles and identities; and existential meaning . The model provides a framework to examine how the interactions between these systems may lead to a wide range of presentations through the meaning we ascribe to salient aspects of our lives (Tay and Silove, 2017).

A Model of Adaptive Processes in the Context of Displacement

We now describe an ecological model to explore how adaptation is impacted by displacement. Figure 1 depicts the individual nested in the layers of family and peers; society; and culture (Bronfenbrenner, 1979, Drozdek, 2015). The overarching process of niche construction operates to promote adaptation across the layers of the environment. This is further delineated into the five adaptive systems identified by Silove (2013) above. The

individual uses these adaptive systems to operate within the nested layers of the environment. Resources (personal, material, social and cultural (Hobfoll, 2001)) are invested in order to promote adaptation. Through the process of niche construction, invested resources modify the environment, producing future resources. This process is moderated by the impact of identity markers, such as gender, history of PTEs, age, ethnicity, sexuality, disability and social, political or financial status.

Figure 2 depicts how adaptive processes are affected by displacement. In environment one, adaptive relationships to the environmental layers are strong. However, following displacement, in a new transitional environment, these relationships are weakened and relationships to the new environment are yet to be strengthened. In addition, the available pool of resources is diminished. As a result, existing adaptive processes are forced to change, either because they are fractured by physical displacement, or because previously adaptive behaviours no longer function to promote access to resources. The impact of PTEs is noted, as this can further undermine adaptive capacities. Finally, the moderating impact of identity markers is noted, in that the impact of displacement on adaptive function and behaviour may differ depending on these markers.

The aim of this paper is to further develop the applicability of the ecological model we outline here to the perceived needs and wellbeing of Syrian refugees living in Jordan. We test this model against findings from a grounded theory analysis of perceptions of psychosocial concepts revealed across iterative interviews with key informants in psychosocial organisations supporting the Syrian refugee community in Jordan. In particular, we explore *karama* (dignity), a key concept relating calls for political freedom to personal and collective dignity in the Syrian uprising (Abbas, 2014) and the Arab Spring (West, 2011). We demonstrate how the broader range of factors included in an ecological perspective more closely match concepts which have arisen in the Syrian refugee community in response to the current crisis.

METHODS

Interviews were conducted in Amman, the capital city of Jordan, in three waves including Dec 2013 – Jan 2014; Aug 2015 – Jan 2016; and Aug - Dec 2016, as part of an iterative grounded theory project. The data presented here was part of a larger participatory action research project applying a grounded theory methodology

(Charmaz, 2014, Strauss and Corbin, 1998) to generate theories regarding community explanatory models of distress; phenomenology of local concepts of mental health; barriers and facilitators supporting community uptake of psychosocial services; and discourse analysis of gendered constructions of identity in this population group. The theoretical model tested was developed through a review of the literature conducted concurrently with this project.

Participants

Key informants within the Syrian refugee community in Jordan were purposively sampled over three years and were recruited through psychosocial organisations in Amman. Key informants are individuals who are knoweldgeable about relevant attitudes and issues within a community (Thurman, Vernon, & Plested, 2007). Participants were 29 Syrians and Jordanians, working in psychosocial organisations supporting the Syrian refugee community, for at least six months, and were knowledgeable about local cultural values and norms. All but two of the Syrian participants were recently displaced. See Supplementary Table 1 for participant gender, nationality and profession. The study was approved by the Sydney University Human Research Ethics Committee (Institutional Review Board) (Project No. HREC 2013/803 & HREC 2015/148) and all participants provided informed consent.

Interviews

The 27 interviews (two conducted in pairs) were structured according to an iterative approach, changing in response to the developing models and findings from previous inteviews. See Supplementary Table 2 for example questions. In the first wave (Dec 2013-Jan 2014), 8 initial interviews commenced with the semi-structured Community Readiness Model interview (Plested, Jumper-thurman, & Edwards, 2009) which explored community attitudes to and readiness to address mental health consequences of displacement (Wells et al., 2018). This was followed by 9 interviews (Jan 2014) exploring community explanatory models of distress . In the second wave of 5 interviews (Aug 2015- Jan 2016) an emergent model of how dignity is impacted by help seeking was presented to interviewees. The model was subsequently modified as participants explained how gender moderated constructions of dignity. In the third wave of 4 interviews (Aug-

Dec 2016), the modified model was presented to interviewees until saturation was reached. Interviews were conducted by the first author, an Australian, female, doctoral student in clinical psychology.

Data Analysis

Grounded theory analysis (Charmaz, 2014, Strauss and Corbin, 1998) was undertaken by RW, DW and CL. Transcribed interviews were coded using *QSR nvivo* (version 11) qualitative analysis software (NVivo 11, 2016). A subset of interviews was open coded by individual analysts until a coding system was agreed upon. Following cross coding, axial coding was conducted, employing sensitising questions (Charmaz, 2014) to generate alternative explanations and hypotheses. Model development was focused on the identification of processes linking key concepts. Developing models were discussed with all the other authors during model development. An iterative process was employed to review data, using constant comparison to compare the model to raw data at each stage of interviewing and model development. Member checking was conducted by asking subsequent interviewees for feedback on the emergent model which was then modified and presented to more interviewees.

RESULTS

We now present exemplars of the themes emerging from the analysis. Two key Arabic language terms emerged. We explore the social processes associated with these phenomena, including gender, identity, interpersonal relationships, safety, justice and their relationships to resources.

***Karama (*Dignity, كرامة)**

Karama (dignity) was described as central to Syrian life, connected to identity and justice, and as a foundation for social exchange. Without basic rights and resources, one's access to *karama* may be seriously undermined.

"Karama means, I'm a human." Syrian male volunteer

"Because here, for the people, the most important thing is karama. If I lose my karama, I lose myself" Female protection worker

Karama was described as integral to identity, in relation to self, family, social standing and culture.

"The Syrian women here in Jordan, they have their identity, the Syrian identity, "I will just teach my children to present the Syrian way for everyone." This is a part of their karama" Female psychologist

Three key qualities and behaviours were associated with how *karama* was described.

1. Patience and strength were described as virtues and as ways of coping.

"It's like being patient. Be patient because you will have a reward from Allah. Or being strong. Be very strong to face these hard things that happened." Male psychologist

"And if someone survived torture, they wouldn't take him to the psychologist, they would say "You're a man, be tough. If you take this, you will go to heaven."" Male volunteer

However, social norms regarding patience were described as different for women.

"[women need] Resilience, definitely. Patience also, but in a different way than men. I think that's because she would be sacrificing a lot, from what I have seen" Female psychologist

2. Self-reliance was described as a necessary component of *karama*

"A man would find it so hard to say I need help, I need money. It's difficult for men to say something like that." Female psychologist

However, this may not apply in the same way to women.

"[for women] Well, maybe not self-reliance, because she relies on her husband a lot" Female psychologist

3. Refusing things was described as a way to demonstrate self-reliance through:

    a) Refusing help

"Many of them…refused to go to any organisation for help and assistance. And even when we used to go to them and tell them if you want anything we will provide it to you, they wouldn't say anything" Male volunteer

    b) Refusing to participate in activities which contravene one's values.

"They understand karama in that they had many offers in Syria to have a good life, to avoid all this trauma, just by doing something against their rules. But they didn't. So… where ever you are, you have your karama." Female psychologist

Refusal was also affected by gender as participants explained that open refusal and resistance is often a path that is not open to women because of the threat of violence from men.

"A women, head on, cannot resist. It is a disaster… because that pathway contains lots of danger or potential catastrophes. If every woman tries to reject or resist, each woman would need at least one policeman to walk with to protect her." Female protection worker

In addition to these behavioural components, *karama,* was described as a socially determined phenomenon, defined in interpersonal context and in relation to providing for one's family

"It gets you more recognition, it gets you more respect from others, I think the way people look at you... No one can live alone, because we are social beings." Female psychologist

"The feeling of taking care of my family and I can't offer them any money or food, or I can't give them the basic things that they need, this can decrease karama." Male physiotherapist

Sudme (صدمة)

The word *sudme* (صدمة) was commonly used in reference to the emotional impact of the crisis. *Sudme* may often be translated into English as trauma, although in lay usage it is not linked to psychological pathology. Rather, it is a normal reaction to an extreme situation.

"It has a spoken meaning which is different than for psychologists…When they say sudme, it means I'm shocked, reaching to the definition of what trauma is... I went through something very hard to go through and right now I can't handle everything in my life. That's how they explain it" Female psychologist

Sudme is much broader than the English word trauma. It refers to PTEs and the whole refugee experience, including the accumulation of day to day stressors which were often described as pressure.

"It's not the shock anymore, it's like what is the result of all of that. Like feeling less than other people, feeling less dignity and they have a saying in the Syrian language... It's like, when you leave your area, you will be of less dignity." Female psychologist

"Adughat [pressure]. A lot of Syrians they are aware that most of their uncomfortable feelings, or negative feelings, are not related to trauma itself, but to the pressure of the stress they have here in the new community, the lack of services, lack of opportunities, lack of social support. All that make them more stressed. It's a very common [term]… they refer to the current situation, not only for the traumatic event itself." Female psychologist

Responses to *sudme* may include intense distress, hopelessness, somatic difficulties and a sense of overwhelming pressure. The emotional impact of PTEs and the accumulation of everyday stressors cannot be disentangled from one another.

"First, they speak about what they are suffering: difficulty in sleeping, difficulty in coming out of the house and facing people, and for the man, difficulty in how they will feed his family. And when he thinks about this, he feels like his head is going to explode from the all that he has." Male religious scholar

Sudme may undermine the social components of *karama* when *sudme* leads to shame.

"It's not acceptable what I mention…about the traumatic event. Do you know why? Because many times it's related to humiliation, it's related to shame, it's related to breaking their karama… They can't answer this question, why this happened to them?" Male psychologist

Sudme was described as undermining *karama* and impacting on interpersonal and familial relationships.

"[many men say] I don't have any dignity. I'm here and I don't have anything… the NGOs are controlling my life, not me…All of that helps them to feel less karama" Female psychologist

"To them it's only weakness and they can't accept being weak …"If I had money, I would be able to sleep at night, I wouldn't beat my sons."" Female psychologist

Impact of gender

A key issue which emerged, was how both *karama* and the impact of *sudme* were affected by gender.

Participants described how women often do not have direct access to *karama*.

"Well it's defined because usually in these cultures women are followers, she gets her karama, she takes it from her man." Female psychologist

This was discussed in relation to women being in a position of dependence.

"For the abused girl or wife it's related to karama… a lot of them, honestly, they prefer to keep silent…Because of fearing from the culture issues… because they are already dependent to the husband." Female psychologist

As a result, women are required to be flexible to the needs of the people they depend on.

"Before the crisis… men were presenting their rules, their orders "Don't understand it. Be flexible for it. Just do it."… "Be dependent."" Female psychologist

However, displacement has led to an interchange of roles because it is acceptable for women to seek support, but not men.

"The woman is the one who gets all the needs of the family satisfied, but not in the way she used to before, more independently… She's starting to not exactly replace, but she's taking some of the roles that the father used to have back in Syria… perhaps right now she is the one who takes the money, so she has the money in her hand." Female psychologist

Grounded Theory Model

Figure 3 displays a model emerging from the above findings. The model depicts how *karama* and *sudme* interact with one another to impact adaptation, represented by processes that contribute to or alleviate distress and family conflict (here after distress). There are separate models for men and women, representing the moderating impact of gender.

For men, *karama* is increased by acts of refusal and self-reliance and the qualities of patience and strength. *Karama* is undermined directly by *sudme* (e.g. by PTEs, such as torture). *Sudme* leads directly to distress but is also amplified by resource and role loss. In addition, refusal and self-reliance mean that men are less likely to access support services, blocking an avenue to alleviation of distress. Finally, distress undermines *karama*. Conversely, *karama* reduces distress.

For women, *karama* is also undermined directly by sudme, leading to distress, amplified by resource loss. Patience and strength may increase *karama*, but there is not a direct pathway to *karama* for women through refusal and self-reliance, which are often not an option. Instead, women have greater access to services which may both directly reduce distress and indirectly increase *karama* by providing opportunities for empowerment and increasing resources for patience and strength.

Comparing the grounded theory model and the ecological model

We will now consider the components of the ecological model and how they relate to the grounded theory model. See Figure 4 for quotes relating to the ecological model.

ADAPT pillars.

Figure 3 highlights areas in the grounded theory model which are related to the ADAPT pillars (Silove, 2013). For example, refusal may be connected to justice when it involves maintaining *karama* by rejecting things which are not consistent with personal values. Ideals of patience and strength may be connected to existential meaning through religion. Self-reliance, role loss and *karama* are all connected to roles and identity in that they provide ways for people to enact identity. *Sudme* is a core concept which is clearly connected to the safety system through its relationship with trauma. Finally, distress and family conflict have direct bearing on interpersonal bonds, while *karama* is partly defined by social affiliations. Of note, this model also highlights the interconnected nature of the ADAPT pillars in adaptive functioning.

Ecological layers.

Karama can be conceptualised at the individual level (promoting personal wellbeing); is often interpersonally determined by how one cares for one's family; can operate as a form of social capital, demonstrating a person's social standing, for example through enactments of refusal; and is often discussed as a phenomenon specific to Syrian culture. Consideration of all these levels can help to uncover how the concept may operate to determine access to resources. For example, cultural norms for men may lead to refusal, supporting personal *karama*, but reducing resources for the family, leading to increased distress and family conflict.

Similarly, sudme can be thought of as a personal reaction to trauma; a phenomenon which impacts on family functioning; a collective social crisis impacting access to rights and resources; and a culture bound idiom of distress.

Niche construction.

We now consider how a change in environment impacts on the adaptive functions of behaviours and consider how gender moderates the process of niche construction, where individuals respond to environmental demands and thereby change their environment.

In Syria.

For men living in Syria before the crisis, access to resources enabled the performance of male gender norms of patience, self-reliance and resistance. These were adaptive in promoting *karama* for the self and family, increasing access to further resources. For women living in Syria before the crisis, access to resources was often restricted or filtered through men. As women were perceived as dependent, less self-reliance was expected of them than men. When women do not have direct access to safety and resources, resistance may be counter-productive and put them in danger of abuse. Thus, behavioural flexibility tended to be more adaptive than resistance, as a diverse repertoire of behaviours and coping skills would be needed to access resources (i.e. a broader niche).

In displacement.

In displacement, for all genders, family access to resources through employment or social connections is diminished. Distress may overwhelm personal coping resources making patience and strength increasingly difficult.

For men, resource loss over time undermines the previously adaptive function of *karama* promoting behaviours because resource loss makes self-reliance increasingly difficult and resistance may undermine access to the very resources which could promote adaptation. This loss is amplified by distress, which undermines personal coping resources needed for resilience.

For women, social acceptability of seeking services to address basic needs gives women direct access to resources such as financial, social, psychological, educational and capacity-building. Access to these resources also reduces distress, promoting future resilience.

Female social norms, which include a broader niche or need for greater flexibility in adaptive functions, enable women to take advantage of resources available in the displacement environment, increasing their adaptive capacities. This, in turn, impacts the social system by disrupting gender roles. In contrast, male norms of self-reliance and resistance prevent them from taking advantage of these resources in the same way. As a result, participants described how many women were taking advantage of services which would have been stigmatised in the past, such as mental health services. In contrast, many men were struggling with loss of role, while norms of resistance mean that men must pay a price (their *karama*) for asking for help.

Discussion

The ecological model presented here resonates with concepts of wellbeing described by Syrian refugees in Jordan, both in the current analysis and a previous systematic review of psychosocial needs assessments (Wells et al., 2016a). Although previous theoretical models have outlined ecological approaches to refugee psychosocial health (Miller and Rasmussen, 2017, Silove, 2013, Drozdek, 2015, Ryan et al., 2008), this paper applies these concepts to an in-depth grounded-theory analysis of the ongoing Syrian crisis, and explicitly examines the transactional nature of issues raised by members of the Syrian refugee community across three

waves of interviewing over the periods 2013-2016. The Syrian community concepts of *karama* and *sudme* demonstrate how the adaptive function of values and behaviour can change substantially with a major change in the environment. The concept of niche construction provides an important framework for understanding how some members of a community will be better placed to respond to and take advantage of the changed environmental circumstances to support their own adaptive function while contributing to changes in their social world. The findings confirm the congruence of the ADAPT concepts with the narrative of key informants working with Jordan's Syrian refugee community.

An ecological approach goes beyond a cultural formulation which adapts imported therapeutic models to local explanatory models (Kirmayer, 2006). Rather, an ecological model calls for a formulation which considers the interplay of social and cultural factors. By identifying how agency is represented in the concept of *karama*, we demonstrate how changes in environment can open up spaces for shifts in agency and power at both individual and collective levels in a way that has empowered some women in the displacement environment (Smith, 2008). Identifying patterns of adaptive behaviour taken up by women does not negate the impact of gendered power relations and violence on women's wellbeing. Worldwide, prevalence rates of anxiety and depression are higher among women, while substance use is higher among men (Steel et al., 2014). Connell's (Connell, 2005) concept of hegemonic masculinity offers a useful frame to consider *karama*. The concept of *karama*, as described in this study, offers a masculinised ideal that is challenging to embody, especially as displacement has undermined access to resources. The distress caused by failure to embody this ideal, along with attitudes that limit men's avenues for acknowledging this distress, may lead to problems for all involved. This is consistent with our previous findings in the Syrian refugee community in Jordan where women identified increases in family violence with men's loss of role (Wells et al., 2016a) .

