

# Mental health of resettled Syrian refugees: a practical cross-cultural guide for practitioners

Nadim Almoshmosh, Hussam Jefee Bahloul, Andres Barkil-Oteo, Ghayda Hassan and Laurence J. Kirmayer

## Abstract

**Purpose** – The purpose of this paper is to prepare healthcare providers in high-income countries to deal with mental health and psychosocial issues among resettled Syrian refugees.

**Design/methodology/approach** – Collaborative work of the authors on a comprehensive review of social context, cultural frameworks and related issues in the mental health and psychosocial well-being of resettled Syrian refugees.

**Findings** – A practical guide that emphasizes the importance of considering the social and cultural dimensions of their predicament and highlighting principles that can help clinicians address the unique needs of Syrian refugee patients.

**Originality/value** – The content of this paper is inspired by the collaborative work of the authors on a report commissioned by the United Nations High Commissioner for Refugee (UNHCR).

**Keywords** Cultural competence, Adaptive coping, Mental health services for refugees, Psychosocial support, Resettled Syrians, Victims of torture

**Paper type** Viewpoint

Nadim Almoshmosh is based at St Andrews Healthcare, Northamptonshire, UK. Hussam Jefee Bahloul is based at the School of Medicine, University of Massachusetts, Boston, Massachusetts, USA. Andres Barkil-Oteo is based at Yale School of Medicine, New Haven, Connecticut, USA. Ghayda Hassan is based at the University of Quebec at Montreal, Montreal, Canada. Laurence J. Kirmayer is based at McGill University, Montreal, Canada.

Key Recommendations for healthcare providers:

- Focussing efforts on advocacy for human rights and improvement of living conditions (e.g. housing, employment, food) and fostering coping skills and resilience are key to effective mental health services for Syrian refugees.
- Healthcare providers should be careful not to over-diagnose mental disorders among displaced Syrians, especially in the early post-settlement phase when refugees face insecurity and have many ongoing daily stressors.
- Providers are advised to avoid psychiatric labelling because this can be especially alienating and stigmatizing for survivors of violence and injustice. Using easy-to-understand terms is recommended.
- Healthcare practitioners should avoid being overly directive. Instead, listening closely to the wishes and views of the person who seeks help will empower them to make their own decisions.
- Services for SGBV survivors may be more acceptable if they are provided within a non-stigmatizing setting, such as general health care or women's centres, without initially addressing the issue of abuse explicitly.

## Introduction

The conflict in Syria has caused the largest refugee displacement crisis of our times. Since March 2011, the Syria conflict has resulted in nearly half of the population being displaced, comprising almost 6.6m inside Syria and more than 5.6m registered refugees who have fled to neighbouring

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countries (UNHCR, 2015). Many Syrians have suffered multiple violations and abuses including torture, forced displacement, sexual violence, witnessing massacres and disappearance of loved ones. In addition, indiscriminate bombardment and shelling have led to mass casualties and spread terror among civilians. Furthermore, parties to the conflict have enforced sieges on towns, villages and neighbourhoods, trapping civilians and depriving them of food, medical care and other necessities. They have also disregarded the special protection accorded to hospitals and medical and humanitarian personnel. The Syrian crisis has been described by the United Nations High Commissioner for Refugees (United Nations High Commissioner for Refugee (UNHCR)) as “the great tragedy of this century” when the number of refugees was approaching the two million mark (UNHCR, 2013).

As the international community has pledged to receive thousands of Syrians since the beginning of the conflict, this paper aims to provide healthcare providers in high-income countries with an overall orientation on how to address mental health and psychosocial issues among Syrian refugees. The main target audience is mental health providers, but the issues described in this paper are relevant to primary care practitioners and other healthcare workers.

Studies done on mental health for refugees and displaced persons emphasize: the need to recognize the fundamental human rights of refugees and advocate for adequate health care and social support; the importance of culturally safe and competent care; and the need to engage with refugees’ resilience (Bäärmhielm *et al.*, 2017). The ADAPT framework provides a useful way to conceptualize the wide range of challenges and coping strategies of refugees who have faced massive human rights violations and can guide trauma-informed care (Tay and Silove, 2017; McGregor *et al.*, 2016; Wells *et al.*, 2018).

