

Mental Health and Psychosocial Needs of Syrian Refugees: A Literature Review and Future Directions

Asli Cennet Yalim
Isok Kim

Abstract: *Since 2011, the Syrian refugee crisis has resulted in a massive displacement of Syrians, inside and outside of Syria. The enormous psychosocial needs of displaced Syrians have been documented by various reports and studies. With expected arrivals of Syrian refugees resettling in the United States in the near future, the intensity of the challenges for both resettlement agencies and the Syrian refugees themselves are expected to increase. A literature review was conducted for publications produced between March 2011 and January 2017. Academic and grey literature were explored to provide an overview of the psychosocial well-being and cultural characteristics of Syrians. Additionally, current models were analyzed to identify future directions for social work practice. It is vital to understand the Syrian refugee crisis through a multidisciplinary lens. Responding to the challenges found among Syrians requires deliberate consideration for sociocultural, historical, and political issues that uniquely describe them and their contexts. Identifying psychosocial needs may facilitate other aspects of resettlement outcomes, such as employment, education, and social integration. Incorporating a holistic model that reflects trauma-informed and human rights perspectives into clinical as well as policy practices is critical for better overall resettlement outcomes for Syrian refugees, and refugee populations in general.*

Keywords: *Syrian refugees; refugee mental health; refugee crisis; refugee resettlement; psychosocial wellbeing*

As of May 2017, over 13.5 million displaced Syrians were in need of humanitarian assistance (USAID, 2017). On average, 3,300 Syrians arrived in neighboring countries every day in 2014 (e.g., Turkey, Jordan, Lebanon, Iraq, and Egypt), creating a large burden on the host countries (Zetter & Ruaudel, 2014). Not all Syrians who have crossed into neighboring countries are registered refugees. Even though nearly half of the Syrian population has been displaced since the crisis began in 2011, only 5.2 million are formally registered as refugees (United Nations High Commissioner for Refugees [UNHCR], 2017). Thus, the majority still do not have refugee status as recognized by the international community. The government of Turkey, alone, has registered almost 3 million Syrians (UNHCR, 2017). The large number of refugee arrivals has begun to exact severe negative social and economic tolls on the region (Zetter & Ruaudel, 2014). Given the host countries' own political and societal challenges, they are having a difficult time meeting even the basic needs of the refugees, and lack sufficient capacity to cope with the vast influx.

Addressing the Syrian Refugee Crisis

Refugee flows are the result of regional and international conflicts, contributing to social and political instability in neighboring countries (Newman & Selm, 2003). Over the

Asli Cennet Yalim, MSW, Doctoral Candidate, University at Buffalo, School of Social Work. Isok Kim, PhD, University at Buffalo, School of Social Work.

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past 50 years, the globalization of technology and communication has popularized images of refugees. Thus, there is a constant reminder of what is assumed to be a “flood” of refugees from “Non-Western” countries to the “West” (Gale, 2004, p. 336). The images of the refugees attempting to cross from Turkey to Greece, and then to other European countries, have been intensified by traditional news and social media outlets. These visual images are often used by governments or media to create political rhetoric around national security in resettlement countries that undermine efforts to provide safety for refugees and their families (Gabiam, 2016; United States Congress House, 2015). Therefore, countries like the United States acknowledge that they would actually prefer these refugees to stay in the region, closer to their home country, and deliver humanitarian assistance through neighboring countries. In 2015, the U.S. government announced that nearly \$419 million would be provided for those affected by the war in Syria (U.S. Department of State, 2015). The monetary aid allows international aid agencies to work in collaboration with host countries to provide shelter, food, water, healthcare, education and employment for Syrian refugees (UNHCR, 2014a). Providing financial support to the neighboring host countries could prevent Syrians from seeking assistance abroad. However, the large numbers of people in need make it extremely difficult for humanitarian organizations to manage even the basic needs of refugees; despite receiving aid from the international community, only about 54% of the money is spent on the direct care of Syrian refugees (Center for Middle Eastern Strategic Studies, 2014). Although keeping refugees in the region may have seemed like a good idea at first, providing financial aid to neighboring host countries may not be a long-term solution to meet refugees’ health and psychosocial needs. Countries with more stable political, social, and economic environments can afford to provide better health care services, social services, education for children of refugee families, employment, job-training opportunities, and housing options for displaced populations like the Syrians.