Applying this ecological model in clinical and research practice

An ecological analysis can guide community level preventative interventions which promote adaptation. For example, research in another post-conflict setting has demonstrated how intimate partner violence leads to distress and explosive anger attacks among women, leading to harsh parenting practices (Rees et al., 2015).

Our model would predict that providing new role opportunities to men in a way which supports *karama* would improve personal wellbeing, as well as reducing conflict and violence among all family members. Given that reporting of and help seeking for mental health difficulties may be stigmatised in the Syrian community (Gearing et al., 2013, Maziak et al., 2002), especially among men (Wells et al., 2016b), outcomes could be measured by developing a locally validated measure of role adjustment and its relation to distress and family functioning. An intervention program would likely be most effectively delivered at the community level.

International consensus calls for a greater emphasis on community-level interventions (IASC, 2007), yet methodologically sound evidence regarding their effectiveness is lacking (Nickerson et al., 2011). Current advancements in methodology, including latent variable modelling (Gilmore et al., 2016), stepped wedge design (Brown and Lilford, 2006), network analysis (Jayawickreme et al., 2017) and rigorous qualitative analysis (Pereira et al., 2007) could lead to considerable progress. We suggest that the model presented here provides an example of an approach that can develop operational and testable hypotheses regarding the role that social, cultural and interpersonal factors play in individual wellbeing among refugees. It provides a method to widen the scope of an individual clinical psychology formulation to explore possible causal and maintaining factors in a broader ecological system.

Threat remains current for many refugee communities who have not been resettled to situations of safety. In such a situation fear-related responses, such as hyperarousal or cognitive bias towards threat-related stimuli may not be symptoms of pathology, rather they are possibly adaptive responses aimed at preventing future danger (Silove, 1998). Theoretical approaches which recognise that threat of human rights violations remains constant, such as continuous traumatic stress (Straker, 2013), may offer more clinical utility and could direct resources to modifiable ongoing risk factors (Miller and Rasmussen, 2014, Steel et al., 2006) or target cognitive mechanisms which help people cope with these realities, for example through enhancing self-efficacy (Brown et al., 2016). The PM+ program (Rahman et al., 2016), which focuses on problem solving skills to address practical psychosocial issues, may offer a useful framework for reducing distress. One of us (OSY) is currently working to train community psychosocial workers in Northern Syria to employ an ecological focus.

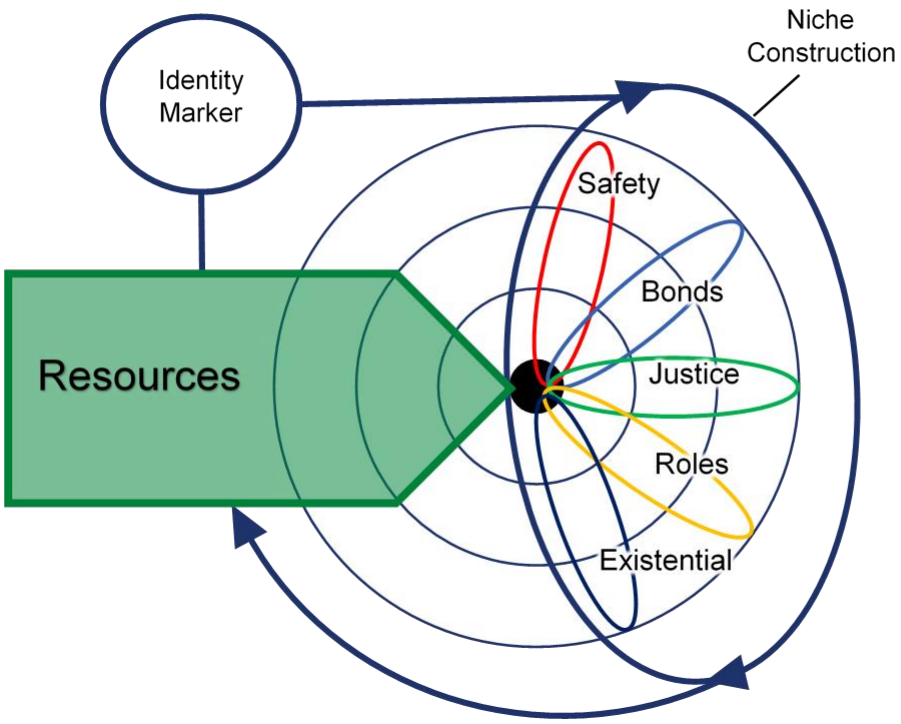
Limitations

This research may have benefitted from an intersectional lens from the outset (Crenshaw, 1991). Such an approach recognises that the impact of identity markers such as gender, class, sexuality or ethnicity may interact and intersect, thus, attending only to one (e.g. gender) may ignore the impact of others (e.g. ethnicity). The focus on gender which emerged during the interviews reflects the issues as raised by community members themselves, which included a binary definition of gender. Such a definition may not represent the experience of all. The issues raised regarding gender-based violence would have benefitted from a more in-depth, critical approach. We would like to caution against an interpretation of these findings that situates violence against women within an orientalist discourse (Said, 1978) that draws attention to the problem of sexism in Arabic speaking cultures, while ignoring that violence against women exists in all cultures (Abu-Lughod, 2013). We acknowledge the fluid nature of culture (Kirmayer, 2006) within historical context and that individual negotiations with *karama* will differ across individuals and settings. We also note that the narratives of change discussed here may have been influenced by the social identity of interviewees, who were psychosocial activists invested in a system of humanitarian action and exposed to care-seeking individuals. As well-educated individuals, their comments may represent the views of a particular class of Syrian society and cannot be generalised to the community as a whole (discussed in greater detail (Wells et al., 2016b). We chose to interview individuals with some professional training as their familiarity with psychosocial issues would provide them with skills for coping with distress and stigma associated with the interview topics. The interviewer was a white, female psychologist from Australia. Her identity may have been a barrier to some participants who may have found it difficult to trust that she would understand and identify with their lived experience and culture or felt that they needed to present a specific image to outsiders. However, this may also have been a strength, as her lack of familiarity with the culture meant that participants needed to explicitly describe concepts, rather than rely on shared understanding.

Conclusions

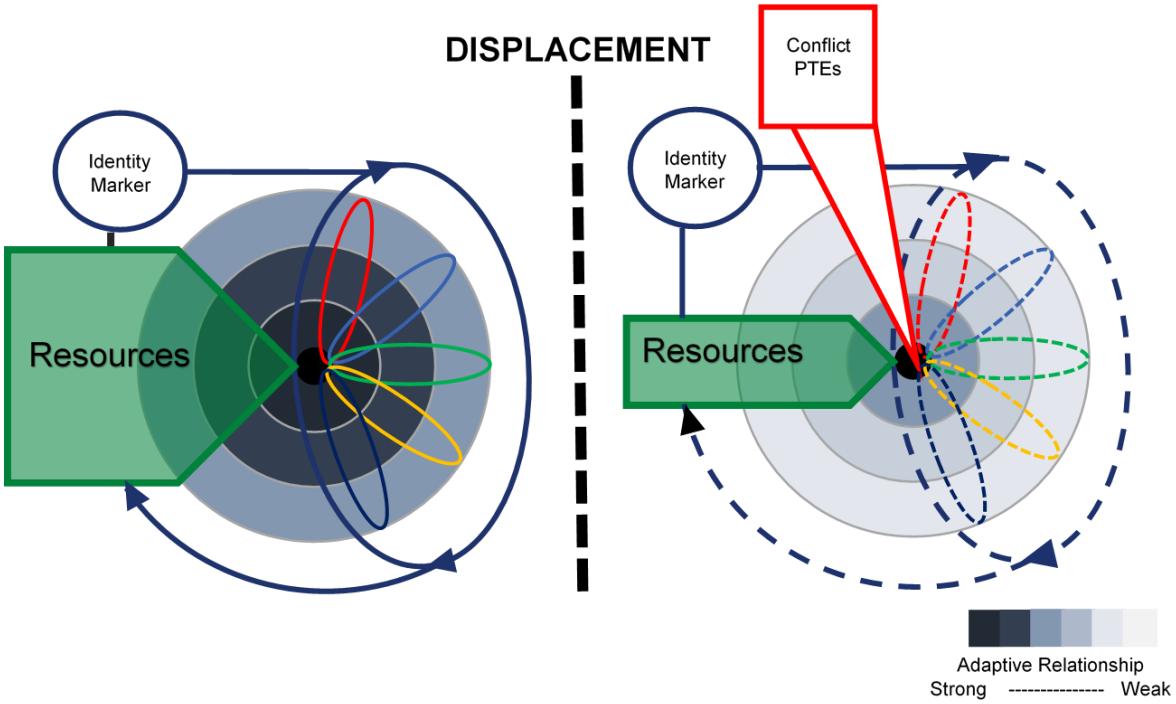
We hope this model can contribute to the formulation of interventions and research questions which help to address the broad range of ecological factors raised by community members in this study. Syria has a high rate of tertiary education (including for women) and many skilled professionals. Research can examine whether their skills are being put to use in the new environment or whether their political status precludes this, as well as what support community leaders, teachers, journalists, religious leaders and engineers need to build capacity in their communities? When assessing the outcomes of programs, we can ask whether niche construction is achieving its end by examining whether programs have increased access to further resources including material outcomes (such as increased access to employment) or psychosocial outcomes (such as increased social capital). We can use this approach to ensure that programs consider all the nested layers of the environment. We hope that such an approach will support the adaptive capacities of communities to come together to rebuild and recover.

Figure 1



Note: The model depicts the process whereby resources are invested in modifying the environment, via the five adaptive systems, which in turn affect available resources. The concentric circles represent the individual nested in the layers of family / peers; society; and culture (Bronfenbrenner). The five adaptive systems (Silove, 2013) are engaged by the individual in relation to the layers of the environment to promote wellbeing. Overarching these systems is the process of niche construction, whereby resources are invested in modifying the environment in order to promote wellbeing. This reciprocal process effects access to future resources. In addition, the process by which resources are invested is moderated by identity markers including gender, age, social status, class, ethnicity, disability and previous history of PTES, affecting the kinds of behaviours engaged for niche construction.

Figure 2



Note: The four environmental layers are depicted in concentric circles before and after displacement. The darkness of the shading indicates the strength of the adaptive relationship between the individual and their environment. Adaptive relationships are stronger for layers more proximal to the individual. Prior to displacement, individuals have developed strong adaptive links through the process of niche construction. Along with identity markers (such as gender, age, social status, class, ethnicity, disability and history of PTEs), this shapes their access to a pool of resources. Following displacement, the individual is literally removed from their environment, resulting in weakened adaptive relationships with the environmental layers. This disrupts the process of niche construction, such that previously adaptive behaviours may no longer succeed in securing access to resources. In addition, the pool of resources is diminished. Finally, the impact of conflict, human rights violations and PTEs also impact on adaptive systems at all layers.

Figure 3.

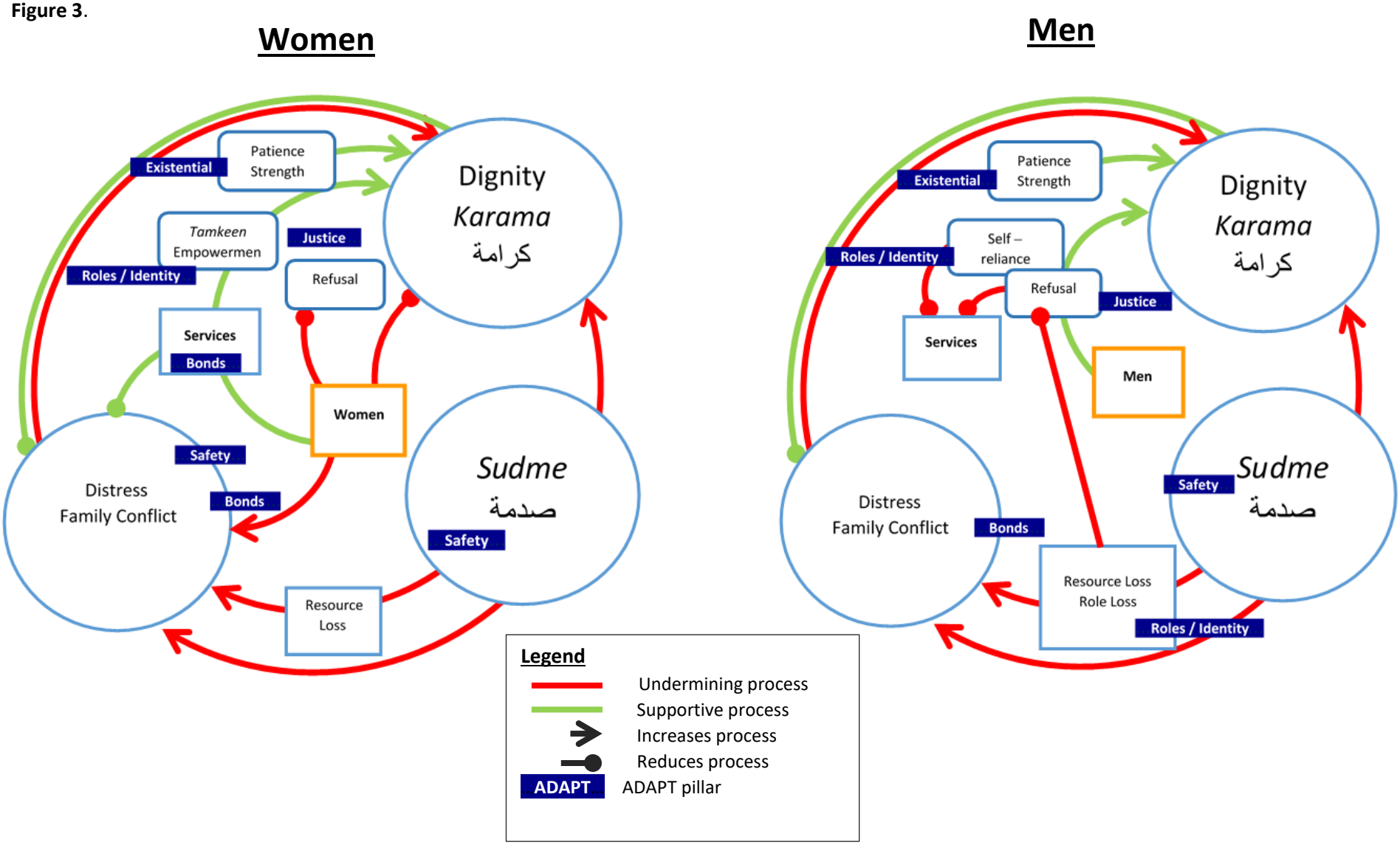
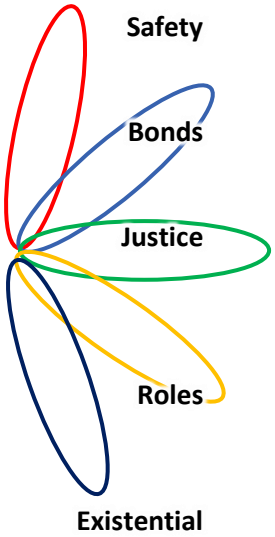

Women
Existential
Patience
Strength
Dignity
Karama
كرامة
Tamkeen
Empowermen
Justice
Roles / Identity
Refusal
Services
Bonds
Women
Safety
Distress
Family Conflict
Bonds
Sudme
صدمة
Safety
Resource
Loss
Men
Existential
Patience
Strength
Dignity
Karama
كرامة
Roles / Identity
Self –
reliance
Refusal
Justice
Services
Men
Distress
Family Conflict
Bonds
Sudme
صدمة
Safety
Resource Loss
Role Loss
Roles / Identity
Legend
Undermining process
Supportive process
Increases process
Reduces process
ADAPT
ADAPT pillar

Figure 4. Components of the ecological model compatible with the grounded theory model.