The content of this article is inspired by the collaborative work of the authors on a report commissioned by the UNHCR. We refer interested readers to this publication for more details (Hassan *et al.*, 2015).

### ***Pre-settlement stressors***

En route to their country of resettlement, Syrian refugees often must navigate a long journey marked by great hardship, suffering and uncertainty. Most Syrian refugees have fled their homes due to an active war affecting threatening their survival and livelihood. Some sought safety in areas inside Syria before crossing the border to one of the neighbouring countries (Turkey, Jordan, Lebanon or Iraq), where they resided in UNHCR-supported refugee camps or stayed in urban settings. Other refugees were brought to third countries directly through the resettlement units programs of UNHCR, and they have been through multiple rounds of selection, interviews and bureaucratic procedures with prolonged uncertainty about their future prior to their resettlement in a host country such as Canada, Australia, a country in the European Union, or the USA.

Refugees often experience an exhausting period in temporary displacement countries, during which time they must expend their dwindling assets and resources. Data from varied refugee settings indicate high levels of exposure to violence experienced by Syrian refugees during their migration journeys (Farhat *et al.*, 2018). Additional stressors come from the inability to access proper education, jobs, adequate housing, or health services (UNHCR, 2014a; Council NR, 2014; Kirmayer *et al.*, 2018). In displacement settings, the social fabric of society is often severely disrupted, and many Syrian families became isolated from larger support structures. Syrian refugees in camps or urban displacement settings often feel a loss of cultural identity, estrangement and may have overwhelming nostalgia for their homeland (Moussa, 2014). Refugees are likely to face massive adjustments after resettlement and maintaining their language and culture may be key to continuity of identity and resilience (Phillimore, 2011; Hadfield *et al.*, 2017). In some countries, discrimination against refugees, language barriers and social tensions also contribute to stress and isolation (Simsek, 2015; De Genova, 2018). In a worldwide study of refugees and asylum seekers worse outcomes were observed in refugees living in institutional accommodation, experiencing restricted economic opportunity, displaced internally within their own country, or whose initiating conflict was unresolved (Porter and Haslam, 2005). The Syrian conflict is still unresolved, and this ongoing instability can be a persistent source of stress that needs to be kept in mind when treating mental health problems in Syrian refugees.

### ***Post-settlement stressors***

When refugees arrive in resettlement countries, their difficulties are not over. The resettlement process itself can be lengthy and stressful. A study of Iraqi asylum seekers in The Netherlands found that the duration of the asylum procedure was an important risk factor for mental health issues (Laban *et al.*, 2004). Social integration also can pose significant challenges for refugees. Post-settlement stressors include unemployment, acculturation stress, lack of vocational or educational opportunities, discrimination and language barriers (Beiser, 2009). Economic considerations take priority in the life of resettled refugees.

Economic challenges dictate their living environment, access to health care (including mental health), and education, amongst other essential needs. According to DeVoretz *et al.* (2004), it takes newcomer refugees to Canada an average of seven to ten years to achieve economic stability. As a result of migration losses and employment restrictions, a significant proportion of refugees live in poverty, and economic instability is a major psychosocial stressor (Beiser, 2009). Forced migration disrupts social networks and communities, and limited social support can contribute to post-settlement stress for Syrian refugees. The presence of long-term relationships has been found to be protective. Refugees can draw strength from their own cultural community, and this sense of community is known to have a protective effect on their mental health (Beiser, 2009).

### **Mental health problems among conflict-affected Syrians**

Not all individuals who have lived through potentially traumatizing events will suffer afterwards from mental health problems; however, an increased risk for mental disorders, especially among children, is well documented in the refugee literature (Tinghög *et al.*, 2017; Silove *et al.*, 2017).

Conflict-affected Syrians may experience a range of mental health problems that may reflect: manifestations or exacerbations of pre-existing mental disorders; new problems triggered by the conflict-related violence and displacement; and emerging issues related to adjustment to the new environment in the countries of refuge. Here we will briefly discuss some salient aspects associated with these migration-related mental disorders.