The lack of appropriate services in neighboring host countries to meet the basic needs of refugees, such as food, housing, and safety, has meant that addressing mental health services has not been a priority for refugees in the region. It is nearly impossible for humanitarian organizations to follow up on the healthcare needs of refugees because of refugees’ relocation patterns in neighboring countries. For instance, Turkey has an unconditional “open door policy” that allows Syrian refugees to move freely within the country’s border. Only about 10% of the Syrian refugees live in camps throughout Turkey, while the rest of them live either in cities along the Turkey-Syrian border, or are dispersed throughout the country (Ferris & Kirişci, 2015). Thus, humanitarian organizations are only able to reach a small percentage of Syrians in need, and are unable to follow-up on their physical and mental health needs. Even in refugee camps, many mental health issues and psychosocial needs are not being addressed because of limited monitoring capacity (Aziz, Hutchinson, & Maltby, 2014). Mental health and psychosocial services barely exist for Syrian refugees residing outside of the camps in neighboring host countries, who are colloquially referred to as “urban refugees” (UNHCR, 2015). They live in cities, towns, and rural areas, often in dire circumstances, and are not easily reachable by humanitarian aid organizations (Cultural Orientation Resource Center, 2014). These logistical barriers make it challenging for academic researchers to carry out studies beyond basic needs assessments on Syrian refugees’ mental health status (Jefee-Bahloul & Khoshnood, 2014).

The neighboring host countries lack long-term refugee policies, resulting in their seeking ways to resettle Syrian refugees in countries that have established resettlement policies. Even though these countries, such as the United States and Canada, have limited mental-health-related services tailored to refugees, they have other policies that can lead to improvements in providing these services to the Syrian refugees. For instance, the United States has the Office of Refugee Resettlement incorporated into the Department of Health and Human Services, which provides assistance for accessing health care, housing, and employment services (Office of Refugee Resettlement, 2016; Pace, Al-Obaydi, Nourian, & Kamimura, 2015). With these basic necessities secured, there is a greater possibility of identifying psychosocial needs and connecting refugees to the appropriate services.

However, the executive order banning travel from seven Muslim countries, which initially went into effect on January 27, 2017, has begun to have a significant impact on individuals and families from these countries, including Syria. It has reignited the debate about whether to further restrict existing refugee processing and security screening protocols. The resettlement program will be capped at 50,000 refugees for the 2017 fiscal year, down from the 110,000-person ceiling instituted in the previous year (Migration Policy Institute, 2017; The White House, 2017). The order has limited the capacity of governmental and non-governmental organizations to respond to the needs of refugees, and created ambiguity globally (Spiegel & Rubenstein, 2017). It is now even more important to create awareness about the needs and challenges of incoming and resettled Syrian refugees, and refugees in general. Thus, this paper aims to provide a review of the current literature addressing the mental health and psychosocial needs of Syrian refugees, and to inform social work practitioners and scholars about the experiences and cultural characteristics of upcoming and/or resettled Syrian refugees in the resettlement countries.

Methods

The literature on refugee studies encompasses a wide variety of academic disciplines, including international relations, law, anthropology, sociology, economics, social work, geography, medicine, psychology, and history (Skran & Daughtry, 2007). The area of refugee studies lacks standard textbooks, a theoretical structure, and a systematic body of data. Researchers must be prepared to incorporate and modify ideas, concepts, and theories from multiple disciplines (Stein, 1986). Some academic journals have devoted certain issues to humanitarian crises; however, this does not guarantee that the information will be delivered to the target audience, such as humanitarian organizations workers, social services workers, and policy makers. Combining the academic and humanitarian platforms can allow professionals to share experiences, interact, and collaborate on needed mental health research areas (Jefee-Bahloul & Khoshnood, 2014).

Recognizing risk and protective factors for the psychological wellbeing of the refugees is a prerequisite for establishing a knowledge base for effective services (Beiser, 2006). To identify factors that play a role in the mental health of Syrian refugees, the literature review focused on articles and reports published between March 2011 and January 2017. Peer-reviewed journal articles were searched through academic and public databases, including PsychINFO, Social Work Abstracts, Academic Search Complete, Journals@Ovid Full Text, ProQuest, Google Scholar, and Medline. A combination of the following key terms

was used: Syrian refugees, Syria, refugee mental health, psychosocial wellbeing, mental health, refugee resettlement, PTSD, and trauma. Additionally, reports from various government agencies and non-governmental organizations were identified via their official websites, including The United Nations Refugee Agency and the World Health Organization (WHO). Grey literature from published chronicles and dissertations were also used to identify relevant literature for this study. Both academic and grey literature were searched using the following inclusion criteria: 1) Studies that examine only the mental health needs and psychosocial wellbeing of adult Syrian refugees, or 2) studies that examine both the mental health/psychosocial wellbeing and physical health needs of adult Syrian refugees. Studies about Syrians' mental health before 2011, when the Syrian conflict began, were not included in this review. Sixteen peer-reviewed journal articles and ten publications from the grey literature met the inclusion criteria. In this paper, the needs of displaced Syrians are reviewed and discussed according to this literature. Additionally, cultural/religious considerations and gender-specific issues emerged as sub-categories based on the review.