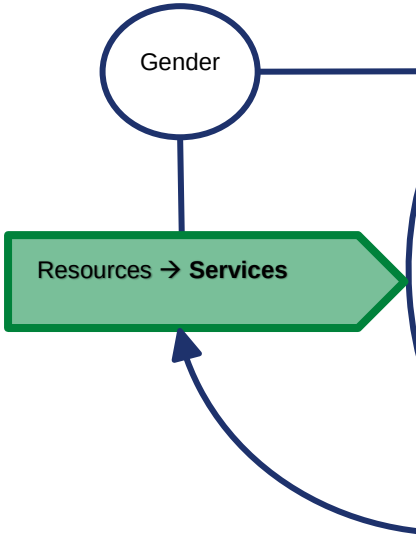
"These people are now in need, so I can make the young men work with very little cost", or sometimes they are exploiting the girls also." Female psychologist

"Because they [men] are trying to appear, to be strong. Maybe they respond in unhelpful ways with coping techniques like abusing their families, smoking or going out until late or being anxious or aggressive with their family. That's their way to cope. They don't use helpful coping technique like asking for help or just crying just show their emotions." Male physiotherapist

"From my experience, the people in Syria who had a role in the situation, their response to the trauma is totally different from the people who are …without any identity for these events. So, people who had a role of doing something, helping people, …a political view, they have a meaning for why this happened… And I met many people who lost their house, their family… but they don't have any PTSD symptoms, because they have a meaning of why this happened" Female psychologist

"Because perhaps some people lost that much… that they feel that one of the very important things to maintain and protect is their karama [dignity]. That's something they have, something they can protect somehow." Female psychologist

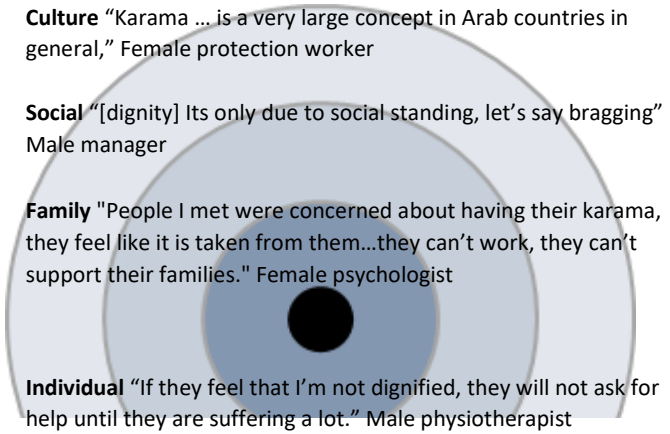
"There is no one who just went out of war we would consider a normal person… If you see someone being killed next you, your whole life is going to be different. Not only referring to a day and night- your whole life ahead. Many things that you considered before that moment important, will be vanished. And others that you did not care about, will be so important after that moment" Male volunteer



"Women are viewed as weaker, its ok for them to ask for help from other people. But a man? It's not ok for him to say anything…to express his feelings "Female psychologist

"If they [men] feel that I'm not dignified, they will not ask for help until they are suffering a lot …[they do] something indirectly like sending their wife to bring the box or to ask for these materials." Male physiotherapist

"Especially for women who are working and their husbands are at home, they don't work, Many of them say, "I'm running the house, I'm working, while he is just still at home, I'm going to the NGOs, I'm always running the house" Female psychologist



Culture "Karama … is a very large concept in Arab countries in general," Female protection worker

Social "[dignity] Its only due to social standing, let's say bragging" Male manager

Family "People I met were concerned about having their karama, they feel like it is taken from them…they can't work, they can't support their families." Female psychologist

Individual "If they feel that I'm not dignified, they will not ask for help until they are suffering a lot." Male physiotherapist

CHAPTER 10:

PERSONAL POSITION, THE JOURNEY OF RESEARCH AND CONSIDERATIONS OF METHODOLOGY

CHAPTER 10: PERSONAL POSITION, THE JOURNEY OF RESEARCH AND CONSIDERATIONS OF METHODOLOGY

The publications contained in this thesis represent the many journeys I undertook to complete this PhD. These include: my professional journey of learning to become a practising psychologist; the physical journeys to Jordan; and my political journey as I came to understand more about the political implications of scientific research and clinical practice. Through this process I have come to understand more about the methodologies I employed and reflect on what kind of methodologies I would aim to use in the future. Research is never a value-free enterprise, so I hope to detail some of my personal values and learning here. I hope this will help me to bridge the 'messy' world of clinical practice in real world settings and the structured language of research publications (Hess, 2005).

METHODOLOGY

Like many PhD students, I began this project with lofty and perhaps unrealistic ambitions. I wanted to engage in participatory action research (Wallerstein & Duran, 2006) in the hope that I could help address some of the power disparities that exist between researchers and research participants, between international workers and displaced populations (Mackenzie, McDowell, & Pittaway, 2007). Originally supervisory support helped me narrow this into a project using the Community Readiness Model (Edwards, Jumper-thurman, Plested, Oetting, & Swanson, 2000). This was an appropriate framework for a PhD level student who was travelling solo to a new context to begin a research program, as the semi-structured nature of the interview and the model itself gave me a coherent structure to frame my initial research. The model's focus on building links with individuals in the community enabled me to build a solid foundation to engage in participatory work, in the form of training, and ensured that this work was relevant to the needs of the people I was working with. From this basis I was able to have sustained engagement with a variety of local people, providing me with links to a range of psychosocial workers to interview over the 3 years of data collection. It was these networks which enabled me to use grounded theory, returning to the community to continue interrogating themes as they emerged.

While I am happy with the way this unfolded, there are a number of ways I would do things differently in hindsight. Firstly, I would have specifically designed the study as an ethnography. That is, I spent considerable time in the local context. However, because I did not set out to conduct an ethnography, I did not specifically collect data in a systematic way which would enable later analysis within this framework. In addition, I did not have ethics approval to use observation, or similar ethnographic techniques in my analysis. As a result, while these experiences informed my analysis, they could not be included in a more formal methodological way in the thesis. Secondly, I would have adopted a more critical feminist, post-colonial and intersectional lens (Crenshaw, 1991) from the start to inform both data collection and analysis. While the methodology of grounded theory calls for bracketing out of

personal position and to not engage in extensive literature review prior to data analysis (Strauss & Corbin, 1998), I now have come the belief that supposed researcher neutrality in situations of unequal power relations actually reinforces these power relations by ignoring their existence. If I had employed a feminist lens I may have focused on issues of gender earlier in the interviewing, rather than having it pointed out to me in the second phase of interviewing. A post-colonial lens would have given me some more theoretical tools to discuss the issues of power relations and orientalism with interviewees. An intersectional lens would have enabled me to explicitly consider the combination of factors such as gender, ethnicity and religion in interviewing. However, given these limitations, I believe that the process of learning actually enabled me to develop my clinical and political voice and identity. I will now discuss the journeys undertaken.

PROFESSIONAL CLINICAL JOURNEYS

The transition in focus through the papers in this thesis represent my own journey to find a voice within the world of clinical psychology. In Chapter 3, I outline a need to modify and culturally adapt clinical assessment tools and therapy. Written in the first two years of my training, this paper represents my focus at the time on seeking recognition within a clinical world focused on individual interventions. One might say I drew on interpretive repertoires associated with evidence based practice in order to assert my own legitimacy (Potter, Wetherell, Gill, & Edwards, 2008). While I questioned a framework which viewed psychiatric categories as universal, I still used this frame of individual psychological disorder in order to think about how psychological intervention might be improved. As a new therapist working in a medicalised discourse, I had not yet developed the confidence to recognise the limitations of this frame. Perhaps it is necessary to be immersed in a discourse before we can deconstruct it.

As I learnt more about a range of therapeutic options outside individualised CBT, I began to see that simply adapting CBT is not enough. The theoretical basis of family therapy and narrative therapy

opened me up to the need to consider a wider range of causal factors in formulating clinical problems, these may include the family or the social group. That is, distress may be viewed as a product of interactions within a family system (Rhodes & Wallis, 2011) and healing may occur through the construction of identity in relation to family and social groups (Carr, 1998). As I began to read more about community psychology (Kelly, 1966; Rappaport, 1987) I came to understand that my role as a psychologist in global mental health may be to support others in the community to work effectively, rather than to attempt to provide direct individual therapy with people whose explanatory models and idioms of distress I am not likely to understand (Patel & Prince, 2010).

PHYSICAL JOURNEYS

My physical journeys included three trips to Jordan for my fieldwork, as well as additional trips to surrounding countries on my own time and dime: Beirut in Lebanon, Gaziantep in Turkey (near the Syrian border), Erbil in the autonomous Kurdish region of northern Iraq and Kavala in Eastern Greece. While not officially part of my research program, these additional trips added considerable depth to my understanding of the living situations of displaced Syrians. I met and made friends with Syrians of many walks of life, playing impromptu musical concerts with Kurdish musicians in Erbil; using my meagre Arabic to help volunteers in make shift camps in Greece communicate with new mothers to ensure they have their health needs met; providing training and ongoing support to friends and colleagues displaced to Turkey; observing the political complexities of life in Lebanon. In every one of these settings I was warmly greeted with the generous hospitality for which Syrian culture is famous. I never felt unsafe as I was invited into homes and tents and engagement parties and weddings and played music with large groups of very enthusiastic children. There is no doubt that these experiences influenced the directions of my analyses. I consider this a strength of this work. Rather than attempting to bracket out my own experience, I have used what I learned in these settings to guide, not only the individual analyses, but the whole direction of my work (Starks & Brown Trinidad, 2007).

Witnessing the lives lived by Syrians in displacement has enabled me to get a small a glimpse of the emotional and symbolic importance of concepts such as *karama* and *sadme.* Hearing these words used in myriad contexts has helped me to build a more embodied sense of their meaning from many points of view. While I can never hope to speak *for* Syrians, I hope that what I have learnt will help me to be an advocate and an ally (Alcoff, 2008). While I hope that I have effectively communicated the importance of these terms within this thesis, I also recognise that my own understanding and personal connections are another important outcome of this research project. I am already undertaking new research programs with the people I have met; providing training programs in ecologically focused CBT to Syrian psychosocial workers in Turkey; engaging in weekly case discussions and clinical support with Syrian psychologists working in Gaziantep, Istanbul and eastern Lebanon via Skype; consulting on qualitative methods to help improve access to health care for Syrian refugees in Lancashire, UK; providing advice and supervision to Syrian psychosocial workers who want to conduct their own research (including co-writing an article about self-care programs for medical staff operating inside besieged areas of Northern Syria, currently in press). These projects outlive my PhD and demonstrate the usefulness of the Community Readiness Model approach. That is, using research as a tool to build collaborative networks rather than a way to extract and decontextualize data. The most important element, I believe, of this work, is that I have learnt about a process for trying to work *together with* rather than *for* displaced Syrians. While I may have learnt about the importance of this project, I would not say that I have learnt how to successfully strike a balance between sharing skills that people have asked me to share and being able to take the time to really listen and acknowledge the contextual knowledge of the people I work with. This is an ongoing process.

If there is one important lesson that I will carry forward into my ongoing work, it is the need to question and understand the nature of my own privilege. It is not possible to overcome my position as a privileged, educated, white woman from a rich nation who has access to a discourse of power – the technical language of science. Over time I have learnt more about my position of privilege, whether this is the freedom to move easily across borders, often without a visa, as an Australian

citizen; living in the knowledge that my family and friends in Australia are unlikely to experience conflict or political oppression; having access to high quality education along with the resources to take advantage of this; having access to political rights as a woman, including reproductive health rights; having English as a first language and being trained in the use of scientific language over many years; secure and stable housing; and the list goes on. Most of the people I have worked with over the course of this research have not had access to many of these privileges, and this will impact on their ability to perform functions within a scientific discourse which could lead to the public recognition of the ongoing work they do. Through authorship on academic papers and supporting these colleagues to write their own papers, I hope to use my privileges to help them get the recognition they deserve, in the hope that this will assist them with professional opportunities in the future (Connell, 2014).

POLITICAL JOURNEY

Through the experience of moving my physical body across borders, I have come to see some of the ways in which even the simple act of traversing space is a political act. This is most certainly the case for people who have been displaced to contexts in which they do not have access to the rights of citizenship or the means to satisfy their basic needs. It is for this reason that there is a need to take a critical lens to the psychological discipline. Just as the feminist movement highlighted the political nature of everyday acts (Hooks, 2000), theories about race (Crenshaw, 1991); decolonisation (Connell, 2014); masculinities and gender (Connell, 2005) offer a rich field help us to link the field of clinical psychology with the social context in which it operates. Only when we begin to do this can we ensure that our work will help people by acknowledging and helping to address the social causes as well as the familial and individual causes of their distress. There is no point in providing individual therapy if we are simply recapitulating systems of oppression through patriarchy and colonisation (Hooks, 1984). Individual psychology is designed for the privileged few. If we are to be of use to a wider range of people – we need to learn how to decentre our knowledge systems (Racine, 2003) and start to

understand how power dynamics play influence our interactions. I will now discuss how the journey of this PhD has caused me to come to new political viewpoints.

Edward Said (Said, 1978) described how symbols of the 'orient' have been co-opted by western culture to create a category of the exotic other; how this was bound up with the development of capitalism and colonialism; and how successive generations of orientalists set out to the 'Middle East' to explore this 'mystical' place. I was determined not to become one of them – yet I soon discovered that I was one of countless students from Australia, the US and Europe, who could use the privilege of our mobility to access exotic experiences. Take for example, a local university advertisement in Sydney which pictures a blond haired young woman handling a goat with a woman of colour in a rural location and reads "Get out of your comfort zone". The international economy of study abroad experiences for students from high income countries may serve to commodify the lived experience of people in low resource settings and serve the career interests of these students, including myself. The localities I stayed in during my trips to Jordan were designated as special zones, patrolled by specific tourist police, where rich foreigners, working in research or humanitarian aid, could easily meet and move. I realised that being aware of the dynamics of orientalism did not enable me to move beyond my own subjective position within this system.

I discovered that participating in truly collaborative action when unequal power relations exist is extremely difficult. I brought with me a set of technologies perceived to be valuable: psychological tools constructed as objectively scientific by a medical discourse. For people living in countries designated as 'not technologically advanced', access to these psychological tools offers considerable upward mobility. Everywhere I went I met people who told me, "No one in Jordan knows anything about psychology." This was even said while I sat next to an accomplished and highly capable female Jordanian psychologist. My protestations that my knowledge, produced in a western institution, was not somehow more advanced or more suited to their specific environment than theirs were often ignored within the limited sphere I moved in. These Syrian psychologists, who lived the same realities

as the people they sought to help, were exposed to the suffering of others every day. It seems that they saw an answer to this suffering in the technologies and training I supposedly embodied. How could I explain that these tools, constructed by and for the privileged in high income settings, could not address the social horrors being played out in the field of war?

I studied psychology because I wanted to alleviate suffering. Yet, I have found the field of clinical psychology inadequate for the task of conceptualising and addressing the full range of sources of suffering. The only satisfactory answer to the kind of suffering I have witnessed came from those who criticised the categories devised through a bio-medical framework (Kleinman, 1997). Kleinman argued that embodied suffering is constructed through both transpersonal (social) and subjective experience. The biomedical focus on subjective meaning making out of unmentionable horrors belies the social and embodied nature of those horrors – and the fact that certain kinds of bodies are designated to endure them. I appreciate the depth of Kleinman's analysis of power, yet I feel that we need a framework to interrogate how power imbalance is being reproduced within our discipline, even as we seek to change it. I cannot step outside of my position of privilege, and the knowledge I have is inextricably intertwined with the structures that produce my privilege. The project of psychology as a science is entangled with the roots of colonialism, with an enlightenment project to construct taxonomies of difference, and thereby categorise and control the physical world. Colonialism extended this project to include human beings and their land. While there have been psychologists who have challenged the use of these categories to repeat oppression, these concerns have often been put to the side in favour of a search for scientific legitimacy.

What I hope for is a discipline which could prepare psychologists to face the challenges of our times. This will involve understanding what how privilege works, how whiteness is constructed and how processes of exclusion operate. In my own research, I had hoped that being aware of orientalism (Said, 1978) and the need for cultural formulation would inoculate me against repeating colonial practices, but this was not enough. It is not enough to be cognizant of past wrongs, or feel a great deal for people

who face horror, or care about those people, or want to do good – because all of these actions have the potential to reproduce colonial relations (Land, 2015). Thus, a journey to the other side of the world brings me back home to Australia to realise that until I confront the reality of my whiteness and my position as a coloniser, living on stolen land, who participates daily in the continuation of genocide, then I cannot begin to think about how to address the processes which have me recapitulating colonising practices - even as I try so hard to undo them.

CONCLUSION

This thesis is an attempt to address these power imbalances by seeking to include the voices of the Syrian people I met and the people who work with them, in local contexts, dealing with daily problems. It is an imperfect attempt which has helped me to understand the narrow frame within which I may be able to offer support. My own contribution may be through advocating for a discourse in clinical psychology which recognises and tries to address power disparities and the impacts of colonisation. Through my publications I have attempted to act as a kind of discourse translator. This has involved taking the language of humanitarian organisations and synthesising them into a format appropriate for a peer-reviewed medical community (Chapter 6). In addition, in Chapters 7 and 9, I have attempted to share something of the values placed on concepts like *karama* and *sadme* and pressure used in the Syrian community with the scientific community. I hope that this contribution to the literature will help to shift the focus from identifying instances of PTSD to recognising the explanatory models and understandings of local communities . In Chapter 8, I have sought to outline some of the challenges faced by grassroots activists and call for greater support in the form of training and supervision.

