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Meeting the Mental Health Needs of Syrian Refugees in Turkey



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Movements such as the Arab Spring (as described by popular media) and recent regional conflicts have forced people to leave their homes and flee to other countries or regions. Syrian refugees are currently the second largest refugee group worldwide, with half of them resettled in Turkey. Turkish government and non-governmental civil organizations have mobilized efforts to address the immediate survival needs of these refugees such as food, shelter and other provisions. Despite efforts to manage the complexity of mental health and social service needs of forcibly displaced people, counseling services are still lacking. This expository article addresses the mental health needs of Syrian refugees and provides implications for counseling professionals working with displaced people from a crisis intervention approach built on principles and perspectives of humanistic mental health. In addition, programs of support, such as the Mental Health Facilitator program, are discussed.

Keywords: Syrian refugees, mental health, Turkey, displaced people, Arab Spring

The Arab Spring has affected many Arabic countries in the region and resulted in regime changes and general disruption in people's lives (Khan, Ahmad, & Shah, 2014). The Arab Spring refers to a wave of revolutionary civil unrest, riots, demonstrations and protests in the Arab world that began in December 2010 in Tunisia, and spread throughout the countries of the Arab League and its surroundings ("Arab Spring", n.d.). The Syrian Republic is embroiled in a civil war in which separatists have been protesting for more democratic rights and the imposition of a civilian government. The region has been further destabilized by the conflict surrounding ethnic origin, and the political and religious activities of the Islamic State of Iraq and Syria (ISIS).

Approximately 6 million people have taken refuge in Turkey, Lebanon, Jordan, Iraq and Egypt since the Syrian conflict began in 2011 (United Nations High Commissioner for Refugees [UNHCR], 2016). According to the UNHCR (2016), the Republic of Turkey (Turkey) has accommodated the largest number of Syrian refugees in the region. The Turkish government quickly took the necessary steps, such as opening the border and providing food and shelter, after the first group of Syrian refugees entered Turkey on April 9, 2011. To date, there are roughly 2.8 million refugees living in camps and urban areas; half of these refugees are children (UNHCR, 2016). The majority of refugees (90%) live outside of camps and are surviving under challenging circumstances compared to the refugees who live in camps. Refugee camps offer health care, education, food, security and social services. However, refugees who live outside of camps have limited access to information and public services such as education and health care.

Syrian refugees are enduring daily challenges to physical and mental survival. In addition to the extreme needs for physical and nutritional interventions, mental health professionals recognize the urgent need for counseling services based on widespread documented reports of refugees' exile

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experiences and exposure to multiple sources of trauma (Sirin & Rogers-Sirin, 2015). This crisis has resulted in a population of displaced people suffering from a number of mental health issues (Alpak et al., 2014; Betancourt et al., 2015; Clarke & Borders, 2014; Özer, Şirin, & Oppedal, 2013). For example, Önen, Güneş, Türeme, and Ağaç (2014) conducted a quantitative study on Syrians who resettled in refugee camps. The results indicated that 19% of refugees reported high levels of anxiety and 9% experienced high levels of depression. In a recent study, Alpak et al. (2014) reported that approximately one third (33.5%) of Syrian refugees showed symptoms consistent with a diagnosis of post-traumatic stress disorder (PTSD).

The fact that many of the displaced Syrians are especially vulnerable children living far from their homes, cultures and countries further highlights the magnitude of the crisis (Özer et al., 2013). Recent reports indicate that up to 50% of the Syrian refugees are children suffering from exposure to severe traumatic events at rates higher than their adult counterparts (Sirin & Rogers-Sirin, 2015). Özer et al. (2013) reported that 74% of Syrian children in a refugee camp have experienced the loss of a family member or a loved one, and 60% of children felt their lives were in danger. These self-reports of distress and concern are consistent with another recent study of 8,000 displaced Syrian children who reported constant fears (15.1%) and suicidal thoughts (26%; James, Sovcik, Garoff, & Abbasi, 2014).