Results

Mental Health and Psychosocial Needs of Syrian Refugees

Many displaced Syrians experience a variety of mental health problems, including distress, sadness, fear, anger, nervousness, disinterest and hopelessness (UNHCR, 2014b). Severe emotional disorders, including depression and anxiety, are the most common mental health problems (54%) the refugees experience (Hijazi & Weissbecker, 2015), with the reported problems causing disruptions in their daily functioning. The stressors faced by Syrians can be classified into three major categories. The first stressor category contains concerns regarding security and protection, such as difficulties obtaining legal status and protection in the host countries, and worries about protecting children. The second category is about limited access to health services, especially for those who require continued care and follow up. The third category is about dealing with misconceptions that often paint Syrian refugees as exploiting their refugee status and diverting resources away from local residents, all of which contribute to increasing group tensions that already existed (Hijazi & Weissbecker, 2015).

Since the Syrian Crisis began in 2011, only a handful of studies have been published examining the mental health and psychosocial needs of Syrian refugees. Almost all of these studies were conducted in either refugee camps or in clinics in one of the neighboring host countries. Barriers to conducting academic research in the region hinder the ability to identify and meet the support and treatment needs of Syrians (Jefee-Bahloul & Khoshnood, 2014). The number of Syrians in need is expected to increase due to the lack of mental health care and professionals in the region. Approximately 600,000 Syrians are estimated to need treatment for severe mental illness, and another 4 million may be suffering from mild or moderate mental health problems (WHO, 2015). The large number of people in need makes it difficult to assess the impact of displacement on the mental health of the population, and to deliver the appropriate services and treatments. In addition, the stigma attached to individuals with a mental illness, and their families, may make it even more

difficult to deliver mental health services to Syrian refugees. For instance, 354 Syrian refugees in a refugee camp in Turkey were asked about their openness to a referral for psychiatry and tele-mental health, which is the use of technology to offer treatment options and accessibility for people with mental illness (Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014; Nelson, 2008). Even though 41.8% of the sample met the criteria for posttraumatic stress disorder (PTSD), only 34% reported the need to see a psychiatrist. Of those, only 45% were open to mental health services via technology. Their reported reasons for declining tele-mental health services were privacy, distortions in the doctor–patient relationship, and unfamiliarity with the technology (Jefee-Bahloul et al., 2014). According to Hassan et al. (2015), many Syrians were also skeptical about psychology, psychiatry and utilizing mental health services in the past, which created a negative perception of mental illness, along with the fear of being stigmatized. Before the crisis, most Syrians viewed mental illness as something that brought shame to the family, and Syrians with mental health needs were usually reluctant to seek professional help. Today, however, with such a large increase in the level of psychological distress among Syrian refugees, they might be more open to seeking professional help for mental health and psychosocial support (Cultural Orientation Resource Center, 2014; Hassan et al., 2015).

El Chammay, Kheir, and Alaouie (2013) conducted an assessment in Lebanon's different districts to gather detailed information about the quality and coverage of services for Syrian refugees. The study illustrated four levels of activities based on the assessment: basic services and safety (Level 1); strengthening community and family support (Level 2); focused non-specialized psychosocial support (Level 3); and specialized or clinical services (Level 4). Focused non-specialized psychosocial support accounted for 52.4% of all activities, while 37.3% of service activities concentrated on strengthening community and family support. This assessment points out the importance of non-specialized psychosocial support services and community programs, which can facilitate improved responses to the present problems of Syrian refugees, and reduce the stigma attached to mental health treatment among Syrians.

Recognition of the Syrians' experiences is critical to evaluating their mental health. Hassan et al. (2015) stressed the need to consider the following conditions for delivering appropriate services: 1) manifestations of pre-existing mental disorders; 2) conflict-related violence and displacement; and 3) the post-emergency context, such as those related to living conditions in the host countries. Almost no data is available regarding pre-existing mental disorders of Syrians before the war. However, the number of Syrians with severe mental disorder symptoms might have increased given risk factors such as potentially traumatic events, forced displacement and loss of social support (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). Additionally, the largest psychiatric hospital in Lebanon reported increased admissions of Syrians after the crisis started (Lama, François, Marwan, & Sami, 2015). Both internally and externally displaced Syrians have faced war-related violence, including massacres, murder, torture, hostage-taking, enforced disappearance, rape and sexual violence (Hassan et al., 2015); these potentially traumatic events increase the possibility of mental health concerns among displaced Syrians. Aside from the impact of pre-resettlement conditions on mental health, Syrians who flee Syria and arrive in a host or a resettlement country may experience further difficulties due to

poverty, loss of livelihood, unemployment, and limited access to housing, health care, and education (Hassan et al., 2015). These conditions do not necessarily result in mental disorders but it is important to differentiate pre- and post-resettlement contexts when helping Syrian refugees. This type of approach to assessment may reduce the propensity to simply label refugees with mental illnesses and allow service providers to deliver more appropriate services.