CHAPTER 11:

DISCUSSION

CHAPTER 11: DISCUSSION

The Chapters contained in this thesis represent an empirical and theoretical journey undertaken over the 5 years taken to complete this PhD, while also completing clinical psychology training. There is a clear development in thinking, from the initial literature review chapters, which detail my attempts to map the available understanding regarding the intersection of culture and mental health in the context of the Syrian conflict (Chapters 1 to 5). An initial concern to ensure that psychological therapy can be responsive to the cultural context of Syrian refugees led me into a sustained engagement with Syrian refugees who work as psychosocial activists in their local communities in Jordan. Through this engagement I learnt about the importance of seeking to understand needs as expressed by community members (Chapter 6). I saw evidence that cultural norms and attitudes to mental health can change rapidly in response to changing circumstances (Chapter 7), thus a narrow focus on cultural adaptation may not always be helpful. Through practical engagement, I learned how community level assessment can guide praxis in a way that translates research directly into tangible outcomes for the community of concern (Chapter 8). Finally, this journey has led to a re-evaluation of the role that clinical psychologists may play in assisting displaced communities. In Chapter 9 I lay out an argument for formulating distress within ecological context and adopting a transactional view.

In this thesis discussion I will lay out some implications of the work presented here. First, I will discuss some reasons why I believe an ecological approach is needed to think meaningfully about psychosocial needs and mental health in displacement settings. I will then outlines some key implications for practice in displacement settings, leaning heavily on principles outlined by Miller and Rasco (2004) and incorporating elements from the ecological model outlined in Chapter 9. I will then discuss in more detail the concept of niche construction. I propose that the concept of niche construction may be a useful tool for addressing some of the limitations to individualised psychological practice raised in this thesis. Firstly, by definition niche construction is bi-directional and acknowledges the interactions between elements at multiple layers. Second, by focusing on adaptation, we may avoid

the need to classify stressors as traumatic or not. Rather, we can seek to understand how beliefs, behaviours and practices can promote resilience for prevention of mental health problems or understand how collective and individual factors can be addressed in order to alleviate suffering. Finally, by exploring the interplay between past PTEs, ongoing stressors (which may themselves be traumatic) and present adaptation we can challenge the need for a theoretical model which places pathogenic forces in the past. Whether traumatic reactions concern past, present or future events, the same neural and cognitive functions may underpin our reactions to them. Current PTSD treatments focus on exposure to past events, yet past events are constructed anew with every recollection, and thus they are always part of an adaptive function within the present. A clinical framework which focuses on improving the adaptive function of cognitive and social processes in the present, which also attends to the social, political and cultural circumstances, may help us to generate clinical therapies which can help people who live with ongoing threat and uncertainty. To close, I recommend some research questions which may be generated through the ecological framework outlined in this thesis.

WHY DO WE NEED AN ECOLOGICAL FOCUS?

INDIVIDUAL THERAPY IS NOT SUFFICIENT TO ADDRESS THE NEEDS OF DISPLACED POPULATIONS

I will now discuss how this thesis is a reaction to some of the dominant paradigms I have been exposed to in my training as a clinical psychologist. I acknowledge that there have been thinkers in the tradition of research into distress and suffering who have discussed the implications of colonisation, race and power in the provision of care, for example Franz Fanon (Bulhan, 2004). However, my personal experience of clinical psychology training in Australia is that these kinds of critiques have not been brought to the foreground. Thus, I have found the dominant theoretical frameworks I was exposed to in this setting insufficient to conceptualise refugee mental health. For example, understanding the intrapsychic factors which influence PTSD symptoms is not sufficient to understand how to discuss

distress with an asylum seeker in Australia, whose political status poses a direct threat to their safety and has direct impact on their symptoms (Steel et al., 2006). Similarly, it could even be harmful to focus a discussion with a Syrian refugee in Jordan, on their personal interpretation of threat cues, when factors at the social level (such as access to employment), or the cultural level (such as attitudes to the sharing of personal beliefs), or the family level (such as family violence), all have a direct impact on distress and safety. What is more, these factors interact with one another, as social and political situations shape ways of thinking and interacting with others, and personal choices, such as choosing to see a psychologist or report protection concerns, can have a direct impact on social status and access to resources (Nasir & Al-Qutob, 2005).

PSYCHOSOCIAL PROGRAMS NEED TO ADDRESS THE FULL RANGE OF CAUSES OF DISTRESS AND SUFFERING

If we seek to intervene to alleviate suffering without a sufficient understanding of the full range of causal factors, we will fail in our efforts to assist individuals and communities to recover from the effects of war and displacement. Doing this may be akin to trying to bail the water out of a leaking boat with a thimble. While it may have an impact, this impact will be dwarfed by the inflow of water from other sources. Whether or not the boat sinks will be determined by the combination of inputs from all sources. If we treat any of these individual factors as deterministic, we will fail to predict or influence the outcome. Rather, we must look at how these factors interact. Syrian psychologists I interviewed in Jordan described the impact of the crisis as a spring of suffering, pouring forth pressures which render their efforts to reduce client distress ineffective (Chapter 7), causing some to give up their work due to burn-out (Chapter 8). That is, the tool of individual focused therapy was not appropriate to the environment in which they worked. If this is the only tool we have to offer, then we have failed to assist psychologists like them, who work so hard to help others in their communities, and the clients they work with, who may enter therapy expecting relief, and their communities, who seek ways to rebuild and recover.

A 'LACK OF FIT' BETWEEN INDIVIDUAL PSYCHOLOGICAL TECHNOLOGIES AND EXPERIENCES IN DISPLACEMENT

The experiences of these psychologists lay bare a serious challenge. A 'lack of fit' (Miller & Rasco, 2004) between our individualistic, western derived psychological tools and psychosocial needs in post-conflict settings. Our review of psychosocial needs among Syrians in Jordan has demonstrated that many of the most often reported causes of distress (e.g., lack of basic needs, rights, employment; loss of role; social isolation; family violence) simply cannot be addressed through an individualistic framework. As a psychiatrist in Lebanon commented on his work with Syrian refugees, "*I see intense, irreversible mistrust and a lack of belief in every principle or rule that is supposed to control our relationships with each other*" (p 1397, Bou Khalil, 2013). As a result, he argues that the category of posttraumatic stress disorder and the tools of psychiatry are inadequate to address the impacts of such a war.

THE NEED FOR AN ECOLOGICAL MODEL OF DISTRESS AND WELLBEING IN DISPLACEMENT SETTINGS

Miller & Rasco (2004) outlined a model for ecological approaches to psychosocial intervention with refugees. They argue that the individualistic focus of western psychology may be incompatible with the lived experience of many refugees. An individualistic focus is often not culturally appropriate and may be at odds with explanatory models. This means that many of the tools designed for intervention in western countries may not be directly applied. Miller and Rasco also argue that interventions should assess, and then respond to issues of importance to the communities they serve. Cultural formulation is imperative at all stages of assessment and treatment including the designing of assessment tools (Bolton & Tang, 2004). Shifting from an individual to a relational perspective is an important step in this process. An ecological approach can help to focus clinicians on the importance of understanding explanatory models of distress and how these relate to the circumstances of displacement. As I

mentioned in Chapter 7, many Syrians perceive the impact of the war and displacement as key causes of mental distress. Thus, interventions which focus on framing distress in terms of the impact of the crisis may help to increase their acceptability.

PRINCIPLES FOR AN ECOLOGICAL APPROACH TO PSYCHOSOCIAL INTERVENTIONS WITH DISPLACED PEOPLE

Using the frameworks provided by Miller and Rasco (2004) and Kelly (1966), I now lay out some principles for engaging with displaced populations to support psychosocial functioning which incorporate the ecological concepts outlined in Chapter 9.

1. The defining characteristic of displaced populations is a change in environment

Not all displaced persons have experienced PTEs, and only a minority of those develop psychological disorders. However, all displaced people have been forced to forego vital resources from their home environments. Therefore, programs should balance the need for trauma focused interventions with interventions which address the consequences of displacement on adaptive systems (Silove, 2013) The concept of *Sadme,* described in Chapter 7 and 9, demonstrates the salience of this issue to people in the Syrian refugee community. While *sadme* includes posttraumatic sequelae, it is also a term which has taken on new meaning in the context of the crisis. It refers to being in a state of shock at what has happened and includes the full experience of conflict and displacement. The sudden change of displacement is a shock. Foregrounding a local concept which acknowledges this link between environmental change and distress may provide space in therapy for people to discuss and address contextual challenges which impact on their wellbeing.

2. **The environment in which a person lives affects their adaptation style (Kelly, 1966). It produces specific roles, skills and relationships. A change in environment requires the development of new adaptive capacities.**

Miller and Rasco argue that interventions should address adaptive difficulties by focusing on environmental stressors, such as ensuring humane treatment, addressing discrimination, promoting family reunion, addressing safety issues, and promoting self-sufficiency. In addition, interventions should support the development of new adaptive knowledge and skills while providing training in how to access resources. Consistent with international consensus (IASC, 2007), this recognises the potential positive psychosocial impacts of programs which may not usually be considered to target mental health. Intervening to promote adaptive capacities is seen as promoting resilience in individuals, families, society and culture.

3. **An ecological perspective recognises the interdependence of individual and environmental factors (Kelly, 1966) by defining mental health concerns as a product of 'a lack of fit' between an individual's adaptive resources and the environment they are in (Miller & Rasco, 2004).**

Such an approach focuses on the relationship between specific behaviours and the environment, rather than pathological processes within the individual. Behaviours which were adaptive in the previous environment may no longer be adaptive in the new environment (Ryan et al., 2008). For example, in Chapter 9 we discussed how Syrian's described how norms of refusal and resistance associated with masculinity may have performed adaptive functions in Syria, where people had access to resources. However, the value of this behaviour changed in the new environment. Interventions should focus on highlighting this discrepancy, while working to build on adaptive strengths which can be brought to bear in the new situation. An example of clinical practice which may aid in this process is narrative therapy, which uses re-authoring of stories to draw out past coping (Carr, 1998), helping the person identify how adaptive skills have functioned previously, in order to consider how they

might operate in the new environment. There is evidence that focusing on personal past strengths can help to ameliorate some cognitive processing deficits associated with PTSD (Brown et al., 2016).

4. **Individuals and communities invest resources in order to modify their environments through Niche construction. This can increase future access to resources through *ecological inheritance*. This inheritance can be lost or diminished in displacement. Interventions should focus on maximising the benefits of remaining ecological inheritance to promote ongoing niche construction.**

The process of displacement effectively removes an individual from their niche. This includes all the resources that they, their family and community, have invested in producing an environment favourable to their flourishing. This could include social status, conferred by familial financial reserves, access to social networks promoting occupational and educational opportunities, social support, family and community reputation supported by culturally determined signs and symbols of valued characteristics. For example, dignity (*Karama*) is perceived as a vital social resource in Syrian culture (Chapter 9). An individual or family's perceived *karama* can determine their place in the social hierarchy. This influences their access to resources. In addition to displacement fracturing access to this resource, human rights violations often intentionally undermine human dignity (Gorman, 2001). Interventions which are designed to restore dignity can help rebuild social capital and provide a link between the old environment and the new. For example, a women's program in Killis in south eastern Turkey, called *Karam,* provides Syrian refugee women with educational and occupational opportunities. Founded by Syrian activist Najlaa Sheekh, it is based on the philosophy that dignity is only possible when resources are gained through work, rather than aid. By linking cultural concepts of dignity with the practical circumstances of displacement, the program creates opportunities for women to use existing skills (e.g. cooking, knitting, design) to attain independence (Needham, 2015; Sheekh, 2015). This niche construction process also modifies the environment, by altering women's positions in relation to family and community.

5. **Adaptive capacities are supported by access to appropriate resources. Access to resources has been disrupted by displacement. Interventions should aim to promote access to resources to enable the development of new adaptive capacities**

The manner in which individuals access resources is affected by their socio-political status, gender, age, race, ethnicity, sexuality, religion and previous histories of adversity (such as abuse, sexual assault, neglect or other PTEs). Although it is necessary to focus on supporting the adaptive behaviours of individuals, interventions must also recognise that the impact of structural inequalities may be beyond the power of individuals to address. Individuals and communities should not be expected to address challenges without the resources or power to do so, especially in situations where doing so may place people at increased risk. A detailed understanding of socio-cultural context is required. For example, Zoabi and colleagues (2011) describe how Palestinian social workers modify their practice when working with families subjected to gender based violence, in order to be sensitive to available resources (e.g. a lack of shelters for people fleeing family violence) and social context (i.e. that leaving situations of violence may result in stigmatisation and social exclusion for women who have no alternative means to access financial resources).

6. **Adaptation is a dynamic, reciprocal process which changes over time. This includes responses to environmental challenges before, during and after displacement.**

International responses to refugee mental health have been criticised for focusing only on the impacts of discrete PTEs experienced during conflict (Summerfield, 2003). However, experiences which challenge adaptive systems can occur at any point in life and may even be more distressing or personally meaningful than those experienced in conflict. Childhood histories of neglect, deprivation, or physical, emotional or sexual abuse, can have profound impacts on development and future adaptive capacities (Cloitre et al., 2009; Herman, 1992). Unfortunately, these kinds of experiences are common in every society (Kessler et al., 2010) and need to be considered in understanding individual adaptive processes. Clearly, the impact of PTEs during conflict and during migration needs to be taken

into account. However, this needs to be balanced with an understanding of how ongoing stressors in displacement impact on distress and wellbeing (Miller & Rasmussen, 2017). That is, a trauma focused lens for all life stages may provide key insights into the intended purpose of key coping behaviours. Finally, this position recognises that an individual's relationship to noxious environments is about more than being the victim of external circumstances. As situations change over time, individuals may display resilience or make positive changes to their environments. For example, the psychosocial workers we interviewed in Jordan, Syrians who had experienced conflict themselves, responded to their situation by working to promote a supportive community in displacement (Chapter 8).

IMPLICATIONS OF AN ECOLOGICAL APPROACH TO PSYCHOSOCIAL INTERVENTION

IMPLICATIONS FOR CLINICAL PRACTICE

An ecological approach can give us pause when approaching therapy with people who have lived through human rights violations. Though there is a long tradition of cultural psychiatry that calls on therapists to discover and respond to the possible cultural meanings of behaviours (Hinton, Rivera, Hofmann, Rivera, Hofmann, Barlow, & Otto, 2012; Kirmayer, 2006; Kleinman, 1998), an ecological approach explicitly asks us to look at the relationship between the individual and the world around them, bringing power relations into focus. An approach that ascribes meaning to culture alone can be at risk of reductionism if care is not taken to understand an individual's relationship to common cultural practices. An ecological approach views attitudes, behaviours and feelings as being in dynamic relationship with the environment, and therefore subject to unique change.

EXISTING THERAPY PARADIGMS

When conducting individual therapy, there may be ways to incorporate ecological considerations to help people make changes in their relationship to the environment while taking into account their social, economic and political situations. A good example of this is Problem Management Plus (PM+),

developed by the WHO to train lay workers to help individuals develop practical problem solving skills (Rahman et al., 2016; WHO, 2016). Another therapy which has shown great promise for survivors of repeated human rights violations and PTEs is narrative exposure therapy (NET) (Neuner et al., 2008; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Onyut et al., 2005). NET involves helping the person construct a coherent life narrative by recounting PTEs, providing exposure to traumatic memories, and also integrating them into a whole life story which focuses on personal meaning. NET showed good efficacy in a refugee camp in Uganda and this may have been supported by the team's long term engagement with the community, including training local staff to administer the therapy. NET has also been shown to be effective in other settings with people who continue to live in situations of threat, such as asylum seekers, and has been adapted for children (Robjant & Fazel, 2010). An innovative team in Ramallah, Palestine have developed an adaptation of narrative therapy which directly addresses the political situation of Palestinian refugees living under occupation. The narrative framework clearly lends itself to discussion of issues of justice and identity and is suited to group work which builds narratives that challenge oppressive social structures. Strategies focus on highlighting skills and coping. For example, a group program with children which resulted in a list of strategies to help families and friends cope with periods of ongoing aerial bombardment. The children recommend that staying connected to one another, and helping one another is a key strategy to coping with this situation (Sehwail, 2005).

MITIGATING POTENTIAL FOR HARM

Theoretical paradigms which inform clinical practice may cause harm by placing the responsibility for deleterious coping strategies and symptoms on the individual without taking into account the impact of rights violations. By exploring the relationship between individuals and their environments, an ecological framework focuses attention on how adaptation is achieved through the use of resources. That is, it highlights how access to resources and structural power inequalities impact on adaptation. Hobfoll's resource based theory of stress and coping challenges psychological theories of stress by

shifting the focus from proximal indicators, like appraisals, to resource based indicators which are mediated by social processes. Appraisals are embedded in the social context, a context which determines access to resources. For example, our systematic review found that many Syrian women reported increases in family conflict and violence in response to the crisis, especially lack of access to work among men (Chapter 6). Our qualitative analysis found that community members described how the crisis impacted on *Karama*, which impacted on family relationships (Chapter 9).