#### ***Loss and grief reactions***

Survivors of armed conflicts struggle with issues of grief due to loss of loved ones, relationships, familiar environments, homes and possessions (Boss, 2002). Profound loss of roles, status and connection to others can erode the sense of agency, self-efficacy and control. In the protracted Syrian crisis, ongoing exposure to news about the conflict and constant fear about the safety of family members can be a source of overwhelming stress (UNICEF, 2014). Moreover, relatives of people who have been forcibly disappeared have to deal with the uncertainty of their fate and the inability to adequately mourn their loss (Council UNHR, 2013).

#### ***Emotional and mood disorders***

Studies show that low mood, complicated grief, and stress related symptoms are common among refugees (Hijazi and Weissbecker, 2015). Most emotional problems fall in the category of mild to moderate mental disorders, and it is important for healthcare practitioners to remember that presence of symptoms does not necessarily indicate mental illness (Almoshmoh, 2015; Bou Khalil, 2013). While exposure to war and displacement may result in mental disorders or exacerbate them, other “sub-clinical” phenomena, including demoralization and hopelessness, may dominate the picture and be related to profound and persistent existential concerns about safety, and trust in self, others, and one’s surroundings (Hijazi and Weissbecker, 2015; Almoshmoh, 2015). For these forms of distress, non-clinical interventions, focussing on improvement of living conditions, may reduce symptoms and promote resilience.

Data on the prevalence of mental disorders among Syrian refugees are emerging. Given the exposure to severe stressors related to war and displacement, an elevated prevalence of mental health problems would be expected. A study done at a large psychiatric hospital in Lebanon reported an increase in severe psychopathology and suicidality-related admissions of Syrians in the

last few years compared to before the conflict (Hijazi and Weissbecker, 2015). In a population-based survey of Syrian refugees resettled in Sweden, mental ill health (defined as symptoms of anxiety, depression and post-traumatic stress disorder (PTSD)) was greatly elevated compared to the general population (Tinghög *et al.*, 2017). A study investigating the prevalence of depression and PTSD among Syrians residing in camps in Turkey revealed high rates of depression and PTSD and highlighted the greater risk for women (Acarturk *et al.*, 2018). Another study of Syrian refugees resettling in the USA screened at primary care found a high prevalence of possible psychiatric disorders related to trauma and stress (Javanbakht *et al.*, 2018). These studies are consistent with a recent systematic review (Charlson *et al.*, 2019), which estimated that approximately one-in-five people in post-conflict settings, Syria included, have psychiatric disorders including depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia.

### ***Victims of torture***

Many torture survivors have symptoms stemming from that experience including depression, posttraumatic stress, panic attacks, somatic symptoms and suicidal behaviours. Feelings of shame and guilt are related to the often humiliating and degrading experiences of torture and may prevent patients from seeking care (Kirmayer *et al.*, 2018). Due to stigma and the complex medical-psychological nature of torture cases, it is advisable to avoid diagnostic labelling. Conventional diagnostic classifications may be insufficient as many clients have torture-related symptoms or problems that do not fit specific categories, and symptom reduction in one area can have beneficial effects on other stress-related problems (Hassan *et al.*, 2015). Integrated multidisciplinary teams can help patients deal with symptoms and improve physical, psychological and social functioning.

### ***Substance and alcohol use***

Studies done in Syria before the war indicated that more than half of males were daily smokers, most of whom were heavy smokers (i.e. average 20 cigarettes/day). Waterpipe or “Narghile” use has been noted in many studies to have an increasing prevalence among Arab youth (Maziak *et al.*, 2013) and Syrians in particular (Ward *et al.*, 2006). There are no estimates of smoking prevalence after the Syrian war; however, numbers would be expected to increase in response to the stresses of war and displacement. In general, Syrian smokers have less success in quitting efforts compared to their counterparts in industrialized countries (Maziak *et al.*, 2004); smoking cessation should therefore be taken into account in treatment planning, given its health, social and economic costs.

Consumption of alcohol in Syria has been traditionally low. Use of alcohol may have increased after the war. A study among Syrian refugees to Iraq found that about half of respondents drank more than five alcoholic consumptions per week (Berns, 2014). Figures on the use of illegal substances are not available but may have increased given the increased production and trade of illegal drugs as a result of the crisis (Arslan *et al.*, 2015). A worrying trend is the use of synthetic stimulants such as fenethylamine (Captagon), a drug that is popular throughout the Middle East and that is produced in Syria and neighbouring countries (Rahim *et al.*, 2012).