The approaches that national and international organizations have adopted toward the mental health care of refugees have been criticized for their focus on Western psychiatric categories, as these approaches pay little attention to the social, political and economic factors that play a vital role in refugees' lives (Jeon, Yoshioka, & Mollica, 2001). An overemphasis on traditional counseling models and individualistic theoretical approaches may also devalue some of the refugees' cultures that are more collectivistic (Brown, Jones, Nilsson, Russell, & Klevens, 2006). Although post-emergency, context-related studies are almost non-existent, most studies in the developing literature on the mental health of Syrian refugees still focus on psychiatric diagnosis and treatments (Acarturk et al., 2016; Alpak et al., 2015; Lama et al., 2015). Trauma-focused models highlighting pathologies may not always be helpful for refugees whose immediate needs are social and economic (Hutchinson & Dorsett, 2012). Institutional and treatment services that pay more attention to refugees' own perceptions and expressions of their needs can be a more appropriate approach for delivering services. It is critical that intervention studies with Syrians and other refugee populations take cultural and sociopolitical context into consideration, to bridge between research and practice with refugees.

Cultural and Religious Considerations

It is important to understand and distinguish among the cultural and religious value systems of Syrians when exploring the perspectives of families and individuals, and when evaluating the psychological and social problems they face. Hassan et al. (2015) underlined the wide diversity of socioeconomic, ethnic and religious backgrounds found within the Syrian population, which influence the dynamics and relationships among members of the Syrian communities and families. These varied backgrounds may have some common religious and cultural characteristics but providers should take care not to overgeneralize these characteristics when delivering services.

As noted by Moustafa (2015), it is difficult to develop a single, generalized Arab or Muslim view on the concept of mental health. Nonetheless, there are several common themes that are unique to Middle Eastern cultures. For instance, the concept of *majnoon*, which roughly translates to "crazy person," "mad," or "insane," is often used to describe individuals who need psychiatric attention. "The symptoms/behaviors associated with *majnoon* overlap with those of psychotic disorders, such as schizophrenia, but not with common mental disorders such as depression, anxiety or posttraumatic stress disorder" (Hassan et al., 2015, p. 24).

It is common to experience and interpret psychological symptoms physically rather than emotionally (i.e., psychosomatic symptoms) in non-Western cultures (Bou Khalil, 2013; Dwairy, 2006). Arabic and Syrian idioms describe distress with both somatic

complaints and psychological symptoms (Hassan et al., 2015). Similarly, a Syrian in need of psychological help may use metaphors, expressions, or proverbs to express distress. The somatic symptoms can be expressed in the Syrian context as heaviness in the heart, cramps in the guts, burden or weight on the chest, or having the feeling of ants crawling over the skin (Hassan et al., 2015). Understanding these cultural expressions of mental health symptoms may allow mental health providers to properly interpret psychological and physical complaints.

Syrian refugees struggle with their sudden loss of autonomy, sense of control over their lives, and loss of their family members and homelands (Hassan et al., 2015; Moustafa, 2015). The idea of carrying on a new life in foreign places causes anxiety, fear, uncertainty, frustration, and emotional disturbances. These experiences influence social functioning and/or result in specific symptoms that may be the criterion for the diagnosis of a mental disorder. Thus, it is important not to over-diagnose Syrian refugees with clinical disorders, since their experiences cannot be described strictly using Western-based, evidence-driven medicine (Bou Khalil, 2013; Hassan et al., 2015). Daily concerns about their safety and difficult life circumstances may exacerbate their mental health conditions, which might contribute to developing mental disorders, but will also contribute to a feeling of demoralization and hopelessness. Improving their circumstances and delivering appropriate services can significantly improve their mental health, which may not then require any psychiatric interventions.

Gender-Specific Considerations

In Syria and neighboring countries, women and girls are strongly affected by the recent conflict. Meeting their basic rights, such as safety, health, and education, are immensely important because women are essential stakeholders in a post-conflict reconstruction and recovery process (Sami et al., 2014).