Several indicators suggest that the severity of the current Syrian refugee crisis is unprecedented. A recent meta-analysis compared the relative rates of mental health disorders between refugees from different world regions and ultimate country of relocation (Fazel, Wheeler, & Danesh, 2005). Fazel et al. (2005) found that while up to 10% of refugees who relocated in Western countries experienced symptoms of PTSD, major depression and generalized anxiety disorder, the frequency of these diagnoses is significantly greater among the current Syrian refugee population (Alpak et al., 2014; Önen et al., 2014). For example, Syrian refugees who resettled in Turkey had a higher incidence of mental health disorders when compared to refugees from Southeast Asia, former Yugoslavia, and Central America who settled in Western countries (i.e., United States, Australia or Canada) collectively referred to as the Organization for Economic Cooperation and Development.

Recognizing the severity of the crisis, Turkey has initiated legal reform, established programs and practices, and requested humanitarian assistance from the international community to help manage the influx of Syrian refugees (Özden, 2013). Turkish government and non-governmental civil organizations have mobilized efforts to address the immediate survival needs of refugees, such as providing food and shelter. Despite these efforts, the available resources, including the number of counselors and other qualified mental health professionals, are inadequate to deal with the constant flow of Syrian refugees (Sahloul, Sankri-Tarbichi, & Kherallah, 2012). The vestiges of war have resulted in an increase in the prevalence of a number of psychosocial stressors and disorders (e.g., PTSD) as well as total desolation of social networks of family, friends and loved ones (Akinsulure-Smith & O'Hara, 2012). These challenges underscore the complexity of mental health and social service needs of forcibly displaced people in the region (Alpak et al., 2014).

This article highlights the challenges faced by the Turkish government related to a humanitarian response to the Syrian refugee crisis. Suggestions are provided for designing appropriate responsive counseling services for refugees from a diversity of sociocultural and geopolitical contexts. Principles and best practices (grounded in humanistic counseling theory) for addressing the mental health needs of diverse displaced people are discussed. Opportunities for generalization and specific cultural applications and adaptations are presented as well.

The Syrian Culture

Syria is located in Southwestern Asia at the eastern end of the Mediterranean Sea. It has its longest border with Turkey on the north, and is bordered by Israel and Lebanon on the west, Iraq on the east, and Jordan on the south. The majority of Syria's population consists of Arabs (90.3%) and the remaining 9.7% consists of Kurds, Armenians and others (The World Factbook, n.d.). Religiously, Syria is a mosaic society. The vast majority of the population (87%) consists of Muslims (74% are Sunni and 13% are Alawi, Ismaili and Shia). Christians (Orthodox, Uniate, and Nestorian) are the largest single minority religious group (10%), and 3% of the population consists of Druzes (The World Factbook, n.d.). Before the beginning of the civil conflict (between the Syrian government and groups of citizens), positive intergroup relationships, for example between Christians and Muslims, were readily observed. However, the current situation of intergroup relationships is unknown since the political equilibrium has changed and continues to change rapidly.

Adherence to religious principles and cultural edicts are fundamental to a typical Syrian's daily life. Islamic creeds and beliefs, such as *Iman* (faith) and *Qadar* (destiny), are elemental and strictly proscriptive of Muslim lifestyle (Eltaiba, 2014). Accordingly, traditions and customs associated with family life (relationships, marriages and future plans) are rooted in cultural and religious traditional practices. Family life is the center of Syrian social structure and extended families are the most common family type (Mahdi, 2003). Intermarriages between ethnic groups, religions and social classes are rare. As an authority figure, the father or the eldest man (grandfather) in the household has the power and is the foundation of a patriarchal structure, giving an advantage to males (Mahdi, 2003).