> *"To them it's only weakness and they can't accept being weak…."If I had money, I would be able to sleep at night, I wouldn't beat my sons" 119*

An individual therapy approach which employs theories of anger attacks as failed emotion regulation (Gardner & Moore, 2008) or as simply a result of stable individual traits (Fulwiler, King, & Zhang, 2012) without considering the social conditions which lead to anger, fails to acknowledge the impact of disrupted access to resources in displacement, such as access to employment or basic rights. Such an approach may not be focusing on the causal mechanisms related to uncontrollable anger, limiting the efficacy of therapeutic work. What is more, such an approach may amount to blaming the victim, causing further harm.

INCLUDING ECOLOGICAL ISSUES IN ASSESSMENT AND FORMULATION

It is possible to incorporate ecological principles into individual assessment, and then develop treatment strategies to address issues raised. Sometimes this may mean developing therapy techniques which step outside the individual therapy room. Silove and colleagues are currently developing a treatment manual using the ADAPT concepts in therapy (Silove, 2013). I have also considered how these concepts may be employed in individual therapy to elicit ecological needs and issues. Firstly, it is important to spend time trying to come to an understanding of the person's explanatory models. Questions such as *What do you think are the causes of your problem? What kind of help do you think you need?* may elicit culturally mediated interpretations of distress.

The ADAPT principles may be used as a guide to widen the scope of assessment questions from those commonly covered in an individual CBT assessment, that is, family background, thoughts, feelings, behaviour and functioning. Each of the ADAPT areas could be covered, looking at needs, challenges, coping skills, strengths and appraisals through the lens of appropriateness to the displacement environment. Some example questions may include:

- **Safety** (physical safety, housing security, vulnerability to sexual assault, domestic violence, access to health care) *Do you face challenges to your safety and security? Can you meet your basic needs so that you and your family are safe / healthy / secure?*
- **Bonds and Networks** (connections to family and friends, loss of loved ones, social isolation) *How has displacement affected your connections to people you care about? (explore relationship conflict, relationship strengths and separation/loss)*
- **Justice** (events or situations perceived as unjust, includes human rights violation and discrimination) *Have you experienced situations or events which you believe are unjust? Do you feel angry about this? (IF YES) Is it sometimes difficult to control your anger? How do you cope?*
- **Roles and identities** (work, education, family role, social role) *What did you used to do from day to before the crisis? How has coming here impacted on the meaningful role you play within your family or community? What options are open to you now?*
- **Existential Meaning** (understanding of one's place in the world, meaning of life and events, spiritual meaning) *Has anything caused you to think differently about life and its meaning, or what is important to you? How does your worldview help you to cope?*

Such a comprehensive assessment would hopefully sensitise therapists and clients to ecological factors and the relationship between the individual and the challenges they face in displacement. Therapy can then be designed to address these ecological issues whether through practical problem solving (such as finding employment or ensuring safety from domestic violence) or symbolic actions

(such as rituals to address spiritual issues or actions to address injustice). Looking at how behaviours, beliefs and practices functioned in the old environment, and how they may need to change in the new environment may help to promote effective use of adaptive resources.

WHAT DOES THIS MEAN ABOUT STANDARD INDIVIDUAL THERAPY APPROACHES?

Drawing attention to these ecological factors need not detract from employing established therapeutic techniques, such as CBT, where they are appropriate. Rather, bringing these ecological factors to the foreground may help to ensure that individual therapy techniques are not employed in ways that may pathologize or damage people by failing to take into account their social context. The steps outlined above are not intended as a recipe, but more as a way to help psychologists broaden their focus in a structured way. For many refugees, working with a psychologist may be their first exposure to a biomedical engagement with distress and suffering, a situation which could amplify the power disparity that often exists between therapist and patient. Assessment procedures that attempt to categorise distress in response to war and displacement within the categories defined in a non-conflict, high resource setting may be difficult for people who may be marginalised by displacement to resist. Standard individual therapy techniques may still be helpful for people who are suffering, or they may need to be adapted to cultural and social context. However, this can only be determined if a broader range of ecological factors are taken into account than is typically collected in an individualistic therapy assessment.

APPLICATIONS OF NICHE CONSTRUCTION IN UNDERSTANDING FUNCTIONING IN ECOLOGICAL CONTEXT

Once information about ecological context has been gathered, concepts that can help elucidate mechanisms involved in adaptation are needed to build useful formulations for intervention and support. The concept of niche construction is a useful tool to conceptualise how specific coping behaviours function to promote adaptation. In order to understand how niche construction operates,

we need to examine the social and cultural levels of the environment by exploring the reciprocal relations between individuals and socio-cultural processes. As discussed in Chapter 9, niche construction refers to the process through which we may modify the environments we live in. This, in turn, influences how that environment impacts on us. That is, when we change our environment, we change the way that environment influences us. When we do this, we carve out a niche (i.e. secures access to resources). In biological terms, we promote our evolutionary fitness by changing our environment. For example, the beaver, in building a damn, creates a new ecosystem which promotes its access to food and selects for individual characteristics which promote dam building. The development of human culture, language and social processes can be similarly viewed through this dynamic relationship (Kendal et al., 2011; Laland, 2008; Marewski & Schooler, 2011). That is, when we engage with culture we have an impact in shaping that culture. This, in turn, affects how we can adaptively function within that culture. For example, over time, changes in linguistic practices change a language, which in turn impacts on the cognitive development of future generations. Niche construction provides a useful model for understanding how individuals and groups can modify their environment and culture in an interactive, adaptive process. This view provides a framework to consider both human agency (in shaping the world around us) and how we are constructed by the social and cultural context in which we live. This relational view brings attention to the kinds of contextually specific skills people will learn in a given environment, skills that are often shared among family and peers.

ECOLOGICAL INHERITANCE

When we construct a niche, we then pass this on to our family, peers and community. Cultural norms and practices can be viewed as a form of *ecological inheritance* which confer survival benefits when they are passed on, while enactments within culture shape its ongoing form (Kendal et al., 2011). Thus, niche construction helps us to understand how culture impacts on an individual's access to resources through ecological inheritance. For example, psychosocial workers we interviewed described the

nuanced ways that women adapt themselves to an environment where they may have limited decision making power.

> *"Having the ability to delete themselves or restructure themselves in the way that the community needs them to be"* 127

The ability to construct oneself so that one's values are consistent within the limits of the environment is a form of ecological inheritance that people I interviewed described as something women pass on to their children. Ryan and colleagues (2008) similarly define cultural resources as a 'toolkit' provided by one's culture, which may have varied usefulness in varied environments. For example, forms of masculinity which place value on resisting help and change may have been adaptive in Syria, but for displaced men, the value of these norms may have changed, making it difficult for men to accept the help they may need (Chapter 9). From this perspective, we can see how events which disrupt access to or the contextual value of *ecological inheritance* (i.e. displacement) can seriously undermine adaptive functioning.

NICHE CONSTRUCTION IN FORMULATION

CBT treatments operate through collaborative relationships to help individuals consider how thinking, feeling and behaving impact on their wellbeing (Keijsers, Schaap, & Hoogduin, 2000). Formulation of the mechanisms involved in the cause and maintenance of distress is a cornerstone of treatment. Therapy techniques include re-evaluation of beliefs, consideration of the impact of thinking processes and changing behaviour in order to reduce distress (Kaczkurkin & Foa, 2015). Ecological approaches can be incorporated into formulation to understand the impact of social processes on thoughts, feelings and behaviours at the individual level. Therapists may ask *a) How might the process of seeking to change thinking and behaviour be affected by the ecology of the previous environment? b) How does this impact on the ability to make the changes to thinking and behaviour required to adapt to the new environment?* As an example, I will now consider how behaviours which were adaptive in the old

environment, may be barriers to change in the new one. This example was inspired by multiple conversations engaged in with Syrian psychologists during training sessions regarding thinking styles often described as “unhelpful” or “maladaptive” in CBT therapy. This was a topic I came back to and discussed with Syrian psychologists in the process of our working together which illustrates how an ecological perspective may inform principles from CBT, helping to avoid causing harm. Psychologists discussed how some of the “distorted thinking” strategies, such as black and white thinking, may have been adaptive in Syria (see below). Consequently, some argued that special care needs to be taken when encouraging people to change their thinking strategies, as the therapist may not be able to predict the social or political costs of changing thinking patterns which may serve to keep people safe. That is, common thinking styles may serve different adaptive functions in different environments. The ideas presented here are a hypothesis, a thought experiment with the ideas presented in Chapter 9. Future research may test them empirically.

THE IMPOSSIBILITY OF NARRATING A STORY

There is considerable evidence that social processes under the Syrian regime were affected by a system of state oppression that forced citizens to inform on one another (Van Dam, 2011; Wedeen, 2015; Yassin-Kassab & Al-Shami, 2016). Living in a situation of dictatorship requires adaptive capacities to protect oneself, and one’s loved ones, from real threats to personal safety, social status and opportunity. This could include thinking processes and means of interacting with others, which operate to maintain safety. For example, black and white thinking (the tendency to see things in all or nothing terms) has been identified as a thinking process which contributes to anxiety and depression (Teasdale et al., 2001) in research in high resource settings. However, in a repressive environment, this thinking style may be necessary for survival. Firstly, if the cost of a single mistake is high (i.e. arrest, torture, death) (Yazbek, 2012), then it makes sense to ensure adherence to imposed rules through rigidity. Second, repressive regimes operate to undermine social capital by creating a situation in which no one can be trusted (Wedeen, 2015). The impossibility of narrating a story originates from

the fact that one cannot share one's experiences with one's loved ones because, under torture, no one can be expected to withhold information. Therefore, one's true thoughts cannot be expressed, so opportunities to receive corrective social feedback to modify beliefs along a continuum, into the grey area, are limited. Situations in which one can play with the social rules and consider the gradients of possibilities must necessarily be supressed. Moving into the grey areas may mean moving into dangerous territory, as it opens up the possibility that others will notice.

Let us consider how this may operate in the nested levels of the environment.

Intrapsychic level

Black and white thinking may become a habitual process, a part of self-policing which is used to stay safe. In situations in which unambiguous social feedback is not possible and the actual threat is high, most stimuli must be placed in the category of threat. This process has been commonly identified in anxiety disorders, for example intolerance of uncertainty in generalised anxiety disorder (Dugas & Ladouceur, 2000), or negative interpretations of ambiguous feedback in social anxiety (Abbott & Rapee, 2004). A tendency to place ambiguous stimuli in the category of threat is used as a strategy to prepare for danger. While such a process may be associated with pathological processes, it may serve an adaptive function in a society where saying the wrong thing could put you and your loved ones in serious danger.

Family / Peers

> *"Never tell anyone, anything. Even if you have blood in your mouth, swallow it"*

common saying

Societal level repression exerts pressure on interpersonal relationships by making grey thinking (i.e., not using all-or-nothing thinking), and the free sharing of thought a kind of betrayal. That is, when you think in the grey, you not only put yourself in danger, but everyone you associate with. For example, people who returned from being arrested could tell no-one about their experiences of torture, as

simply knowing what has happened, puts others in danger. A cloud of silence must necessarily remain between people in intimate relationships. Swallowing the blood in your mouth means suppressing your internal feelings, no matter how it hurts. The visceral nature of this metaphor demonstrates how the concealment operates at all levels of communication, including subtle non-verbal signs. Therefore, concealment must be all or nothing.

Society

"You are with us, or you are against us"

common saying

Divide and conquer tactics are a common tool of repressive regimes. The strategy of driving wedges between the diverse religious (Sunni, Shia, Alawite, Catholic, Assyrian, Chaldean etc.) and ethnic (Arab, Kurdish, Armenian, Assyrian etc.) communities in Syria has been well documented from the Ottoman empire, to the French occupation, to the current regime (Van Dam, 2011; Yassin-Kassab & Al-Shami, 2016). This may mean that children learn to speak one language at home (e.g. Assyrian or Kurdish), but only speak Arabic outside the home. Signs of identity must be suppressed in public spaces, in which absolute rules of affiliation must be strictly observed. People are taught to fear the other as inherently threatening, as in-group out-group processes are intensified.

Culture

A delicate dance of obfuscation

If culture is a form of ecological inheritance, then adaptive behaviours in such an environment would be those which promote safety, by effectively obscuring one's true opinions. In order to evade detection within an educated society, these forms of concealment will necessarily become sophisticated. In an environment where surveillance is pervasive (enacted through informing by community members), obfuscating cultural practices will be selected, which in turn will contribute to a cultural discourse which may become more sensitive to these practices, further increasing

sophistication of concealing practices. Miriam Cooke (Cooke, 2007) discussed how artists operating in 1990s Syria, used a sophisticated array of artistic practices to avoid being targeted by a regime whose paradoxical repressive tactics simultaneously called for dissent and subservience. Thus, a delicate dance was required to walk a tight-rope of artistic authenticity and maintaining safety.

IMPLICATIONS OF NICHE CONSTRUCTION FOR RESEARCH

FOCUS ON INCREASING ADAPTIVE RESOURCES TROUGH ACTION RESEARCH

Niche construction may help to guide research which identifies the ecological inheritance of displaced communities and explores how to use these resources in the new environment. Cultural resources may be used to build links with the local community and strengthen refugee community identity. Occupational resources should be assessed so that participatory programs may be designed to take advantage of them. Syria has a high rate of tertiary education and many skilled professionals, a stark example being the Syrian medical staff who continue to provide medical services under threat of arrest, torture and bombardment (Othman, Steel, Lawsin, & Wells, 2018). Although there is a lot of research attention paid to cultural adaptation of therapies and whether intensive trauma focused therapies are effective in refugee populations (Lambert & Alhassoon, 2015), one area that is not being addressed is understanding how effective organisations are at implementing programs to take advantage of community resources. For example, Jordans and colleagues examined multi-layered programs to address psychosocial needs of children in four armed conflict settings (Jordans et al., 2011). They found evidence of moderate symptom reduction, yet local psychosocial staff reported significant distress as a result of working in the program. There is evidence that training local staff is a low cost way to increase access to effective care in low resource settings, but sustainability will be determined by how well these programs are implemented to address the needs of local staff (Othman et al., 2018). A novel approach may be to turn the research questions around. Instead of international organisations assessing the skills of local staff, independent researchers may assess the skills of

organisations in implementing programs in a participatory manner. In this paradigm, the local organisations (psychosocial workers and management staff) would be interviewed to determine what aspects of participatory engagement are effective in developing sustainable programs, and what aspects serve as barriers. The results could be used to develop guidelines to hold international organisations to account.

MULTILEVEL ANALYSES

Niche construction could serve as a guiding principle to design multilevel analyses. These could examine individuals nested in groups within a given context. In addition to measuring symptom improvement, markers of adaptation could be measured. For example, considering some of the Adapt concepts (Silove, 2013) some variables that could be measured might include family cohesion and social capital to understand bonds and networks; markers of social discrimination and the perceived impact of rights abuses to understand justice; opportunities to fulfil role functions or define new ones for roles and identities. Longitudinal analyses could look at how access to various resources impacts on functioning within these systems as well as on individual distress. These could be nested within organisational variables which explore how international organisation and local conflict related factors impact on the functioning of local organisations.

RESEARCH WHICH EXAMINES INTERACTIONS WITH THE ENVIRONMENT IN THE PRESENT CONTEXT

Research into displaced populations needs to examine challenges in relation to the present. For many people in countries of first asylum, it is not possible to plan for the future, as there is no way of knowing where they will be living in the near or distant future. In addition, the concept of PTEs as a product of past experiences may not be applicable for people who live in situations of ongoing threat. In the model we outline in our systematic review, we describe how displacement stressors interact with

distress caused by experience of PTEs and recommend interventions that can address psychosocial outcomes associated with environmental stressors through promoting resource access. As Tay and Silove point out (Tay & Silove, 2017), it is important to note that there is no one-to-one correspondence between PTE exposure and psychological disorder, and there is no sharp delineation between PTEs and displacement stressors, rather they exist on a continuum, and their personal salience is mediated by the meanings we make of these experiences. As Miller and Rasmussen note (Miller & Rasmussen, 2017), it may be the temporal proximity and pervasive nature of stressors in displacement which results in suffering, while past experience may provide a frame through which these are experienced. Tay and Silove contend that events in the present are interpreted with reference to our past experiences, and it is not useful to create a sharp delineation between past, present and future. What is required is a theoretical lens to conceptualise the interactions between temporal and interpersonal dynamics while attending to our place in a social system. Niche construction may provide such a tool, as it describes reciprocal causal pathways. Thus, we are not limited to a model which describes events in the past (e.g. PTEs) being mediated by events in the present (displacement stressors). Rather these are in constant interplay in the form of ongoing human experience. A conceptual shift away from describing traumatic stress reactions as purely related to the past, and instead examining the impact of noxious experiences at any time point on adaptation in the present could offer new avenues for care.