In the Syrian culture, although men have historically been perceived as protectors of the family, this perception has now dramatically changed. Women continue to take care of the family; their workloads have increased while men's workloads have decreased overall because legal restrictions make it difficult for Syrian men to find employment in the host countries. Thus, they experience boredom, disempowerment, and low self-esteem. Lower self-esteem may lead refugee men to express their masculinity negatively. For example, these feelings are used as excuses to act violently against family members. This has contributed to an increase in gender-based violence among Syrians (Anani, 2013; Charles & Denman, 2013). Syrian refugee men reported that they are physically aggressive toward their spouses and children (UNHCR, 2014b).

The lack of employment among Syrian refugees has also disproportionately affected women and youth. Child labor and survival sex among young girls have increased, with refugee households succumbing to impoverishment, and issues of their immediate well-being rising (El Chammay et al., 2013; Zetter & Ruaudel, 2014). Girls as young as 10 years old have been used for prostitution. The number of early marriages has increased, because families want to "protect their daughters from being raped and ensure that they are under the protection of a man" (Anani, 2013, p. 76). Many families also arrange marriages for

their young daughters in order to alleviate financial burdens. They believe that girls can be protected if they are married into a more financially secure family (Charles & Denman, 2013). However, this results in marriages happening at a very early age for these girls. Some families even resort to selling their daughters to older men in order to decrease their overall family expenses. According to aid workers in Lebanon, young girls and women also consider prostitution in order to provide money and food for their families (UNHCR, 2013). This issue is not restricted to Lebanon; in some camps in Turkey, women have been sold under the guise of “temporary marriage.” Two women refugees, who act as companions to male customers at a bar in Turkey, explained that women between the ages of 15 and 50 have been sold for up to 5,000 Turkish Lira (about \$1700 US Dollar) in the camps (Acarer, 2015). These arrangements are not only made by families; there are also many organized illegal groups involved in this issue. Government controls in the camps are inadequate for preventing Syrian women and girls from facing these challenges.

Sami et al. (2014) underlined the fact that these risks to refugee women and children are significant, and that gender-based violence (GBV) might worsen as the conflict in Syria continues. The lack of adequate shelter caused by overcrowded camps and high rent in urban areas increases the risks for women, particularly those in female-headed households. In Jordan, nearly half of households headed by females have no monthly income, and mainly survive on donations. Additionally, women and girls are exposed to harassment, including offers for sex and marriage in the community (CARE, 2013).

Syrian parents and other family members also end up demonstrating poor parenting skills due to distress borne out of their refugee-related experiences (James, Sovcik, Garoff, & Abbas, 2014). Refugee household members spend time at home, and rarely socialize due to safety and security concerns for women and children. Males who are the heads of households feel depressed, anxious, and useless since they are unable to adequately provide economic and psychological safety for their families. Fathers are also ashamed that their children are unable to continue their education, and that some male children are working at low-paying and harsh jobs to help support their families (CARE, 2013).

Some researchers looked into the psychosocial needs of Syrian refugee women through studies that included women’s health conditions. A needs assessment conducted in Lebanon indicated a significant relationship between violence and reproductive health among displaced Syrian women. Thus, better reproductive health services in refugee settings, along with referrals to psychosocial services, are immediate needs for refugee women (Masterson, Usta, Gupta, & Ettinger 2014). According to the UN Population Fund, about 1.7 million women need access to reproductive health services (as cited in Sami et al., 2014). However, many women are unaware of reproductive and psychosocial services provided by humanitarian organizations and NGOs available to them (Al-Qdah & Lacroix, 2017; Charles & Denman, 2013). In the long term, the loss of education about, and access to, reproductive health may contribute to negative effects on their well-being in terms of fertility, health of offspring, and maternal care (Charles & Denman, 2013).

Another important issue for Syrian refugee girls is their inability to continue their education due to the conflict. These girls are at risk of survival sex and early marriage. Furthermore, school-aged children without access to education severely compromise their

chances to lead a stable life in the future, as they are more likely to suffer from prolonged psychological stress (Charles & Denman, 2013). Access to education at all ages is one of the priorities in supporting children's mental health and well-being (Patton et al., 2016). Promoting schooling in each neighboring country could directly affect children's future. However, in some cases, refugee children are the family breadwinners because it is easier for them to find paid work in host countries like Turkey (Human Rights Watch, 2015). Not being able to provide for their families and witnessing their kids' vulnerability due to financial and social struggles may additionally contribute to parents' sense of powerlessness and psychological distress (Dejong et al., 2017). Access to education for refugee children may reduce child labor, deter early marriage and recruitment by armed groups, foster their mental health and resilience, strengthen social cohesion, and raise hope for an entire generation (Human Rights Watch, 2015; UNICEF, 2014). Securing education for children can be done through advocacy by establishing minimal accreditation standards, assessing and monitoring children's vulnerability, strengthening institutional mechanisms and referral systems; fostering awareness among parents about available educational options in host countries, and addressing gender-based violence and specific needs of girls (MSYD, 2017; UNICEF, 2014).