### ***Challenges to providing adequate mental health services for refugees from Syria***

Refugees generally show great resilience in adapting to their forced migration and resettlement and supporting this resilience is central to mental health services (Simich and Andermann, 2014). This requires attention not only to individual characteristics of refugees and their families but also to structural and cultural features of the receiving society that affect refugee adaptation and social integration (Panter-Brick *et al.*, 2018).

It is important to conceptualize challenges facing provisions of mental health services to resettled refugees in the light of pre- and post-settlement stressor dynamics. Even when services are available, displaced Syrians and refugees from Syria may still be unable to access mental health care or psychosocial services due to financial issues, language barriers, stigma and acculturation. One important reason may be lack of financial resources to pay direct or indirect costs, such as for transportation or medications (Office for the Coordination of Humanitarian Affairs, 2013).

Refugees experience a loss of control over many aspects of their lives and the process of resettlement can exacerbate this predicament. This loss of power and control must be carefully considered to avoid creating situations of helplessness and dependency and conveying a message to people that they do not possess the means for helping or healing themselves. A person-centred approach to clinical dialogue, partnership and collaboration can contribute to empowerment and mental health promotion. Displaced Syrians can feel robbed of power and control over most aspects of their lives, and they are likely to gain a sense of empowerment only if they are actively involved in decision-making of the intervention plan.

Stigma is another challenge facing the provision of mental health services to Syrian refugees in western countries. In Syrian culture, emotional suffering is perceived as an inherent aspect of life. However, the explicit labelling of distress as “psychological” or “psychiatric” may be a source of shame and embarrassment, due to the risk of being labelled “crazy” by the community. “Madness” casts shame on patients and their families, and makes the decision to seek professional help and adhere to treatment a complex process (Ciftci *et al.*, 2012). It is advisable for practitioners to avoid using psychological jargon and psychiatric labelling. Integrating mental health services into other care settings, such as a general medical clinics, or child and family or community centres may reduce stigma and facilitate access to, and utilization of mental health services (Gearing *et al.*, 2013).

Identifying and measuring psychological distress among refugees can be challenging because of language differences and cultural variations in ways of expressing distress (Bäärnhielm *et al.*, 2017). Therefore, caution is needed when using clinical assessment and diagnostic scales, which may have limited or untested validity and reliability in refugee populations (Hollifield *et al.*, 2002). Only a few existing tools have been validated in multiple cultural and migration contexts. A study on prevalence of mental health, trauma and post- migration stress among refugees from Syria resettled in Sweden found certain measures used to assess anxiety, depression, PTSD, war related traumatic experiences and low subject well-being had good internal consistency, including the Hopkins Symptom Checklist, Harvard Trauma Questionnaire and WHO-5 Well-being Index (Tinghög *et al.*, 2017). These scales have been used frequently with refugees and in population-based surveys and translated versions have been shown to have adequate psychometric properties among Arabic speakers (Hollifield *et al.*, 2002; Tinghög and Carstensen, 2010). However, a systematic review found that many screening and measurement tools require further development and cross-cultural adaptation and validation for assessment of trauma and mental health in refugee youth (Gadeberg *et al.*, 2017).

## Cross-cultural principles for working with Syrian refugees

Helping refugees navigate their varied post-settlement situations needs more than a “clinical” lens. Looking at the migration and resettlement process from a cultural perspective suggests approaches that may be complementary too and, in some cases, more effective than traditional clinical interventions. There is wide consensus that such support should include psychosocial interventions that strengthen individual and community resilience, resources for self-help, and advocacy for security and protection and for adequate humanitarian aid, including basic health services and livelihood support (Inter-Agency Standing Committee, 2007). This advocacy can be grounded in the recognition of basic human rights but requires adopting local languages of social, moral and political accountability to mobilize an effective response (Kirmayer, 2012; Kirmayer *et al.*, 2018). The World Medical Association (World Medical Association, 2015) states that every person has the right to medical care of good quality without discrimination. Physicians and other professionals and organizations involved in the provision of health care have a joint responsibility to recognize and uphold these rights.

The following principles can help clinicians address the unique needs of refugee patients.

