

Exploring the Mental health Needs and Suffering of Syrian refugees

Background

Syrian people were part of the “Arab Spring” and started an uprising against their oppressive regime aiming for political change and freedom. The Syrian regime responded with extreme force and brutality from day one that led later on to what is now described as civil war.

An estimated 9 million people have fled their homes since the start of the Syrian crisis in 2011, taking refuge in neighbouring countries or within Syria itself. According to the United Nation UNHCR over 3 millions have fled to Turkey, Jordan, Lebanon and Iraq.

I volunteered with colleagues in trying to help cover some of the mental health needs of Syrian refugees from early on in the conflict. I went on my first visit to refugee camps and communities in Turkey and Jordan. Refugees’ initial thoughts were of this being a short ordeal with strong sense of resilience and defiance. Anger and frustration were also prevalent as well among most people. Difficulties in adjusting to the new reality they found themselves in did take its toll on many. Large families living in tents and in confined places and often having to compete with others to attend to basic needs added more to the frustration to this usually proud people. As their stay got longer despair and hopelessness started to surface with some general feelings of gloom.

Mental health needs

The needs of people here vary widely from the most basic but necessary and sometime hard to get i.e. food, shelter and safety to the most severe end of the spectrum of complicated grief reactions, severe PTSD and Depression in some. Most agencies were focusing more, understandably at least in the beginning, on meeting the basic needs. Attending to mental health needs in this part of the world is neglected and below standard at the best of times let alone at times of huge crisis like this.

The more humanitarian agencies arrived the less coordination happened between them. The fact that these agencies have different emphasis on dealing with mental health and having different terms of references meant some valuable efforts being wasted. This is partly due to lack of coordination and often non-existence patients’ information sharing. Little outreach work is done in the community which means large number of needy people can be missed.

With more refugees coming to some of the already ill equipped countries the more they felt the strain. Some of the host countries are not, understandably, always welcoming and restrictions on movement and allowing refugees to work are imposed. For many, usually hard working Syrians, this feeling of entrapment has its toll on them. Combined with the huge loss and increasing sense of ongoing humiliation, as people had to rely on charities and UNHCR food vouchers, this had its impact on family members and able men in particular. Previous research on the effects of loss and humiliation showed it is strongly linked with major depression and anxiety (Kendler *et al*)¹. The role of life events and the onset of depression were also highlighted by the work of Brown *et al* ². Despite feeling relatively safe

in these new environments, the fact that the tragedy is continuing with no end on site one can easily imagine the negative effects of this on mood of people.

Forced displacement has its known general uprooting effects on individuals. These include feelings of estrangement, loss of identity and disorientation, insecurity, loss of role, disturbance of social networks and schooling and the occasional exploitation by the local communities. For some there is also the intense fear for the fate of relatives left behind or those who are missing. We should not forget here the specific effects of severe trauma and war atrocities that many refugees have witnessed or been subjected to.

Some of the most common mental health problems I noticed were **symptoms** of anxiety, sadness, hyper-vigilance, social withdrawal, relationship problems and flashbacks of recent trauma on. Some would qualify for diagnoses of mental health disorders i.e. PTSD, severe depression but most cases I came across were of varying degree of adjustment disorders. Stigma of mental illness in the Syrian society is very high which means delay in assessments and often hinder follow up for those who found the courage to be seen in the first instance. I have no doubt that so many severe cases of mental health problems in these communities continue to suffer in silence, for reasons of stigma, and also due to lack of trained mental health professionals to turn to.

Worst affected

There are some horrific stories of torture and witnessing violence. Description of intense fear of unpredictable bombardments and also unforgettable scenes of killings had its severe effects on some.

The worst affected cases I saw were sadly of young children who lost one or both parents and siblings and there are many of these. Some gave a description of horrific scenes they witnessed of their family members being brutally killed. It is long been argued that one of the most significant war traumas of all, particularly for young children, is simply separation from parents and this is often more distressing than the war activities themselves (UNICEF report 1996a)³. Some Syrian children have experienced both.

There also the occasional reported stories of rape and gang rape which is a well known weapon of war. The speculation is that there are much higher numbers of unreported cases of rape and sexual violence that may never be uncovered because of sensitivities and shame with lack of means to follow and prosecute.

Epidemiological Studies

Various surveys and epidemiological studies are reported by various groups which reveal very high prevalence of PTSD, depression and anxiety, some reaching more than 40%. One has to be cautious about the outcome of these studies as they are often done in challenging environments and on emotionally charged samples. The high prevalence rates of some of these are hard to justify as there are no comprehensive assessments with robust methodology being done. It is also hard to generalise the results of some as often meaningful community samples and from those internally displaced are missed. As far as I know there are no validated clinical scales to assess reactions to trauma in Syrian population that can be used widely in various settings. Over-medicalising the responses to

stressful situations in these surveys can creep in and lead to misrepresentation and over-inflated prevalence rates.

Inability to mourn the loss of relatives or missing persons complicates the grief and can lead to hyper-vigilance and various depressive and anxiety symptoms. Lots of refugees have lost their houses and valuables in the process if not one or more family members as well. Here you would expect people to be feeling miserable with mixed feelings of frustration and anger which in turn can hinder engagement in the evaluation of need process. Making clinical diagnoses of mental illnesses under these circumstances need some expert clinicians to distinguish them from expected responses to extreme stress. It is not the mere completion of survey tools.

These variables have to be taken into account when studies are conducted if we are to reach a more accurate picture of the psychosocial effects on people amid this crisis.

What can be done?

It is not all doom though particularly when people do support each other in these communities and the positive effects of this need highlighting and encouraging.

There is a need for better co-ordination among aid agencies to better orchestrate their efforts in meeting the mental health needs of these refugees. Many agencies work in same towns and camps which are not always necessary and could mean duplications. Moving branches to different sites and areas and developing community teams will help uncover the real mental health needs of people and encourage other sufferers to come forward.

Training teams and volunteers on encouraging and highlighting the importance of **self-help**, problem solving and the role of affected individuals in dealing with their conditions. Patients/affected persons' role is vital in all cases and it becomes more important where there is lack of resources.

Ensuring workers and volunteers are well supported and supervised is important to reduce occurrence of burn out. More psychiatrists, psychologists and trained mental health nurses are needed to achieve this task.

Use of innovative ways to help support volunteers i.e. Telemedicine, video-conferencing sessions, provide supervision using internet facilities etc.

More well conducted research and epidemiological studies with validated scales to better understand the current and future mental health needs of Syrians are to be encouraged. I call upon academic institutions and research centres to give this area a priority as there are lots of lessons to be learnt from the psych-social effects of this unprecedented crisis.

Dr Nadim Almoshmosh

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1-[Arch Gen Psychiatry](#). 2003 Aug;60(8):789-96.

Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety.

[Kendler KS](#)¹, [Hettema JM](#), [Butera F](#), [Gardner CO](#), [Prescott CA](#).

2-[Psychol Med](#). 1995 Jan;25(1):7-21.

Loss, humiliation and entrapment among women developing depression: a patient and non-patient comparison.

[Brown GW](#)¹, [Harris TO](#), [Hepworth C](#).

3-Impact of Armed Conflict on Children UNICEF Report 1996a Garca Machel