Practice and Policy Recommendations

There have not been any studies published that look into resettlement outcomes of Syrian refugees in the United States. Among the reasons for the lack of studies are the disputes over resettling Syrians in the United States, with strict screening processes and only a relatively small number of resettled Syrian refugees to date. In addition, Syrian refugees resettled in the United States have mostly been assigned to places where they have personal or family connections (Welsh, 2015). Thus, Syrians are not usually placed together in the same towns or cities, but are scattered throughout the United States, which makes it difficult to conduct a viable study.

The expected arrivals of Syrian refugees in the near future means that the number and intensity of challenges for both the resettlement agencies and the Syrian refugees themselves are also expected to increase. The following intervention and policy recommendations are made to deliver better services for Syrian refugees—those who are already resettled and those who will be resettling in the United States in the future.

Elements of Effective Interventions with Syrian Refugees

With the number Syrian refugees ever-increasing, it is crucial that refugee mental health models respond to the needs of the population in relevant and appropriate ways. Multi-layered models that are used by UNHCR programs in the pre-resettlement context have been helpful for Syrian refugees in camps and urban settings (Budosan, Benner, Abras, & Aziz, 2016; Hassan et al., 2015). These models can be adapted to refugees' post-resettlement settings. The programs include four layers: 1) Basic services and security; 2) community and family support; 3) focused psychosocial or non-clinical support; and 4) clinical/psychiatric services (Hassan et al., 2015). Security is an important aspect because most persons with early posttraumatic symptoms are expected to recover if conditions of safety are re-established (Jefee-Bahloul, Barkil-Oteo, Pless-Mulloli, & Fouad, 2015).

Thus, a basic needs assessment along with a mental health screening can be helpful during the first months of resettlement. Providing this type of assessment is critical within the first three months so that appropriate referrals can be made while refugees still have access to intensive case management. Some elements beyond basic and safety needs can be added to the second and third layers of the models for the Syrian population in the post-resettlement context. Efforts should support individuals to restore relationships and build healthy patterns of interaction. This can be accomplished through creativity-based programs using the arts (e.g., theatre, singing, drawing, or poetry) and community activities designed to attract people with social events, educational workshops, cultural shows, or community dialogues (Jefee-Bahloul et al., 2015; Nazzal, Forghany, Geevarughese, Mahmoodi, & Wong, 2014).

A few psychosocial and community-based interventions were tested with Syrian refugees in Turkey and Jordan. Budosan et al. (2016) implemented a three-component model with urban Syrian refugees at an outpatient health center and a community center. First, a mental health team received comprehensive training to become familiar with intervention, and with issues among displaced Syrians. The second component consisted of non-intrusive care and support through assessing the needs and concerns of refugees. The last component included educational activities (English, Turkish language, computer classes, etc.), vocational activities (cooking, journal & media design, graphic design, a beauty course), and recreational activities (children's activities, cinema, music, etc.). These activities aimed to restore social cohesion, and to rebuild trust and capacity. According to the results, there were improvements in resilience and general well-being measurements. The model seems to meet the increased demand for context-sensitive, multi-level, and community-based interventions. Another study was undertaken at the Zaatari refugee camp in Jordan. It was based on a vocational program with women refugees (Jabbar & Zaza, 2016). The results indicated that women's confidence, self-esteem, and skills improved; the program helped women to generate income to build a better life, and gave them hope after experiencing conflict-related traumas. One last intervention study with Syrian refugees was conducted at an urban area in Jordan. It was designed to help refugees rediscover their basic psychological needs, learn how to satisfy them in small but meaningful ways that are achievable within their circumstances, and promote well-being within their new way of life (Weinstein, Khabbaz, & Legate, 2016). The intervention aimed to enhance need satisfaction through encouraging small acts that facilitate closeness and reconnection with family or loved ones, instill a sense of achievement and engagement in interesting acts, and encourage self-congruent decision-making. This intervention reduced need frustration, symptoms of depression, and general stress. Although these studies were conducted in host countries, the findings offer ideas about what might work for Syrian refugees in the United States, or in any other resettlement country. Utilizing a similar integrated approach with multilayered services can be helpful to improve the psychosocial wellbeing of Syrians.

Some Syrian refugees may need a social space where they can share their challenges and deal with their past experiences. This element does not usually require clinical treatment; rather, it is a psychosocial support group that re-creates social networks and facilitates engaging in meaningful daily activities (Hassan et al., 2015). Community

members from refugee groups can be good candidates for a role in peer-to-peer support. Prominent individuals in communities (e.g., imams, leaders, and women with strong social networks) need to be consulted on traditional ways of healing and the appropriateness of the model. Mental health professionals can play an instrumental and supportive role in this type of intervention but not a lead role in facilitating pathways of natural recovery from stress (Silove, 2004).