### ***Ensure cultural safety and cultural competence***

The context of service delivery is often an important factor in the acceptability of any mental health service for refugees. The ability to provide “safe spaces” for refugees, particularly women and children,

can allow participants to re-build their social agency and help them tolerate the stress associated with discussing intimate issues related to life changes, acculturation, loss and even more sensitive concerns like domestic abuse (Mercy Corps, 2014). Safe space can be established through a gentle explanation of the setting (clinic, hospital, counselling centre, social-services centre, etc.), clarification of privacy issues, use of trained interpreters and culture brokers, respect for the customs and traditions of the refugee, and simply allowing refugees adequate time to tell their stories in the ways they want to tell them.

In general, when seeking more specialized mental health services (i.e. psychiatry), due to stigma Syrians may be more likely to talk to their general physician about their problems. Thus, the clinical presentation of somatic complaints such as headaches, nausea, dizziness, appetite change, and insomnia may provide an opportunity for assessing the psychosocial well-being of refugees. These symptoms may be caused or exacerbated by psychological and social stressors and concerns.

Many women and girls are exposed to sexual and gender-based violence (SGBV), which has increased substantially due to the conflict (Global Protection Cluster, 2013; UNHCR, 2014b; Ouyang, 2013). Because of shame and fear of social stigmatization, women and girls, as well as boys and men, are often reluctant to report instances of sexual violence or harassment, or to seek treatment (IRC, 2013; Sexual and Gender Based Violence Sub-Working Group Jordan, 2014). Like other mental health issues, suffering related to sexual violence may be expressed by survivors through somatic symptoms. Survivors of rape and other forms of sexual violence have an elevated risk of developing mental disorders, and trauma-informed mental health care should be offered as part of multidisciplinary services for those affected (Ellsberg *et al.*, 2008). Creating a safe environment and ensuring that staff are trained to respond to disclosures of SGBV in a confidential and appropriate manner may increase the likelihood that survivors will feel comfortable to disclose and access services. In addition, survivors should be helped to identify supportive members of their social network. The social stigmatization and risks of further abuse or domestic violence need to be carefully assessed and addressed (US Department of State, 2014). Participation in “community-based” programs on parenting and relationship challenges in the country of resettlement can improve couple and family functioning and avoid stigmatization.

Refugees’ understanding of mental illness and psychological suffering may be closely connected to their social, cultural and religious background. Clinical assessments will be more accurate and appropriate when they integrate questions that explore the local modes of expressing distress and understanding symptoms (Kirmayer, 2012). The Cultural Formulation Interview (CFI) in the Diagnostic and Statistical Manual (DSM-5) of the American Psychiatric Association provides one simple approach to assist mental health practitioners in this aspect of assessment (Lewis-Fernández *et al.*, 2014; Mezzich *et al.*, 2009). The CFI prompts practitioners to ask questions about patients’ views of the illness and their expectations for care as well as psychosocial stressors and supports, and relevant aspects of their ethno-cultural identity. A supplementary module to the core CFI provides questions to explore issues related to migration. Cultural formulation provides a framework for systematic exploration of social and cultural context. Moreover, clinical assessment needs to focus not just on symptoms and distress, but also assess social functioning and explore contributors to assess positive mental health, including strengths, resiliency factors and coping skills.

### ***Promoting resilience and adaptive coping***

With forced displacement, people generally feel a loss of sense of control, which undermines their sense of safety. In protracted situations of uncertainty, a sense of helplessness, lack of self-efficacy and erosion of basic trust in others can emerge which impair coping with daily problems.

To survive forced displacement, refugees may use various ways to cope with the inevitable psychosocial distress. This may include individual actions to reduce stress, as well as social activities such as spending time with family and friends, engaging in social circuits, or talking with a trusted person. Unfortunately, refugees often lose hope and resort to maladaptive

coping strategies such as smoking, obsessively watching the news, and withdrawal or “doing nothing”, which may cause negative rumination (Al Akash and Boswall, 2015; Momartin *et al.*, 2004). Displaced Syrian adults may resort to such passive and individual coping methods because they have a sense there is little else they can do, with little control over their life circumstances (International Medical Corps, 2011; International Medical Corps, Jordan Health Aid Society, 2013).