Addressing the Needs of the Syrian Refugees

Turkish officials have utilized a physiological and psychological needs-based approach (Inter-Agency Standing Committee [IASC], 2007) in the planning for a response to the refugee crisis. The approach has largely been adapted from humanitarian organizations (e.g., Red Crescent, UNHCR) that provide relief, crisis interventions and emergency services. Counseling services are usually not the immediate priority of refugees; most refugees will not seek available counseling or even be able to take part in counseling activities if they do not have a roof over their heads or food in their stomachs and are struggling to survive (International Federation of Red Cross and Red Crescent Societies [IFRCRCS], 2009). Consistent with Maslow's (1943) original theory, crisis intervention efforts need to address the most immediate needs that threaten basic survival (e.g., hunger, safety) first. Once these basic needs have been met, individuals can address other difficulties associated with the experience of trauma (IFRCRCS, 2009). In this respect, the crisis level and needs of refugees determine the priority of counseling and psychosocial support services. National and international mental health crisis intervention organizations (IASC, 2007; IFRCRCS, 2009), such as the Turkish Red Crescent organization, have adopted IASC guidelines (2007) and the recommended four-level approach, which is described below, to assess the urgency of needs for refugees and victims of natural disasters.

Level 1: Basic Needs and Security

Syrian refugees are in need of basic services such as shelter, nutrition, education, medication and health care services. Approximately 1.4 million Syrian refugees are children (Orhan & Gündoğar, 2015; UNHCR, 2016), and the United Nations Children's Fund (UNICEF; 2014) has reported that these children are at risk of being a "lost generation." Moreover, security is a source of distress because of recurring aggression towards refugees who live out of the camps. These events continue along the border with Turkey. For example, a car bombing killed 57 refugees and wounded at least 80 Syrians near a border crossing between Turkey and Syria (UNICEF, 2014).

Level 2: Situation of the Community and Family Support

There is a sense of distrust within the Syrian refugee community that is rooted in the ongoing conflict in Syria (Chammay, Kheir, & Alaouie, 2013). Displaced persons from both sides of the conflict are often resettled together, despite differing political affiliations. Refugee families are struggling to survive in the midst of widespread fragmentation. For instance, Özer et al. (2013) reported that 74% of children in the Islahiye refugee camp had experienced the loss of a family member, affecting the well-being of the whole family.

Level 3: Focused, Non-Specialized Counseling Support

According to the Disaster and Emergency Management Presidency (DEMP; 2013), 51% of Syrian refugees report a need for some form of psychological support. In the same report, approximately 26% of refugees indicated dissatisfaction with the mental health care they received. In parallel with this finding, Chammay et al. (2013) stated that Syrian refugees felt disrespected by the mental health professionals.

Level 4: Specialized Counseling Services

In Turkey, counseling services are different than those in the United States and other developed countries. Turkish counseling services have focused exclusively on school settings and most counselors work as school counselors (Korkut, 2007; Stockton & Yerin Güneri, 2011). When compared to the United States, there are no specializations in the counseling education system in Turkey, such as clinical mental health, career counseling and addictions counseling. In Turkey, mental health services are provided within the medical field; thus, the majority of professionals who work in mental health have consisted of psychiatrists and nurses (Yilmaz, 2012). This situation has affected the availability of counseling and mental health services for Syrian refugees seeking assistance. The efforts of DEMP, Red Crescent, UNHCR, and other non-government and non-profit humanitarian organizations (e.g., Humanitarian Relief Foundation, Support to Life) are not enough to meet the counseling and mental health needs of Syrian refugees.

Mental Health Needs

Empirically validated research on the mental health needs of the Syrian refugees in Turkey and other countries (e.g., Lebanon) is limited due to a lack of focus on the assessment procedures and diagnostic reporting (Chammay et al., 2013). As documented by previous reports of forcible displaced peoples, Syrian refugees are at especially high risk for mental health problems as well as social and physical concerns and uncertainty about the future and current situation in Syria. Individual accounts of extensive violence, death and war illustrate the distress of refugee life at the personal level. For example, the following illustrates one refugee's account of witnessed chaos in Syria:

The soldiers were gathering men in some areas. They interrogated a father, "Which one is your son?" the soldier demanded. The desperate man pointed out his son. The soldier then cut the man's son's throat first, then they shot the father. They were killing and burning so many people that the smell of burning bodies spread through the entire city, like a blanket of death smothering any hope of survival. (Korucu, 2013, p. 90)

This story highlights not only the experience of physical pain, but also fears, losses and spiritual wounds associated with protracted exposure to physical and emotional trauma. Although all refugees did not experience traumatic events or witness a massacre, they fled with other refugees who experienced loss, trauma and torture. The stories spread to others in camps and in the media, and as a result many fled to other countries to protect themselves and their loved ones.