Psychosocial but non-clinical groups can also be developed with Syrians, using a strength-based perspective. According to Boswall and Al Akash (2015), stigma and isolation are common among Syrian women in Jordan due to limited resources and a lack of networks. An intervention that targets this and similar populations may create contexts in which silent and isolated people can be reached (Fitzsimons & Fuller, 2002). Facilitating groups at smaller, local facilities can be helpful for increasing participation in activities in both pre- and post-resettlement contexts. Thus, there should be creative solutions to increase participation by isolated people, and decrease the stigma about mental health.

A further area of study into the mental health of refugees should also consider the circumstances in resettlement countries. Studies of refugees' mental health have a tendency to emphasize the impact of past traumatic events, particularly in the country of origin and/or in the process of flight (Kim, 2016). Scant attention is paid to the impact of post-resettlement experiences on mental health. Competently designed and implemented interventions that focus on long-term benefits and on sustainability are what refugees need once the resettlement agencies have departed the scene (Williams & Thompson, 2011).

Resettlement Policy

Addressing mental health services may not become a priority even after refugees resettle in the United States because the U.S. refugee resettlement policy focuses heavily on refugees becoming self-sufficient in a short time (i.e., 6-8 months; Beiser, 2006; Pace, et al., 2015). This policy offers overseas and domestic medical screening guidelines for every refugee who resettles in the U.S. (Centers for Disease Control and Prevention, 2013). The guidelines are designed to ensure that refugees' health problems do not become obstacles to employment, and the focus is primarily on screening for communicable diseases. However, this may mean that significant opportunities to protect the refugees' mental health are being missed through the narrow focus on their employability based purely on physical health status.

Even for the U.S. population in general, navigating the complex U.S. healthcare system and getting access to mental health services are challenging because of stigma, cost, and a shortage of mental health care professionals (Bushak, 2016). Difficulties in understanding the U.S. health care system limit accessibility to services for refugees as well. In 2015, the Office of Refugee Resettlement implemented the Refugee Health Promotion Program to increase health literacy among refugees (Office of Refugee Resettlement, 2016). This program relies on self-sufficiency in navigating the complex U.S. healthcare system (Pace, et al., 2015). Given the difficulties refugees face in trying to be self-sufficient in such a short time, language and structural barriers, it is critical to implement policies and programs that provide easier pathways for refugees to access care services, as well as comprehensive

health education programs (Beiser, 2006; Pace et al., 2015).

Improving ways to detect mental health needs early in the resettlement process may facilitate a better adjustment by the refugees overall, which would have a subsequent positive impact on other aspects of resettlement outcomes, such as employment, education, and social integration. For instance, poor mental health outcomes are associated with unemployment and social isolation among resettled refugees (Blight, Ekblad, Persson, & Ekberg, 2006; Hollander, 2013). Paying more attention to psychosocial needs through a mandatory mental health assessment in the early stages of resettlement might improve daily functioning and long-term adjustment to the host country.

Taking intersectional characteristics of refugees into account—particularly for Syrian refugees—should be a prerequisite for policymakers. Being a refugee coming from an Arabic-speaking country may result in experiences of discrimination and xenophobia against Syrians. Despite a lack of evidence, Syrian refugees are considered a threat to U.S. national security (The White House, 2017). Political discourse about needing to implement stricter security measures in refugee screening and banning Syrian and other refugees from Muslim countries from entering the United States can normalize the enforcement of discrimination and exclusion. This rhetoric increases confusion and misunderstandings among local communities. The risks of everyday discrimination and micro-aggression attached to the political discourse can lead to psychological distress among those who are perceived to have minority characteristics such as gender, race, or religion (Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012). Initiating programs that bring social harmony, and changing the political rhetoric are critical for successful overall refugee resettlement, which would help to reduce misconceptions about the refugees. Implementing community-based protection strategies that include promoting refugee rights, creating public awareness on refugee issues, and preventing abuses may reduce negativity and hostility towards refugees in host countries (Al-Makhamreh, Spaneas, & Neocleous, 2012; Zetter, & Ruaudel, 2014). Having refugees take on advocacy roles may also protect and empower those who resettle in another country. Activities such as information dissemination, collective decision-making with consideration for sociocultural norms, and cooperating with agencies whose are responsible for serving the refugees can help transform policies and services at local, national, and global levels.