CURRENT THREAT: A CONCEPTUAL SHIFT FROM UNIDIRECTIONAL MODELS

While the category of PTSD is defined in relation to past experience of PTEs, people living in insecure situations of displacement, exposed to ongoing danger, can develop similar symptoms related to anticipation of future threat (Steel et al., 2006). A growing body of literature examining future focused threat demonstrates that the description of traumatic reactions as exclusively related to the past may be a mischaracterisation. Mental simulation of future events relies on many of the same neural mechanisms as simulation of past events (Schacter, Addis, & Buckner, 2008). Reductions in memory

specificity which were considered to be related to memory dysfunction in PTSD have been demonstrated to be impaired in processing of future events. Brown and colleagues showed how a group of veterans with PTSD displayed reduced specificity in describing future events when compared to combat veterans without PTSD (Brown et al., 2013). Williams presents the CARFAX model (Williams, 2006), and argues that reduced specificity in describing episodic events may be a by-product of cognitive avoidance strategies aimed at reducing the frequency of trauma related intrusions. He postulates that top down processes are employed to prevent access to specific details of PTEs, yet considerable cognitive resources are required to supress these specific details. When this process becomes habitual it leads to impairments in executive functioning and concomitant increases in intrusion frequency. Thus, the processes which underlie posttraumatic cognitive impairments appear to influence more than just memory. The CARFAX model may have specific relevance for people living under threat for long periods due to intractable conflict situations, as the likelihood of such processes becoming habitual is increased. While focused at the individual level, this theory may be useful in providing strategies for therapy which take into account the reality of current threat. CBT for PTSD relies on modifying threat appraisals to incorporate information about safety in the present (Ehlers & Clark, 2000). But for people for whom present threat is real, a different approach is needed, one that helps alleviate the debilitating impact of past traumatic experience on the ability to cope with current stress.

CONCLUSIONS

The refugee experience is multi-faceted and cannot be encapsulated in discourses of pathology or victimisation. Rather, individuals face the challenges of displacement with a range of resources for action in response to changing situational demands. This thesis has looked at what kind of assistance the discipline of psychology may be able to provide to support resilience within communities of displaced Syrians in Jordan. Critiques regarding the application of Western psychological constructs in

culturally and linguistically diverse settings have been integrated into mainstream psychological practice, as indicated by the inclusion of a cultural formulation interview in the diagnostic and statistical manual (DSM, 2015). However, understanding how culture impacts on the ways that people access support for distress does not address the broad range of practical challenges refugees face. Rather, we need a conceptual framework to understand how individual, family, social and cultural factors interact and intersect. This may mean finding ways to allow the conceptual frameworks of the communities of concern to guide formulation and action. This is both to help include an individual's own explanatory models in therapy, and to acknowledge that people who experience injustice are best placed to understand how it operates.

In this thesis I have looked at how psychology needs to move beyond cultural formulation to ecological formulation. I have shown how bringing into the foreground concepts defined within the community of interest (*Karama* and *Sadme)* more closely match the lived experience of displaced Syrians, and I have looked at how these concepts are marshalled by people within the displacement environment to achieve personal ends. I have also shown how explanatory models of and attitudes to mental health difficulties can change rapidly in response to changes in ecological systems. I have attempted to highlight the need to include community members as active participants in action to address the psychosocial outcomes of conflict and displacement. This ecological framework acknowledges the need to generate and refine methodologies which can measure outcomes at the community level, can measure transactional variables and may help make psychology relevant to the lived experience of Syrian refugees.

APPENDICES

APPENDIX 1

SUPPLEMENTARY MATERIAL TO CHAPTER 6[6]

[6] Supplementary material to Wells, R., Steel, Z., Abo-Hilal, M., Hassan, A. H., & Lawsin, C. (2016). Psychosocial concerns reported by Syrian refugees living in Jordan: systematic review of unpublished needs assessments. *British Journal of Psychiatry, 209*(2), 99-106. doi:10.1192/bjp.bp.115.165084

METHODS

Table S1. Systematic Search Criteria February 2011 – May 2014

Academic Databases	Subject Headings (keywords)
Psychinfo	*Refugees* AND *Psychological Needs* OR *Needs Assessment* (*Syria**) *Refugees* (*Syria**)
Medline	*Refugees* AND *Needs Assessment* AND *Syria* *Refugees* (*Syria**)
SCOPUS	*Syria** AND *Refugees* AND *Needs Assessment* OR N*eed Assess** (*Syria, refugee**) *Syria** AND *Refugees* - limited to subject areas: medicine; sociology; arts; multidisplinary; psychology (*Syria, refugee**)
PILOTS	*Refugee** AND *Syria*
Science direct	Limited to subject areas: Arts and Humanities, Medicine and Dentistry, Nursing and Health Professions, Psychology, Social Sciences (*Refugee** AND *Syria** AND *needs* W/10 *assess**)
PROQUEST	*civil war -- Syria* OR *Syrians* OR *Syria* OR *Syria* AND *Needs Assessment Methodology* OR *Community Needs Assessment* OR *Comprehensive Needs Assessment* OR *Needs Assessments* OR *Needs Assessment* AND *Refugees*

Grey Literature Databases	Keywords
New York Academy of Medicine Grey Literature	*Syria** AND *Refugee**
Open Grey	*Syria** AND *Refugee**
Open Grey	*Syria** AND *Needs*
National Repository of Grey Literature	*Syria** AND *Refugee**

Websites	Search Terms
The Inter-agency Information Sharing Portal for the Syria Regional Refugee Response (http://data.unhcr.org/syrianrefugees/country.php?id=107)	*Jordan* AND *Reports AND English*
Google; World Health Organisation (who.int); IRC (www.rescue.org); REACH (www.reach-initiative.org); UNICEF (www.unicef.org.au); Handicap international (www.handicap-international.org); IMC (www.internationalmedicalcorps.org); EMPHNET (www.emphnet.net); Global communities (www.globalcommunities.org); Un Ponte Per (www.unponteper.it); CARE (ww.care.org); ALNAP (www.alnap.org); Reliefweb (www.reliefweb.org); MHPSS (www.mhpss.net); Refworld (refworld.org); International Federation of Red Cross and Red Crescent Societies (www.ifrc.org); International Organisation for Migration (www.iom.int); Save the Children (www.savethechildren.org); Centre for the Victims of Torture (www.cvt.org); War Child (www.warchild.org)	All sites searched on Google, using the terms *Syria** AND *Refugee** AND *Needs assessment* AND *Jordan,* limited to the given website and to results between the dates 01/02/2011 and 01/06/2015

Note: Subject headings and key words used in systematic search are presented for each database and website searched.

Table S2. Checklist of Qualitative Methodologies with Criteria used to Rate Rigour.

Checklist Item	Quality Criteria Low = 0	Medium = 1	High = 2
Credibility			
Does the report include member checking or participant validation	Not described / employed	Data is discussed with participants or community members and findings revised	Community members are involved in the analysis procedure in ongoing consultative process
Does the report privilege the knowledge and expertise of Syrian refugees? Provide exemplars, first person accounts?	Provides aggregated data within confines of externally derived categories.	Discusses views raised by respondents, does not provide first person exemplars.	Minimally thick description which discuss views of respondents as knowledge relevant to the research question, provision of first person exemplars
Involves refugees as actors in process (data collection, analysis, consultation)?	Not employed/ described	Participatory process mentioned but not described or use of practices which employ knowledge of community members, such as consultation, but which do not afford design, analytic or decision making power	Involvement of community members in a key stage of the study (e.g. design, data collection, analysis, writing of the report) in a manner which affords decision making power.
Transferability			
Is there a clear account of sampling procedure?	Not described / employed	Only convenience sampling	Combination of sampling (convenience, snow ball, random) or use of random sampling with a large sample size
Does purposive sampling lead to a sample relevant to the needs of the study?	Not described / employed	Awareness of the need to access specific groups with minimal steps taken to improve representation	Specific strategies employed to ensure specific groups are represented, e.g. female heads of household, the elderly.
Evidence of adequate or thick description?	Very limited description of results or only quantitative details	General discussion of themes	Detailed description of themes which are related needs of specific groups and linked to originating context
Is presented data clearly contextualised with all relevant info about subjects and settings?	No or very limited demographic information	Some demographic and information about setting	Demographic and setting information clearly identifies population and context and identifies relevant sub-groups of the community

Confirmability			
Have researchers have adapted the design to the specific context, have they been flexible to context specific needs during data collection?	Not described / employed	Limited discussion of need to adapt tools or consider interviewer characteristics	Adaptation of questionnaires to context or use of data/consultation to guide further investigation, attention to effect of characteristics of interviewers (e.g. gender) on sampling and how questions may be answered.
Is sensitivity of tools to research question, limitations of tools discussed? Is openness to perspectives of participants clear? Is there free listing of needs?	Copies of tools not provided and not discussed in text	Description of tool includes some discussion of how their use may impact on results or tool provided and not discussed	Tools are provided in report or tools validated in the humanitarian or cultural context (e.g. use of WHO tool kit resources) or free listing of needs is employed along with discussion of possible limitations of tools.
Have researchers discussed their relationships to participants, possible effect on outcomes, researchers input, role and possible bias?	Not described / employed	Mentioned in text, but no evidence of use of specific reflexive techniques.	Issues discussed and techniques to address bias are employed such as, member checking, supervision or independent rating
Dependability			
Is there a clear connection to an existing body of knowledge relevant to specific research questions?	Very minimal review of previous literature or assessment	Review about general context for refugees in Jordan.	Review of literature about specific topics linked to current research questions
Are there clear accounts of data collection processes ?	Not described / employed	Sampling procedure is described, collection procedures are minimally described.	Sampling method is justified in relation to aims of study, description of data collection and analysis is sufficient for replication
Training provided or trained staff employed?	Not described / employed	At least one day of training provided or staff described as having some experience	Multiple days of training provided and/or specialist staff employed

Supervision or peer debriefing?	Not described / employed	Some mention of avenues for staff to obtain on job skills development or peer support	Organisational framework which 1) encourages on going skills sharing from more experienced staff (such as research groups contain staff with mixed levels of experience) and/or 2) provides regular opportunities for peer support
Reference is made to accepted procedures for analysis? (e.g. thematic coding, independent raters)	Not described / employed	Reference made to analysis, but techniques not labelled or described	Analysis techniques are appropriately labelled or described in order to enable replication.
How are different knowledge sources dealt with (e.g. triangulation and contrasting)?	Not described / employed	More than one data source employed	Multiple sources employed and information compared between sources
Ethics			
Ethics statement? (e.g. informed consent, expectation of reward)	Not described / employed	Mention of informed consent or ethical guidelines	Ethical considerations discussed, informed consent and/or expectation of reward procedures described

Note: Checklist items, including criteria outlined by Popay and colleagues [3] and Blaxter [4] are presented in rows within the four qualitative methodology domains and ethics. For each checklist item, criteria used to score reports as low, medium or high are presented in columns.

The systematic search was conducted in two waves. The first search was conducted in May 2014 and inluded the sites listed in table S1 (excluding additional sites described in wave 2), between February 2011 and May 2014. In June 2015 a second search was conducted to update the data and to search additional websites. All of the websites listed in table S1 were searched again between the dates June 2014 – June 2015. In addition, the following sites were searched between February 2011 and June 2015: International Federation of Red Cross and Red Crescent Societies (www.ifrc.org); International Organisation for Migration (www.iom.int); Save the Children (www.savethechildren.org); Centre for the Victims of Torture (www.cvt.org); War Child (www.warchild.org). All additional sites searched on Google, using the terms Syria* AND Refugee* AND Needs assessment AND Jordan, limited to the given website and to results between the dates 01/02/2011 and 01/06/2015.

QUALITATIVE ANALYSIS

Theme coding was conducted as described in the main paper. The data from the second search was coded into emerging themes in the same manner as the first search. Where emergent themes were the same between papers, they were combined into single themes. Where themes differed between analyses, data from the alternate search was examined to determine whether this theme could also be discerned. In cases where the data supported it, themes were merged. Themes which were mentioned in less than 6 studies and only 1 search were excluded. Themes which only emerged in one analysis, but were strong themes within this search (i.e. mentioned in more than 6 studies) were included. The themes which were included and excluded based on these criteria are included below as well as an examination of differences in emergent themes between searches.

RESULTS

Demographic information and study characteristics for the 29 studies that met inclusion criteria are presented in table S3. Papers 1-18 were identified in search 1, while papers 19-29 were identified in search 2.

Table S3. Study Characteristics

Study	Needs Type	Location	Dates	Age	Sample size	Sampling	Interview Format	% Male	% Female Headed	Years of Education (%)	Region of Origin (%)
1	General	Irbid & Ramtha	May - July 2012	>18	426	Conv	I, FGD		11%	9% I; 61% P; 30% S	63 Deraa, 28 Homs
2	MHPSS	Za'atari	2-7 August 2012		91	Snow, Conv	KI, FGD	≈50%			85 Deraa; 12 Homs; 3 Damascus (camp statistics)
3	General	Irbid, Madaba, Mufraq, Zarqa	13 Jan - 28 Feb 2013	50% <18; 4% >60	240	Rand, Snow	I, FGD	49%	18%	11% I; 54% P; 26% S; 8% U	12 Deraa; 56 Homs; 19 Damascus; 2 Hama
4	General	Amman, Mafraq, Ramtha, Irbid, Zarqa, Ma'an, Karak	Nov 2012	-	500		KI, FGD				
5	MHPSS	Ramtha, Mafraq, Irbid	7-29 Jan 2012	*M*=37	342	Snow, Conv	I, FGD	72%		I 29%; P 46%; S 20%; U 3%	Homs >Deraa > Damascus > Aleppo
6	General	Amman	Oct 2013		117	Snow, Conv	I, FGD	50% (less for FGDs)	10%		5 Deraa; Homs 85; 8 Damascus; 2 Hama
7	Reproductive health,	Za'atari, Irbid & mafraq.	17-22 March 2013	15-49	159		FGD				
8	General	Karak, Ma'an, Mafraq & Tafileh	Jan 2013	*M*=37 (29% <18)	213		I, FGD	64%		5% I; 21% U	19 Deraa; 47 Homs; 17 Damascus; 8 Aleppo

9	Education	Za'atari	12-17 March 2013		1675	Rand	I, FGD				
10	General	Mafraq & Ramtha	Sep 2012		141	Rand	I, FGD				
11	General	EJC camp	Oct - Nov 2013	Youth - elderly	149		KI, FGD	50%			
12	General	Aqaba, Ma'an, Karak, Tafileh	Mar 2013	Children - Adult	225	Conv	KI, FGD				Deraa; Homs; Homs & Idlib
13	Education	Mafraq, Amman, Irbid & Ramtha	Jan 2013		888		I			> Jordanains included in study	
14	Children	Irbid	Mar 2013		60			"ensured equal participation"			
15	MHPSS Adolescents	Za'atari	2-11 June 2013	Parents *M=40.8;* Youth *M*= 14	255	Rand, Conv	I, FGD	46% adolescents; 27% parents	32%		
16	Special needs	Irbid & Amman	Oct 2013		1287	Rand, Snow	I				
17	General, Women	Za'atari, Amman	Dec 2013		36	Conv, Snow					
18	General	Amman, Zarqa, Mufraq & Irbid	13 Jan - 5 March 2014	53% <18; 4% >60	384		I, FGD	46% of family members	25%	11% I; 35% P; 41% S; 13% U (U 50% female)	23 Deraa; 48 Homs; 14 Damascus
19	MHPSS	Za'atari, Amman, Irbid, Mafraq, Ramtha	Jun-Jul 2013	18-80. *M=42*	1811	Rand, Conv	I	49%		47% I or P	60 Deraa, 18 Damascus, 8 Homs, 4 Rif Damascus, 5 Other