Mental health practitioners need to work with refugees on re-establishing positive and resilient pre-settlement coping strategies. Encouraging individuals to use of their own resources and problem-solving skills may be all that is needed to begin to restore a sense of self-efficacy. Training in specific self-help skills can benefit those with more limited repertoires or maladaptive coping styles. Becoming more involved in their communities, being part of decision making and taking small steps to plan for the future can reduce the risk of learned helplessness and associated psychiatric morbidity (Almoshmash, 2016).

For Syrian women, especially, social networks and family serve as important means of coping. Organizing charity and support groups and bazars can be a good way to feel connected and relevant (Al Akash and Boswall, 2015; International Medical Corps, Jordan Health Aid Society, 2013). In response to trauma, shame, and stigma, or the unfamiliarity of new cultural environments, some women may isolate themselves, refusing to engage in old routines or adopt new ones. Displacement makes it difficult to maintain pre-settlement daily routines. Syrian women report using passive coping strategies such as sleeping, crying, smoking cigarettes and seeking time alone (International Medical Corps, 2012). UNHCR has recognized that refugee and asylum-seeking women are key to addressing the current crisis (UNHCR, 2001). If they are engaged as active and dynamic participants, and receive appropriate support for self-care through receiving country policies, women can play a central role in promoting mental health in their families and communities (Spitzer, 2006).

Syrian men may not feel comfortable seeking other ways of dealing with distress due to feeling helpless or due to the cultural expectation that men not show weakness to maintain their “masculinity” (Farhat *et al.*, 2018; Hasoon, 2015). It is important to advocate for these men and assist them in finding work rapidly after settlement in Western countries in order to prevent social marginalization, isolation and deterioration of their mental health.

There may be a tendency among traumatized individuals in unfamiliar environments to avoid situations where they can learn new skills, leading them to insulate themselves from corrective experiences. The principles of self-management developed in health psychology, and Bandura’s theory of self-efficacy emphasize individuals’ capacity to learn to carry out specific tasks using their own resources and skills (Bandura, 1977). This theory can inform strategies for building resilience and improving psychosocial functioning. A strong sense of self-efficacy leads to confidence in one’s ability to achieve goals (Benight and Bandura, 2004). Learning to reappraise problematic situations and rethinking ways to respond can help individual’s resolve some of their problems and set up a positive cycle for further adaptation and recovery. Resilience-focussed interventions with Syrian refugee groups in the neighbouring countries to Syria have been applied with remarkable success (Ziter, 2017).

### ***Provide psychosocial support***

Educating refugees about the varied responses to trauma, and available resources for physical and mental health is a key while establishing rapport. Many people may not understand that behavioural changes and symptoms they experience (e.g. becoming isolative, aggressive or fearful) are manifestations of being mentally unwell. Talking about common, non-stigmatized manifestations of stress like changes in concentration, sleep and appetite may be a good way to begin a more thorough mental health assessment. Somatic symptoms may be prominent in clinical presentations of refugees with mental health problems. Integration of mental health care in primary care settings is ideal. Educating refugees about the somatic components of reactions to trauma, and the role of mental health practitioners in the healthcare system of healthcare referrals may relieve the confusion and concern of a referral to psychology or psychiatry (Hinton and Otto, 2006; Hinton *et al.*, 2006).

Health care providers can help refugees build social “mastery” by restoring relationships and a sense of community, which are central to the well-being of the person (Van der Kolk, 2015). Social support, including interactions with family, friends and caring professionals can play a particularly important role during major transition periods by enhancing coping, moderating the impact of stressors and promoting health (Simich *et al.*, 2005). Unfortunately, for many Syrian refugees this valuable family support may not be available, due to loss, separation and the lengthy process of family reunification. Because family is held in high esteem for Syrians, it is common to bring a family member along to health care visits. This should be used as a valuable opportunity to educate and help support the individual within the unit of the family.

Cultural and linguistic barriers can make it more difficult for refugees to access mental health services, and it is important to find ways to address these problems and ensure the availability of trained medical interpreters to aid this. Culture brokers, who can clarify cultural differences between the perspectives of patient and provider, can supplement linguistic interpretation (Kirmayer *et al.*, 2013).