Each refugee client has different needs, and “not every refugee who seeks counseling will require individual therapy for psycho-emotional issues. Counselors should not assume simply because of a traumatic background, intense loss, and other aspects of refugee experience that a refugee is necessarily psychologically impaired” (Baker, 2011, p. 122). In addition to basic physical needs, counselors need to be aware of and focus on the wellness and psychological needs of refugees. Research on well-being (Davidson, Murray, & Schweitzer, 2008) has highlighted the fact that health and wellness is indicated by more than a “lack of diagnosis” (Savolaine & Granello, 2002). There are common concerns that affect refugees in general. For instance, distress about the future, housing, employment, and separation from the family and the culture of the host country or community are predominant issues in refugees’ lives. These factors affect their emotions and holistic wellness (Clarke & Borders, 2014; Tempny, 2009). There are specific situations that affect the mental health of Syrian refugees. First, 83% of Syrian refugees have experienced a traumatic event (Chammay et al., 2013). The intensity of the experience and duration of exposure may affect the level of mental health. Stories and experiences of refugees who were exposed to the traumatic events can frighten other refugees who did not experience a traumatic event, triggering anxiety and stress. Second, unmet physiological needs may exacerbate feelings of insecurity and affect healthy psychological responses. Moreover, refugees’ lack of personal awareness of their own mental health needs can affect help-seeking behaviors. Third, there may be acculturative stress stemming from cultural differences and adaptation to the host culture, which can adversely affect mental health factors after immigration. Specifically, high risks exist for children who lost one or both of their parents in the war. Last, hearing about and seeing people continuing to die in the conflict through news and social media can increase or sustain depression and PTSD symptoms (Alpak et al., 2014).

These compounding mental health issues exacerbate the daily struggles faced by Syrian refugees and underscore the need for mental health intervention (Alpak et al., 2014; James et al., 2014; Özer et al., 2013). One of the most important counseling services would be multicultural transition and adaptation to a new (even if only temporary) living situation.

The Availability of Multiculturally Competent Mental Health Counselors

The impact of a counselor’s awareness of personal cultural values and a client’s worldview is foundational to multicultural counseling competence (Arredondo et al., 1996). We believe that mental health professionals in Turkey will be better able to provide culturally sensitive counseling support to refugees when they make efforts to understand and appreciate the customs and traditions of their Syrian clients (Arredondo et al., 1996). Despite the proximity and often shared religious ideology, considerable differences between Turkish and Syrian citizens (e.g., language, beliefs, cultural practices) may influence the quality of social services refugees receive in their host country. Although Turkey is the neighbor of Syria and shares many cultural and historical ties, a healthy process of cultural transition and adaptation is needed for refugees. More counselors, mental health facilitators (MHFs) and interpreters are needed to provide adequate mental health services, guide the refugee community in meeting their physiological needs, and inform the host culture to decrease prejudice.

Barriers, Challenges and Implications for Counseling

Counseling professionals need to be mindful of the diversity of displaced people. The majority of Syrian refugees fleeing to another country for survival bring different political experiences, levels of education, religions, ethnicities and levels of income to the resettled environment (DEMP, 2013). Counselors may face some challenges and barriers to providing services when working with this unique population. These challenges may include, but are not limited to, language, culture and dependence on Western-based counseling interventions. For example, some refugees might not

attend group counseling if they are assigned to the same group with refugees who have different religious beliefs or ethnicity (Eltaiba, 2014). In such cases, counselors' sensitivity and skills for addressing issues of cultural heritage and historical background of culturally different clients can transform disadvantages into advantages (Sue, Arredondo, & McDavis, 1992). There are effective resources and handbooks that provide detailed guidelines for working with refugees and forced migrants (Hinkle, 2014; IFRCRCS, 2009; UNHCR, 2013). A counselor can create his or her own guidelines for specific or general challenges of working with a refugee population. Specifically, when counselors work with Syrian refugees to create treatment plans, they should consider clients' culture, religion, ethnicity, worldview and language in order to be more effective.