Bowen and Murshid (2016) suggest a conceptual framework in which trauma-informed care (TIC) can guide social policy and advocacy efforts to address social problems related to trauma. Of the five TIC principles (safety, trustworthiness and transparency, collaboration and peer support, empowerment, choice, and intersectionality of identity characteristics), the principles of safety and trustworthiness may be the most critical when instituting a policy for Syrian refugees, and for refugees in general. Policymakers should ensure that policies clearly articulate the importance of providing a basic safety net for refugees while guaranteeing that refugees are treated with dignity and respect. Identifying issues that arise due to the lack of trust between institutions and refugees may also facilitate the successful integration of refugees. A refugee policy with TIC principles can create new pathways for psychological safety among refugees because of TIC's commitment to preventing re-traumatization.

Finally, the role of social workers is to some extent ambiguous in host countries (e.g., Jordan) and academic programs lack staff with a degree in social work or experience (Al-Makhamreh et al., 2012). Internationally, there has been a lack of social work involvement in policy development, service provision and advocacy related to refugee issues (Harding & Libal, 2012). In host and resettlement countries, social workers should be acknowledged as key players in refugee policy decisions and delivery of psychosocial services. The international alliances between educators, practitioners, researchers from professional associations and social work educational institutions need to be built to address needs of today's refugees (Al-Makhamreh et al., 2012). Social work as a profession must advocate on behalf of displaced people and have a more activist role to promote social justice and human rights in *all contexts*; not only in Global North (Harding & Libal, 2012).

Conclusion

Addressing the mental health and psychosocial needs of Syrian refugees requires deliberate considerations of sociocultural and historical issues that uniquely describe Syrian refugees and the contexts that result in their refugee status. In addition to physical and mental health problems, the cultural, historical and political aspects of the Syrian refugee experience should be reflected in social work research, practice, and policy. Therefore, promoting research that is based on multidisciplinary perspectives incorporating various viewpoints about Syrian refugees' mental health may be vital. An understanding of unique issues involved in working with Syrian refugees would allow social work practitioners and scholars to deliver the most effective interventions, and improve policies to better serve Syrian refugees.

Several vulnerable and marginalized Syrian refugee groups (e.g., LGBTQ refugees, elderly group, and refugees with specific needs due to disability, injuries or chronic disease) could not be included in this review since the needs of these groups have not been addressed in the literature including social work. The risks these groups face due to limited services and discrimination escalate their psychological stress and contribute to their feelings of powerlessness. The needs of vulnerable and marginalized refugees must get more attention and be a part of humanitarian practice conversations to assist them to restore control over their lives (Al-Qdah & Lacroix, 2017; Hassan et al., 2015). These groups might be better identified through innovative methodologies such as participatory rapid appraisal or transformative mixed-methods (see Al-Qdah & Lacroix, 2017 and Mertens, 2012).

Other groups whose needs do not get adequate attention in the literature is older school-aged refugees such as high school- and university-aged Syrians. The official language in almost all neighboring countries is Arabic except Turkey; the country has hosted the largest Syrian refugee population. Turkish proficiency is the core challenge for especially older school-aged Syrian refugees (Karipek, 2017). The Lebanese curriculum also includes French and English depending on the school (Dejong et al., 2017). Lack of language proficiency results in low self-confidence and socialization, and feelings of inadequacy, insecurity, hopelessness and worthless in the host country. (Human Rights Watch, 2015; Karipek, 2017). Almost 50% of Syrians in Lebanon ages between 15 and 24 reported having thoughts about committing suicide (UNFPA, 2014). The mental health and

psychosocial needs of these individuals are evident. As the conflict in Syria enters its seventh year, the literature regarding these groups is still scant. There should be more local and global endeavors to make the needs of these groups more visible. Additionally, there is a need for a more concerted effort in developing social work scholarship on refugee mental health and wellbeing so that the role of social work as a profession and a discipline on these issues can globally and locally be recognized.

The length of the conflict and its effect on the displaced Syrian population will determine the future of refugees' migration patterns and needs (Dewachi et al., 2014). Organizations must ensure that their work strengthens the local systems in the region. The international arena needs to consider today's refugees as more than just a displaced group, but also as individuals on their way to becoming citizens of the future (Mollica & McDonald, 2002). Services that strengthen psychological well-being and prevent re-traumatization need to be adopted by international, national and local efforts. The impact of the conflict may well last a lifetime for Syrian refugees. Delivering services with a more holistic model for understanding refugee experiences, and adopting a human rights perspective and trauma-informed care to clinical and policy practices are critical to responding to the psychosocial needs of the Syrian refugee population and other refugee populations in a more effective and meaningful manner.

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Author note: Address correspondence to: Asli Cennet Yalim, MSW, Doctoral Candidate, School of Social Work, University at Buffalo, The State University of New York, 685 Baldy Hall Buffalo, NY 14260-1050. E-mail: asliyali@buffalo.edu