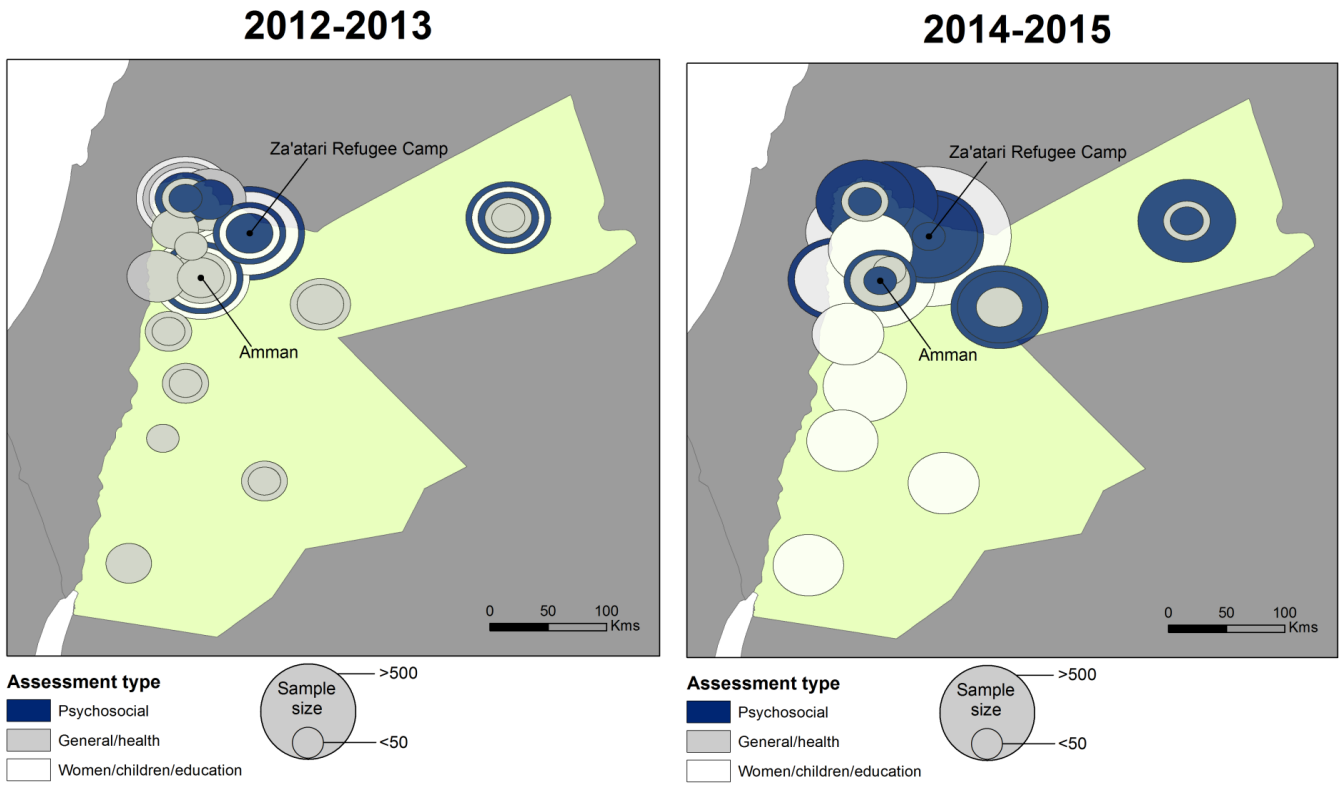
20	Health	Irbid, Ajloun, Jarash, Mafraq, Zarqa, Madaba, Ma'an, Balqa, Amman	Dec 2013	16-76+	FGD 6 - 10 (600 from 30 clusters	Rand, Snow	I, FGD	46%		20% I; 37% P; 35% S; 4% U	47 Deraa, 21 Homs; 20 Damascus; 7 Hama; 3 Aleppo
21	Adolescent MHPSS	Mafraq, Hartha	Jan - Jun 2014	12-19	40	Conv	FGD	50%		50% enrolled in school	
22	Women, MHPSS	Camp and Host community	Feb-Apr 2014	17-85	48	Conv	I	0%	100%		
23	Health	Ruseifah, Zarqa			104		FGD	31%			
24	MHPSS, children	Amman, Zaatari		Children - Adult	80	Conv	I, FGD	53%			
25	Women's MHPSS		may-Jul 2014		198 (region)	Conv	FGD, I	0%			
26	Education	Amman, Al Balqa, Zarqa, Madaba, Irbid, Al Mafraq, Jerash, Ajloun, Karak, Tafiela, Ma'an, Aqaba	May - Jun 2014	Children	6878	Rand	I, FGD		19%	50% P	
27	Education	Za'atari	May - Jul 2014	Children	1958	Rand, Conv	I, FGD	50%			
28	MHPSS	Za'atari, Zarqa, Balqa Amman Jordan Valley	Feb-Apr 2014	Youth - elderly	1975	Conv, Snow	I, FGD		18%		
29	MHPSS, Youth	Irbid, Mafraq, Ramtha, Zarqa, Za'atari	may-Jul 2014	12-17	2028	Conv	I, FGD	approx 50%	35%	75% attending school	Dara'a 61; Homs 19, 11 Damascus

Note:

Demographic and sampling characteristics of each study are listed.

Sampling - Conv = convenience sampling; Snow = snowball sampling; Rand = random sampling
Interviews - I = individual interviews; FGD = focus group discussions;
FHH = female headed household
Household size - *M* = mean
Years of Education – I = illiterate; P = primary school; S = secondary school; U = university

Figure S1. Sample Sizes of Psychosocial Needs, General or Health Needs or Specific Sup-populations Needs in Study Locations.



The sample sizes in various locations are represented by the size of circles, with larger circles indicating larger sample sizes. Shading represents the focus of studies. A minority of studies focused purely on psychosocial issues. There were more studies focusing on general or health needs in the years 2012-2013 while there were more studies focusing on specific issues, such as women's needs, in the years 2014-2015.

SEARCH 1 (FEBRUARY 2011 – MAY 2014)

The systematic search returned 905 articles from which 217 duplicates were removed and 481 were excluded based on title. The full texts for 210 articles were retrieved and the following were excluded due to: Not in English (2); Not a needs assessment (146); Not a full report (5); Not among Syrian refugees (1); Not in Jordan (7). The remaining 54 articles were text searched for key terms and a further 31 were excluded as they did not report on psychosocial needs. This left 18 articles satisfying the criteria for inclusion in the analysis. Studies reported results from a total sample of 7818 refugees in 12 regions in Jordan, including those in refugee camps or residents in host communities, between May 2012 and March 2014. Respondents ranged in age from below 18 years to above 60 years and originated from six regions in Syria, most predominantly Deraa, Homs and Damascus. Psychosocial needs were the primary focus of 17% of the reports. The remainder of needs assessments were intended to determine current general needs (67%) including basic needs (e.g. housing, food), educational (11%), reproductive health (5%).

SEARCH 2 (JUNE 2014– JUNE 2015)

The systematic search returned 1352 articles from which 219 duplicates were removed and 1015 were excluded based on title. As many grey literature reports were not indexed, enabling easy identification of duplicates, many title excluded on the basis of title may have in fact been duplicates. The full texts for 57 articles were retrieved and the following were excluded due to: Not a needs assessment (36); Not among Syrian refugees (3). The remaining 18 articles were text searched for key terms and a further 7 were excluded as they did not report on psychosocial needs. This left 11 articles satisfying the criteria for inclusion in the analysis. Studies reported results from a total sample of 7902 refugees in 13 regions in Jordan, including those in refugee camps or residents in host communities, between June 2013 and July 2014. Respondents ranged in age from below 18 years to above 60 years and originated from six regions in Syria, most predominantly Deraa, Homs and Damascus. Psychosocial needs were the primary focus of 18% of the reports. The remainder of needs assessments were intended to determine health (18%), educational (18%), women's (18%) and children's and youth's (27%) needs.

QUALITATIVE ANALYSIS

NEW THEMES INCLUDED IN RESULTS

Search 2 identified the theme *discrimination* in 8 studies (73%). Refugees reported that discrimination affected their ability to access health care, education, nutritional food and caused many to avoid venturing into the host community. Data from search 1 was examined revealing similar reports in 4 (22%) of studies. See table S4 for references to papers within each search. One explanation for increased reporting of discrimination may be that as the crisis has continued over multiple years, the good will of host community members may have been somewhat exhausted. In addition, as the number of refugees living in host communities has steadily increased, pressure on housing and employment in the host community has increased, causing greater tension between refugees and the host community. The theme *worried or stressed by circumstances* was reported in 4 studies (36%) in search 2. Examination of search 1 data revealed this theme in 6 (33%) of studies. This more general theme appeared to more accurately characterise the manner in which refugees discussed the impact of conflict and displacement on their emotional wellbeing than the more specific excluded themes discussed below. The theme *Anger* was identified in 6 studies (55%) and was subsequently identified in 4 studies (36%) from search 1. It may be that feelings of anger have increased over time as initial hopes of returning home have been dashed and ongoing frustrations of displacement stressors has led people to feel hopelessness about being able to effect practical outcomes, leading many to have difficulty controlling their tempers.

REMOVED THEMES

Children are affected by violence and *Fear of separation* were two themes which did not emerge in the second search and were discussed in less than 6 of search 1 reports. It may be that, as the crisis continues, many refugees have spent so long in displacement, that everyday stressors are discussed more readily than the effect of violent experiences during conflict [1]. Fear of separation (see table S2) may be a common reaction to PTEs, from which the majority of individuals spontaneously recover [2].

Increasing family conflict was also was also reported in less than 6 search 1 studies, and none of search 2 studies. It appears that the phenomenon of anger leading to increased family conflict is captured within the theme of *stress leads to family violence*, discussed in the main paper.

INCLUDED THEMES ONLY EMERGING IN SEARCH 1

The theme of *Violence in the refugee community* emerged in 8 search 1 studies (44%), but not in search 2. This theme was included in the overall analysis as it as clearly a prominent theme in search 1. The difference between searches may have been due to methodology, as many search 2 studies had a specific focus, whereas more search 1 studies were about general needs. This theme emerged in focus group discussion a number of general needs studies in search 1. In addition, the increased perception of discrimination from the host community may have overshadowed these concerns in search 2 studies.

Table S4. Themes Included or Excluded from Main Analysis

Theme		Exemplar	Search 1	Search 2
Themes identified in search 2 and subsequently identified in search 1 data				
Environmental Stressors	Discrimination	*"Many focus group respondents perceived this poor treatment by healthcare staff as prejudice against Syrian refugees and spent a good deal of time discussing the discrimination they felt played an important and highly detrimental role in their healthcare experiences in Jordan"* **20** *"They alleged one community member was denied child delivery assistance and out of desperation travelled to Amman to give birth"* **28**	**3, 6, 10, 13**	**19,20,21,22,23,26, 28,29**
Symptoms of Distress	Worried or stressed by circumstances	Worry and concern over the situation and relatives in Syria was the most commonly expressed problem by the respondents representing 29.5% (39 responses) **19** "Most FGD participants summarised the consequence of displacement as making them feel constantly anxious and stressed" **28**	**2, 5. 6, 8, 12, 16**	**19, 21, 28, 29**
	Anger	*"I'm depressed; I'm short-tempered—I never was before. But here…I beat my daughters—this one I beat every two to three days; this other all the time. I don't want to; I just—I'm angry all the time*."—Nour, 38, Jordan"**25**	**2, 5, 11, 12**	**19, 21, 23,24, 25, 28**
Removed Themes				
Symptoms of Distress	Children are affected by violence	"*We've seen the army torture the family in front of the kids, …we can't sleep or concentrate because we're angry and mad since this is all for no reason*...Focus group of fathers of adolescent Syrians in Za'atari" **14**, pg 19	**3, 5, 9, 12, 14,**	
	Fear of separation	"*Deep inside of me I know that me and my children are safe, but I can't help myself to feel very anxious if one of my children returns back late to the caravan*." Female adult" **16**, pg 10	**2, 5, 14, 16**	
Violence in the refugee community	Increasing family confict	""*I cannot control my outbursts of anger, my husband and I quarrel all the time and he is threatening to divorce me*"-Pregnant mother with one baby residing in the camp with her husband" **3**, Pg 8	**3, 4, 16, 18**	
Included Theme only emerging in Search 1				
Violence in the refugee community	Youth aggressive behaviours in camps	"*the teens are now disrespectful, defiant, and rudely talking like I'm a sibling, not parent. This is no way to raise a kid in a camp. They don't respect or listen to us anymore- only listen if we beat them.*" – Focus group of fathers of adolescent Syrians in Za'atari." **14**, pg 19	**3, 9, 10, 11, 14, 16, 18, 17**	

Note: Themes which emerged during the second wave of searching and were apparent in the first wave upon inspection were included in the overall analysis. Themes which emerged in only one wave of search and had less than 6 instances were excluded, themes with more than 6 instances in one wave were included.

APPENDIX 2

SUPPLEMENTARY MATERIAL TO CHAPTER 8[7]

[7] Supplementary material to Wells, R., M., A., Hasan, M., Said Youssef, R., Steel, Z., Hunt, C., . . . Lawsin, C. (2018). Community Readiness: A Rapid Ecological Assessment Tool to Build Psychosocial Service Capacity in the Syrian Refugee Community in Jordan. *Submitted to American Journal of Orthopsychiatry*.

Supplementary Table S1. Stages of Community Readiness with Suggested Intervention Strategies for Each Stage

9. High Level of Community Ownership	Detailed and sophisticated knowledge exists about Mental Health prevalence, causes, and consequences.	Promote momentum and growth: sophisticated data analysis and media tracking; diversify funding; Apply skills to other issues.

Stage	Characteristics	Intervention
1. No Awareness	Mental Health is not generally recognized by the community or the leaders as a problem (if it truly is an issue as indicated by standard measures).	Raise awareness about mental health: One-on-one or small group activities
2. Denial / Resistance	At least some community members recognize that Mental Health is a concern, but there is little recognition that it might be occurring locally.	Raise awareness that mental health concerns exist in the local community: Media reports; presentations; community groups.
3. Vague Awareness	Most feel that there may be a local concern, but there is no immediate motivation or willingness to do anything about it.	Raise awareness that the community can do something to change the issue: Attend existing groups; garner support; present local data.
4. Preplanning	There is clear recognition that something must be done and there may even be a group addressing it. However, efforts are not yet focused or detailed.	Raise awareness about concrete plans to tackle mental health concerns: Collect data on existing programs; invest community leaders in planning; identify local resources.
5. Preparation	Active leaders begin planning in earnest. The community offers modest interest in efforts.	Gather information to plan strategies: Local data on mental health and community attitudes; develop practical plans for funding applications.
6. Initiation	Enough information has been gathered to justify initiation of efforts. Activities are underway.	Provide community-specific information: Train professionals; identify funding sources; publicise relevant intervention programs.
7. Stabilization	Activities are supported by administrators or community decision makers. Staff are trained and experienced. The efforts are stable.	Stabilise effective programs: Evaluate existing programs; modify and improve programs; provide training.
8. Confirmation/ Expansion	Efforts are established. Community members feel comfortable using services and are supportive. Efforts may expand to related issues. Local data are regularly obtained.	Expand services: external evaluation of programs; present evaluation data to the public, suggesting improvements.

In-depth evaluation guides new directions. Model is applied to other issues.

Adapted from Plested, B. A., Jumper-thurman, P., & Edwards, R. W. (2009). *Community Readiness: Advancing HIV/AIDS prevention in Native communities. (Community Readiness Model Manual, Revised Edition).* (p. 65). Fort Cillons, CO; & Jumper Thurman, P., Barbara, A., & Ruth, W. (2003). Community readiness : The journey to community healing. *Psychoactive Drugs*, *35*(1),

Supplementary Table S2. Example CRM Questions

Community efforts to address the problem & Community knowledge of efforts	
	What services or efforts are available in the Syrian refugee community to address mental health problems? What are the strengths of these services? Please explain what the community knows of these services, such as what they provide, how to access.
Leadership	
	Who are the "leaders" specific to mental health in the Syrian refugee community? How do the leaders in the Syrian refugee community support current mental health services? Please explain.
Community climate	
	What is the Syrian refugee community's attitude to mental health services? What are the primary barriers to accessing services in the Syrian refugee community?
Community knowledge about the issue	
	What type of information is available in the Syrian refugee community regarding mental health? Is local data on mental health available in the Syrian refugee community? If so, from where?
Resources related to the issue	
	To whom would an individual affected by mental health problems turn to first for help in the Syrian refugee community? Why?
	What is the community's attitude about supporting mental health services, with people volunteering time, making financial donations, and/or providing space?

Supplementary Table S3. Dimensions of the CRM with Anchored Statements for Each Stage

	1.No Awareness	2. Denial/ Resistance	3. Vague Awareness	4. Preplanning	5. Preparation	6. Initiation
A. Community Efforts To what extent are there efforts or services that address mental health in the refugee community?	No awareness of the need for efforts to address mental health in any capacity	No efforts addressing prevention or early detection of mental health concerns	A few recognize the need to initiate some type of effort, but no immediate motivation	Some have met and begun a discussion of developing community efforts	Efforts (programs/activities) are being planned	Efforts (programs/activities) have been implemented
B. Community Knowledge of Efforts To what extent do community members know about treatments available and how effective they are? Who can access the services?	Community has no knowledge of the need for efforts addressing mental health	Community has no knowledge about efforts addressing mental health	A few have heard about efforts, but the extent of their knowledge is limited	Some members of the community know about local efforts	Members of the community have basic knowledge about local efforts (e.g., purpose).	An increasing number have knowledge of local efforts and are trying to increase community knowledge of efforts
C. Leadership To what extent do community leaders and influential people support efforts to address mental health concerns and community use of the services?	Leadership has no recognition of mental health concerns or leadership absent	Leadership believes that mental health is not a concern in their community	Leader(s) recognize(s) the need to do something regarding mental health	Leader(s) is/are trying to get something started	Leaders are part of a committee or group that addresses mental health	Leaders are active and supportive of the implementation of efforts
D. Community Climate What are the prevailing attitudes of the community toward mental health concerns and use of mental health services?	mental health is not considered, unnoticed or overlooked within the community. “It’s just not our concern”	“There’s nothing we can do,” or “Only ‘those’ people do that,” or “Only 'those people' have that	Neutral, disinterested, or belief that mental health does not affect the community	Beginning to reflect interest in mental health. “We have to - do something, but we don’t know what to do.”	“We are concerned about this,”; beginning to reflect modest support for efforts	“This is our responsibility”; beginning to reflect - modest involvement in efforts
E. Community Knowledge About the Issue To what extent do community members know about and/or have access to information on mental health concerns and services?	Mental health is not viewed as an issue that we need to know about	No knowledge about mental health	A few have basic knowledge of mental health, and recognize that some people may be affected	A few have basic knowledge of mental health, and recognize that some people locally may be affected by the issue.	Some have basic knowledge and recognize that mental health occurs locally, but information and/or access to information is lacking	Some have basic knowledge of mental health concerns, including means of prevention, and options for treatment. General information is available

F. Resources Related to the Issue To what extent are local resources – people, time, money, space, etc. – available to support mental health services?	There is no awareness of the need for resources to deal with mental health concerns	There are no resources available for dealing with mental health concerns	Not sure what it would take, (or where the resources would come from), to initiate efforts	Individuals, organizations, and/or space available that could be used as resources	Some members of the community are looking into the available resources	Resources have been obtained and/or allocated for mental health

Adapted from (Plested et al., 2009) (Plested, Jumper-thurman, & Edwards, 2009).