Social and community workers have a professional duty to advocate for the human rights of refugees, and to work with them to achieve civic and social integration in their new communities (Nash *et al.*, 2006). Providing family-friendly living accommodation, teaching positive parenting skills, and facilitating access to education and health care are key forms of support for refugee families (Fegert *et al.*, 2018). Finding meaningful employment will improve overall well-being and foster better integration with the host community.

### *Consider psychological therapies*

For some refugees exposed to complex trauma or for those who present with a diagnosable mental disorder, more intensive clinical interventions may be required. Refugees from Syria represent a diverse population, and therapists are advised to consider the sociocultural nuances of each individual case (Kirmayer and Gómez-Carrillo). In general, an existential approach to psychotherapy that acknowledges their social world and predicament is useful when working with refugees and trauma survivors. This begins with creating an environment where the refugee feels at ease and confident that the therapist will be there for them consistently over time. Therapists are advised to allow refugees to tell their story at their own pace (Kinzie and Fleck, 1987). Avoidance is a common defence mechanism in cases of trauma and influences the refugee’s openness to discuss certain topics at different stages of the therapy. Focussing on the “here-and-now” and present-day stressors, trying to help the refugee “work through” post-settlement life stressors, and encouraging the use of available community support are crucial to establishing and maintaining an effective therapeutic alliance.

There are very few studies of Syrian refugees’ response to psychotherapy in countries of temporary refuge. In line with treatment guidelines for PTSD among refugees with other backgrounds, a course of trauma-focussed treatment should be offered to refugees seeking treatment for trauma-related symptoms (Ter Heide *et al.*, 2016). Trauma-focussed treatments include narrative exposure therapy (NET), culturally adaptive cognitive behavioural therapy (CA-CBT) and EMDR. A recent meta-analysis by Lambert and Alhassoon (2015) looked at the efficacy of trauma-focussed therapy for refugees (Lambert and Alhassoon, 2015). They found a large effect size (especially for NET and CA-CBT) for trauma-focussed treatment in refugees, both for PTSD and depression. These results provide evidence for the efficacy of trauma-focussed therapy for treating refugees, and point to important areas for future research. A recent study using EMDR on Syrian refugees in Turkey had some promising results; however, further studies with larger samples are required (Acarturk *et al.*, 2015).

These modalities should be considered in post-settlement settings. However, caution is advised and the use of such modalities should include outcome evaluation, because differences in treatment settings and culture compounded by post-settlement stressors and dynamics, may influence their effectiveness. We emphasize here the importance of a careful diagnostic formulation that takes into account social and cultural contextual factors that may mediate the individual’s response to therapeutic interventions.

### *Use medication when indicated*

For the minority of Syrian refugees who are suffering from severe and disabling mental disorders treatment with medications may be an important part of their care. Thorough assessment is especially important because refugee populations commonly suffering from a wide variety of comorbid conditions (Hollifield *et al.*, 2002). Treatment of comorbid mental and physical conditions may require multiple medications, increasing the risk of drug-drug interactions and side effects. Issues of non-compliance are common (Kane *et al.*, 2013) and culturally informed psychoeducation may improve compliance.

Being prescribed medication can legitimize the sick role and provide an acknowledgment of the reality of the individual's suffering. However, given the high prevalence of stigma, being labelled as a psychiatric patient or receiving "psychiatric" medications may have its own personal and social costs. Here again, exploring the meaning of medication and negotiating treatment through a patient-centred approach is essential (Kirmayer *et al.*, 2016).

### **Conclusion**

In this guide for practitioners providing care to Syrian refugees, we have emphasized the importance of considering the unique social and cultural dimensions of their predicament. Each individual has their own trajectory and a person-centered approach is essential for adequate assessment and appropriate care. The UNHCR report on the mental health and psychosocial well-being of Syrians provides a comprehensive review of social context, cultural frameworks, and related issues (Hassan *et al.*, 2015). As practitioners acquire more experience working with resettled Syrian refugees knowledge of effective approaches will increase. At present, the tools available from cultural psychiatry provide a solid starting point to for culturally responsive care (Kirmayer and Gómez-Carrillo, 2019).

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## Corresponding author

Nadim Almoshmosh can be contacted at: [nalmoshmosh@standrew.co.uk](mailto:nalmoshmosh@standrew.co.uk)

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