Language Barriers

The majority of Syrian refugees have resettled in Jordan, Lebanon, Iraq, Egypt and Turkey (UNHCR, 2016). While Syria, Jordan, Lebanon, Iraq and Egypt are Arabic countries and have a common culture and language, the majority of people in Turkey have a Turkish heritage and speak Turkish. Furthermore, the availability of Arabic-speaking counselors in Turkey is limited. Government organizations and social service agencies have experienced difficulty finding bilingual personnel as well (e.g., medical doctors, counselors; DEMP, 2013). Providers have responded by employing language interpreters to facilitate counseling contacts with refugees. Language barriers may create trust issues due to the existence of a third person in the session and it may be difficult for the counselor to establish rapport with the refugee client (Akinsulure-Smith & O'Hara, 2012; Baker, 2011). In this respect, several best practice approaches for maximizing the beneficial usefulness of interpreters are warranted. First, counselors may need to meet with the interpreter to explain confidentiality and the goals of the counseling interview; discuss the interpreter's cultural background and cultural expectations; explain the need for detailed translation in the assessment; and discuss seating positions in the session (Baker, 2011; Paone & Malott, 2008).

When counselors work with interpreters they also need to consider interpreters' citizenship status. Interpreters who are themselves refugees may be vicariously vulnerable to experiences reported by clients. Therefore, a program of careful screening, ongoing training, supervision and support for interpreters is vital (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Programs of support, such as the National Board for Certified Counselors' (NBCC) Mental Health Facilitator (MHF) program (Hinkle, 2014), would be helpful for Turkish counselors and interpreters. The MHF program covers the global aspects of community-based mental health training. The MHF initiatives are designed to empower local community members with skills for providing basic mental health services to people who are in crisis (Hinkle, 2014). By working with local volunteers, the MHF programs bridge the gap created by limited access to mental health services provided by mental health professionals, such as professional counselors, psychiatrists, social workers and clinical psychologists. The MHF curriculum includes implementation strategies for nonclinical, basic assessment, social support and referral services (Hinkle, 2014). While the current MHF curriculum and materials are available in the Arabic language, recent reports indicate that materials have not yet been translated to Turkish. Access to culturally sensitive training programs like MHF may be a crucial element to increasing the impact of mental health initiatives targeting refugee populations. Turkish governmental authorities and non-profit organizations would be wise to take immediate action with NBCC to adapt this program to Turkish.

Language immersion efforts are one promising approach to minimizing the impact of linguistic barriers. For example, approximately 87% of the Syrian refugees in Turkey reported that they wanted to learn Turkish (DEMP, 2013). The government and non-profit organizations have Turkish courses for refugees in the camps and cities. Counselors may use these classes as one of their referral sources.

The classes also give an opportunity for clients to attend an activity, engage in the society, meet with new people from their own cultures and communicate with local residents.

Challenges Due to Refugee-Host Community Relations

A rapid influx of migrants can place considerable stress on the fiscal and emotional resources of the host country (Orhan & Gündoğar, 2015). The current Syrian refugee crisis has shifted from a humanitarian to a political crisis for other countries (e.g., Germany, Sweden, France; Hebebrand et al., 2016). Many refugees who live in Turkey are trying to fly to other European countries. However, politicians of those countries are not willing to accept refugees because of security, resources and possible dissent of their citizens (Hebebrand et al., 2016).

Although Turkey and Syria have longstanding historical ties and similar cultural and religious orientations, refugees will almost certainly experience acculturative stress, oftentimes as a result of negative reception from the host country (Betancourt et al., 2015). For instance, residents of the Gaziantep province, which has the second highest number of Syrian refugees in Turkey, protested against refugees and initiated physical attacks on them. The conflict increased the tension in the city and forced authorities to resettle some refugees in other provinces.

Bektaş (2006) has indicated that attempts at a multicultural curriculum in Turkish counseling education programs are not enough, and there is not a current mechanism or system (e.g., CACREP) to promote multicultural counseling competencies among Turkish counselors. Governmental and non-profit organizations need to consider diversity and ethical considerations when recruiting counselors for counseling and mental health services. The Turkish government's policies toward the ongoing situation in Syria might polarize the government officials and mental health professionals who work with the Syrian refugees. At this point, counselors should be aware of their own personal views, biases and political ideas. They should be able to focus on their role as counselor rather than as resident or citizen.