Supplementary Material S4. Example of Anchored Rating Scale to Asses Competence in CBT Skills

Scoring System outline

1	Does not employ skill
2	Employs skills but does not indicate understanding of theoretical basis, or how it relates to client's needs OR indicates understanding of rationale, but does not successfully employ skill.
3	Employs skill and indicates basic theoretical understanding
4	Employs skill and demonstrates sound understanding of theoretical basis and ensures client understands skill rationale and content
5	Employs skill to a high standard, is capable of adapting to the needs of the client due to flexible application of theoretical concepts, ensures client understands skill rationale and content and works to engage client's motivation and hope in using the skill

Cognitive Model

Can explain the thoughts, feelings and behaviours and how they interact to influence emotional experience

1	Does not label the thoughts, feelings and behaviours
2	Describes the thoughts, feelings and behaviours but not how they interact to influence emotional experience
3	Identifies thoughts, feelings and behaviours and explains how thoughts lead to feelings and behaviour, which, in turn, influence thoughts.
4	Identifies thoughts, feelings and behaviours and explains how thoughts lead to feelings and behaviour, which, in turn, influence thought **AND** provides a clear, simple example
5	Identifies thoughts, feelings and behaviours and explains how thoughts lead to feelings and behaviour, which, in turn, influence thought **AND** provides a clear, simple example **AND** links to client's experience in conversational style

Explains how intervening in each of the different channels can help regulate emotion in different ways

1	Does not link the channels to intervention
2	Mentions that intervening in one of the thoughts, feelings and behaviours will influence emotion, but does not link to theoretical framework
3	Describes how intervening in one of the channels (e.g. through focused breathing) will influence responding in other channels which in turn influences emotional experience
4	Describes how intervening in one of the channels (e.g. through focused breathing) will influence responding in other channels which in turn influences emotional experience **AND** provides clear concrete example

5	Describes how intervening in one of the channels (e.g. through focused breathing) will influence responding in other channels which in turn influences emotional experience **AND** provides clear concrete examples, asks client to generate examples in collaborative way

Works through an example from the client's experience, collaborating to explicate the concepts

1	Does not help client generate own example
2	Encourages client to generate example, but does not clearly link aspects of the example to the theoretical concepts
3	Works through example from the client's experience, demonstrates how to break the experience into the thoughts, feelings and behaviours
4	Works through example from the client's experience, encourages client to break the experience into the thoughts, feelings and behaviours
5	Works through example from the client's experience, encourages client to break the experience into the thoughts, feelings and behaviours **AND** encourages client to explore the emotional impact of each of the thoughts, feelings and behaviours

Supports client self-efficacy in implementing technique and helps client develop sense of mastery

1	Does not encourage client to generate own material
2	Encourages client to develop own material, but does no praise
3	Encourages client to develop own material and praises efforts
4	Encourages client to develop own material, praises efforts **AND** encourages client to reflect on mastery
5	Encourages client to develop own material, praises efforts **AND** encourages client to reflect on mastery **AND** supports client to flexibly adapt skill

Communicates need for regular practice

1	Does not discuss need for practice
2	Mentions need to practice but does not provide rationale
3	Discusses the importance of practice, provides rationale, encourages client to consider implementation
4	Discusses the importance of practice, provides rationale, helps client to make concrete practice plan
5	Discusses the importance of practice, provides rationale, helps client to make concrete practice plan **AND** is responsive to contextual issues affecting implementation

Supplementary Material S6. Syrian Colloquial Emotion Identification Wheel and Distraction Activities

Difficulty communicating distress is a major barrier to care for refugees[1]. Health care practitioners need to take the time to understand their clients' difficulties through the lens of that client's explanatory models of distress[2]. We drew on the STAIR model[3], which uses the emotion wheel to help clients differentiate emotional states to improve emotion regulation, and help build a shared understanding in the therapeutic relationship.
We employed the clinical and cultural knowledge of Syrian and Jordanian psychologists working with Syrian refugees in Jordan to develop a list of idioms common in Syrian colloquial Arabic, within six domains of emotional experience. This allowed us to develop a clinical assessment tool designed to promote cultural formulation of emotional distress.

Methods

Participants worked in groups to develop lists of idioms commonly used to express emotions by members of the Syrian refugee community, within each of 6 domains. The lists were presented to the group, who made suggestions. The lists were translated into English and reviewed by 3 independent Syrian psychologists. Final lists were placed in a wheel format to enable clients to easily point to expressions that describe their feelings. In addition, participants identified distraction activities to be used in the context of emotion regulation which would be culturally appropriate and accessible.

Results

Workshop participants reported that the tool would be useful for assessment, psychoeducation and building a shared vocabulary. Psychological disorders have traditionally been stigmatized in Syrian culture, and community members may not be accustomed to talking to professionals about emotions. Men in particular may face pressure not to discuss feelings. As a result, clinical conversations about emotional experience may be difficult to initiate. Participants indicated that the tool would help to normalize distress and open discussions in which clients could indicate a range of emotions in terms familiar to them.

Conclusions

Developing a shared understanding of distress is a necessary step for effective therapeutic work. Many health practitioners avoid comprehensive cultural formulation as they are unsure how to generate such a discussion[2]. The tool may help clients put difficult feelings into words, in terms they can identify with. Therapists can use this as a starting point to cultural formulation, delving deeper into the socially constructed meanings of idioms, and how this connects to the client's own understanding of their distress. We hope this tool will help psychologists working cross-culturally with Syrian refugees to explore constructions of self and suffering with curiosity.

Limitations

Given the diversity of dialects and sub-cultures within Syria, and that the idioms were colloquial, it was difficult to reach consensus on the best idioms to include. While many Syrians may identify with these phrases, others may not. The tool should be used with this in mind, encouraging clients to make changes. Clients and translators may differ in the way they pronounce and understand the idioms. These regional linguistic differences can be used to learn more from the client about the precise part of Syria they come from and how this connects to ethnicity, class, rural vs urban, and cultural aspects.

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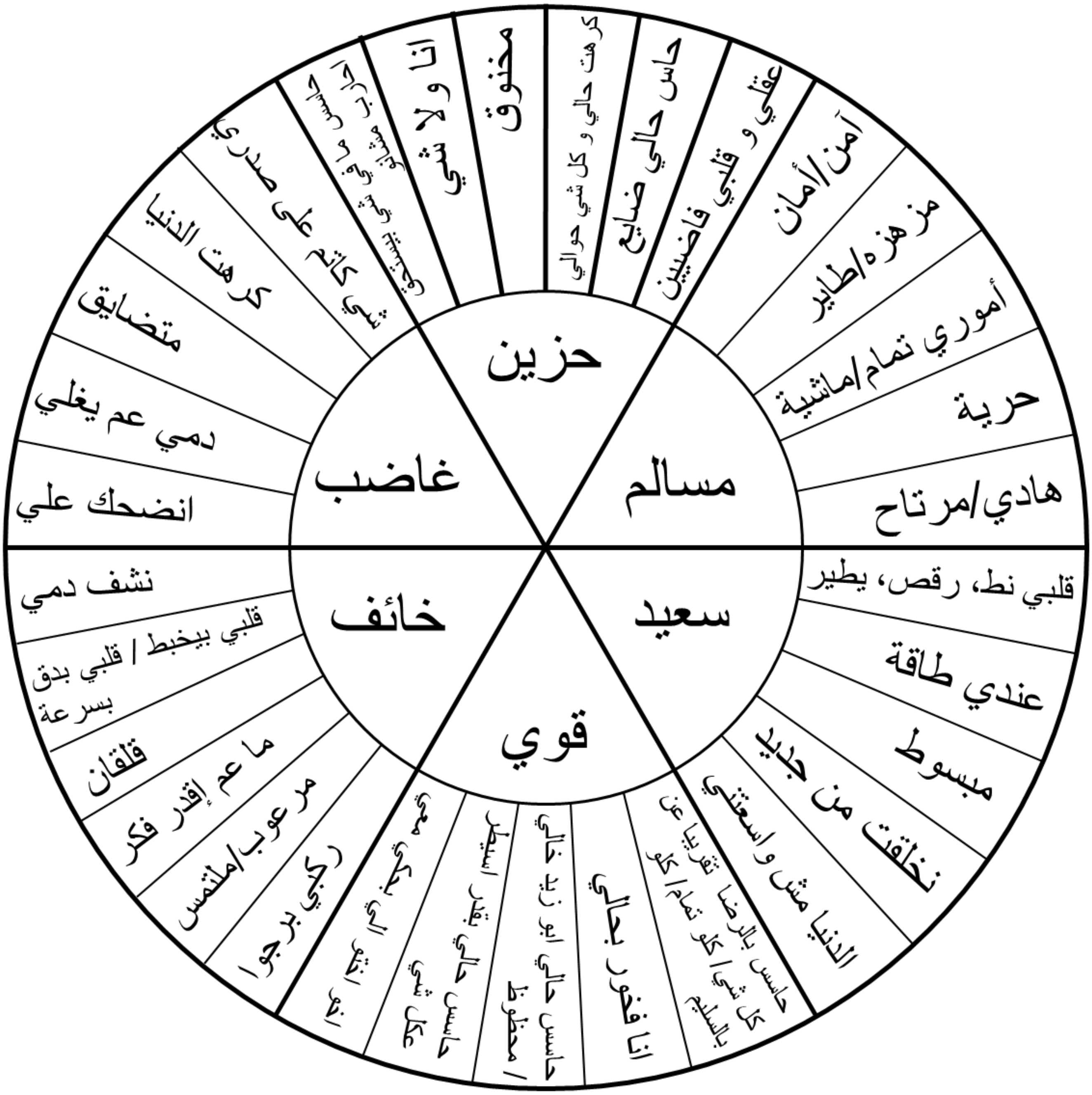

حزين
مسالم
سعيد
قوي
خائف
غاضب
هادي/مرتاح
حرية
أموري تمام/ماشية
مزهزه/طاير
آمن/أمان
عقلي و قلبي فاضيين
حاس حالي ضايع
كرهت حالي و كل شي حوالي
مخنوق
انا و لا شي
شي كاتم على صدري
كرهت الدنيا
متضايق
دمي عم يغلي
انضحك علي
نشف دمي
قلبي بيخبط / قلبي بدق بسرعة
قلقان
ما عم إقدر فكر
مرعوب/ملتمس
ركبي برجوا
حاسس حالي بقدر إسيطر عكل شي
حاسس حالي ابو زيد خالي / محظوظ
انا فخور بحالي
حاسس بالرضا تقريبا عن كل شي / كلو تمام / كلو بالسليم
الدنيا مش واسعتني
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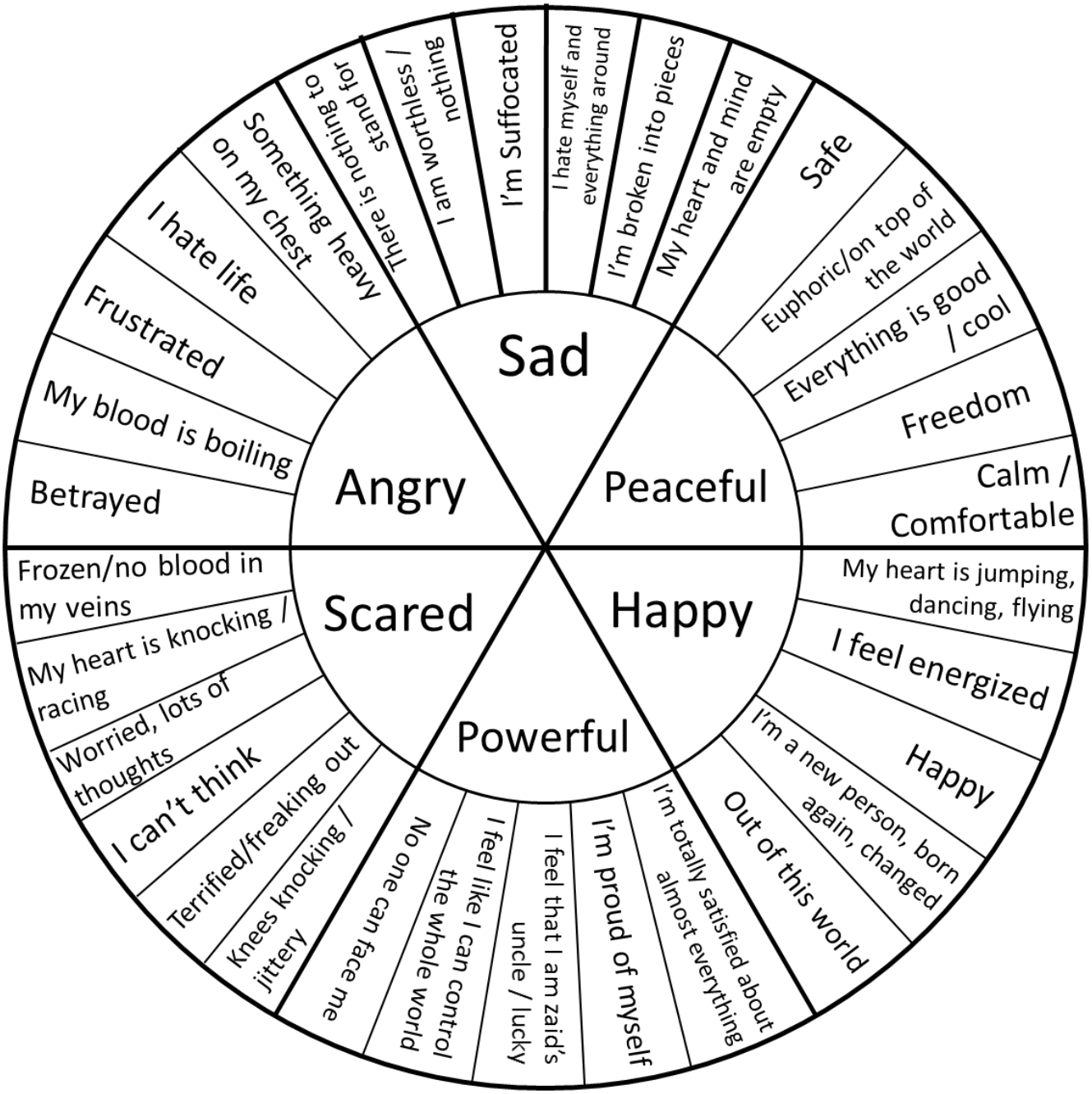
Sad
I'm Suffocated
I hate myself and everything around
I'm broken into pieces
My heart and mind are empty
Peaceful
Safe
Euphoric/on top of the world
Everything is good / cool
Freedom
Calm / Comfortable
Happy
My heart is jumping, dancing, flying
I feel energized
Happy
I'm a new person, born again, changed
Out of this world
Powerful
I'm totally satisfied about almost everything
I'm proud of myself
I feel that I am zaid's uncle / lucky
I feel like I can control the whole world
No one can face me
Scared
Knees knocking / jittery
Terrified/freaking out
I can't think
Worried, lots of thoughts
My heart is knocking / racing
Frozen/no blood in my veins
Angry
Betrayed
My blood is boiling
Frustrated
I hate life
Something heavy on my chest
There is nothing to stand for
I am worthless / nothing

Culturally Appropriate Distraction Activities

Activities
Ask what they used to do
Go for a morning walk
Cooking, with family members
Family Time
Share a meal or tea
Play games
Help a friend or relative who needs you
Paint
Dance
Listen to Music
Tell or read a story
Go out to buy bread

Contributing
Offer someone help, e.g. crossing the road, bags, help a neighbour
Hug your child
Educate your children (reading/ writing)
Volunteer (refer out for community groups e.g. beauty, cooking, sewing, women's)
Recycling – Build something useful from available materials.

Opposite Emotions
Look at old pictures
Pick pictures and memories from the past, write them on old cards, make a memory wall
Matte, Argileh, Shisha, Hooka
Chess
Toweleh (Backgammon)
Play Cards
Change the furniture / appearance of your house
Beauty (eg. go to the baths, dead sea mud, with others)
Make craft from simple materials
Garden / farm, do it for others
Teach others to cook

Sensations
Smell lavender
Wash face and hands
Clap
Rub your hands and put them on your face to warm it.
Comb your hair
Find your heart beat
Count stars
Look at clouds

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