With respect to provision of clinical mental health services, tensions between residents and refugee groups may interfere with effective receipt of counseling interventions by refugees. These events might cause mistrust towards counselors since they can be seen as part of the system, members of the host culture or representatives of the authorities (Vanguard, 2014). Holistic and advocacy-based services are more beneficial for refugees to cope with cultural difficulties (Baker, 2011; Clarke & Borders, 2014). These services include psychosocial support, counseling, referral sources, education and programs for the host community. Furthermore, counselors can provide additional services, which are not listed here, based on the needs of refugee clients.

Cultural and Spiritual Challenges

Syria represents an Eastern culture with dominant collectivist characteristics (Samovar, Porter, & McDaniel, 2010). The religion of Islam plays a role not only in individuals' personal lives, but also in social life and society. Religion and spirituality are a way of life for Muslims across different cultures (Eltaiba, 2014). Religion determines the relationship between men and women, social roles, laws of inheritance, what people can and cannot eat, childcare, marriage and more. In addition to the culture of religion, traditions guide people's lives as well. As mentioned before, the Syrian culture has a patriarchal structure. In this situation, men have more rights and freedom than women (Mahdi, 2003). For example, this patriarchy can create problems when counselors plan for group counseling. It can be difficult for women to talk about or share their problems in front of men. In this respect, dividing groups based on gender can be more effective.

In such cases, religion and spirituality can be explored in individual counseling sessions. Research has shown that religious coping can be used effectively by refugees (Clarke & Borders, 2014). For example, a Muslim refugee client might think that he or she deserves the current circumstances and whatever happens is Allah's will. This belief represents the basic idea of *Qadar* – destiny or fate – and should be addressed carefully by the counselor because *Qadar* includes the individual's will and belief that everything comes from Allah/God, and since refugees are under stress they can give up all the responsibility to Allah or God. A holistic approach that focuses on both the individual's and society's values and needs should be implemented since culture and religion provide significant means for coping.

Challenges With Counseling Interventions

Many migrants and forced refugees are not familiar with the concepts of counseling, which might seem strange to them (Akinsulure-Smith, 2009; Akinsulure-Smith & O'Hara, 2012). Refugees need to understand the services available in order to benefit maximally from them. The government and humanitarian agencies need to use terms that make sense for Syrians. When organizations prepare brochures, handbooks, reports and name plates, they should explain available mental health and counseling services, define *counselor*, and explain their services. Most Turkish counselors who work with Syrians were educated in Turkish counseling programs, which were modeled on U.S. programs and included Western-based counseling theories (Mocan-Aydin, 2000). This Western-based education and theories might decrease the effectiveness of counseling and challenge counselors because Syrians come from an Eastern culture. Since they have moved to a new culture, been separated from families, and experienced pressure and persecution, many refugees do not understand their new culture or know where to find help. In this respect, a group of Syrian mental health facilitators trained with the NBCC MHF program can be a valuable resource for working with this population (Hinkle, 2014). The inclusion of trained community volunteers will likely increase refugees' access to mental health services while simultaneously decreasing the work load of professional counselors.

Conclusion

Over 2.8 million Syrian refugees have resettled in Turkey in the period of 2011 to 2016 (UNHCR, 2016). As the refugee population continues to grow, host nations will need to prepare a systematic response to this continuing humanitarian crisis in ways that support the basic human needs of forcibly displaced people. The Turkish government has responded to the presence of Syrian refugees with interventions that support basic survival needs (i.e., food and shelter). The availability of mental health and social services for refugees is limited and remains a focus of humanitarian assistance. Counselors should be cognizant of the traumatic experiences refugees often endure in the context of displacement and ongoing conflict. Counselor training and facilitation of community-based mental health advocates such as those provided by MHF can increase the impact of available counseling interventions for refugees. In addition, the IASC four levels crisis intervention approach, which is used by the Turkish Red Crescent organization, can be beneficial to address traumatic experiences and the needs of refugees.

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