



A LITERATURE REVIEW

Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey:

Sources of Distress, Coping Mechanisms, & Access to Support

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TABLE OF CONTENTS

1. Introduction

2. Mental health and psychosocial context for Syrian refugees

- 2.1 Mental health and psychosocial problems, and major sources of distress
- 2.2 Local expressions of distress and culture-specific concepts of mental health
- 2.3 Explanatory models of mental and psychosocial problems
- 2.4 Concepts of the person
- 2.5 Coping strategies
 - 2.5.1 Overall strategies
 - 2.5.2 Individual strategies
 - 2.5.3 Coping strategies for men
 - 2.5.4 Coping strategies for women
 - 2.5.5 Coping strategies for adolescents
 - 2.5.6 Coping strategies for children
- 2.6 Role of Religion

3. Turkish Mental Health Care System

- 3.1 Mental Health policy, legislative framework and leadership in Turkey
- 3.2 Relative role of government, private sector, NGOs and traditional healers
- 3.3 Descriptions of the formal mental health services

4. Challenges facing Syrian refugees in accessing mental health services

5. Recommendations for future programing

6. Conclusion

1. INTRODUCTION

Humanitarian organizations responding to large-scale crises have the challenge of acting quickly and comprehensively, but in a way that takes into consideration the specific needs of the target population. Ideally, organizations should utilize resources available and adjust to the limitations present within each situation. To support the work of International Medical Corps (IMC) responding to the Syrian refugee crisis in Turkey, this report will review available literature on the unique mental health needs and coping strategies used by Syrian refugees, as well as the mental health services that are available in the country.

While the effects of the Syrian refugee crisis have been felt across the world, the countries adjacent to Syria have been the most impacted. In Turkey, it is estimated that by the end of 2016, there will be 300,000 Syrian refugees living in one of Turkey's official refugee camps and 2.45 million in urban or rural communities throughout the country (Turkey Regional Refugee & Resilience Plan, 2016-17). When Syrians first began fleeing to Turkey they were welcomed as "guests"; more recently, Turkey has recognized that these refugees are a permanent presence in the country, and have initiated policies to provide for the health, educational and livelihood needs of displaced Syrians (International Crisis Group, 2016).

2. MENTAL HEALTH AND PSYCHOSOCIAL CONTEXT

Before fleeing Syria and during the journey to Turkey, many Syrians have witnessed or experienced the death of loved ones, physical harm, violent and terrifying situations. The psychological impact of conflict-related violence coupled with the ongoing stressors related to displacement can have a significant impact on the mental health and psychosocial well-being of Syrian refugee adults and children. Some of these ongoing challenges include lack of resources, risks of exploitation, violence, discrimination, disruption of social networks, and lack of livelihood options. These challenges can result in a sense of hopelessness, which in turn contribute to psychological distress, increased family violence, diminished sense of dignity and control, and a reliance on negative coping skills (Hassan, Kirmayer, & Mekki-Berrada, 2015). Pre-existing mental health conditions may be exacerbated, or psychosocial distress may be brought on by daily stressors (Hassan et al., 2015).

As the conflict shifts into a protracted crisis, it is important to gain an understanding of Syrian culture-specific expressions of distress, healing practices, and coping strategies. Understanding the way in which Syrians may experience and cope with psychological distress and mental health problems can offer practitioners insight into how to be the most helpful. This can be used to develop programming that is most effective for the Syrian refugee population, shaping community initiatives to promote resilience and increase the use of positive coping mechanisms.

This review is intended to examine the overall landscape and current mental health context for Syrian refugees at a broad level. It is outside the scope of this report to evaluate the needs and recommendations for all sub-populations within the Syrian refugee community, however it should be noted that special consideration and evaluation should be conducted for these specific populations which account for a considerable portion of the refugee population, including services for SGBV survivors, torture survivors, the LGBTQI community, and those experiencing substance abuse issues.

2.1 Mental health and psychosocial problems and major sources of distress

A comprehensive review of the current state of mental health for Syrians, both internally displaced as well as refugees, conducted by Hassan et al. (2015), found that the primary issues for many Syrians are related to loss and grief. This includes loss of deceased family members as well as emotional, relational and material losses. Pervasive emotional problems that were identified include sadness, grief, despair, fear, anxiety, frustration and anger. Cognitive problems such as perceived loss of control, helplessness, worry, ruminations, boredom, and hopelessness are all widely reported. Some of the physical symptoms refugees identified including fatigue, problems sleeping, loss of appetite and medically unexplained physical complaints. Also common are social and behavioral problems such as withdrawal, aggression and interpersonal difficulties.

2.2 Local expressions of distress and culture-specific concepts of mental health

According to Hassan et al. (2015), while Syrians consider suffering a normal part of life, the concept of a “psychological well-being” or “mental health” is not commonly understood and can carry a negative association. When distressed, indirect, general expressions may be used to describe their current well-being, such as *ana ta’ban* (أنا تعبان, ‘I am tired’) or *nafsiyti ta’banah* (نفسيتي تعبانه, ‘my psyche is tired’). These expressions can represent a range of emotional symptoms. As with many Arabic communities, Syrian presentation of mental health problems may initially be expressed as physical complaints within a medical setting.

Below are common local idioms of distress that are used by Syrian populations; these idioms can be used to better understand the clinical meaning of an expression, to create a stronger alignment between the client and provider, and also to explain to clients the purpose of interventions. The content presented here follows the description and grouping of the report, “Culture, context and the mental health and psychosocial wellbeing of Syrians” by Hassan et al.

General distress:

- Heaviness/pain in the heart
- Cramps in the gut
- Pain in the stomach or head (similar to fatigue)
- Tightness in the chest
- Numbness of body parts
- The feeling of ants crawling over the skin

Fear and anxiety:

- ‘Habat qalbi’ (هبط قلبي) or ‘houbout el qalb’ (هبوط القلب), literally ‘falling or crumbling of the heart’, correspond to the somatic reaction of sudden fear
- ‘Khouf’ (خوف, ‘fear’) or ‘ana khayfan’ (أنا خيفان, ‘I am afraid’) are direct expressions of fear
- ‘Kamatni kalbi’ (قلبي قمطني, ‘my heart is squeezing’) or ‘atlan ham’ (عتلان هم, ‘I am carrying worry’) generally refers to anticipated anxiety and worry

Feeling nervous or tense:

- ‘Asabi’ (عصبي, ‘nervous’) is used to describe anxiety as a character or personality trait
 - Syrian adolescents in Jordan used ‘asabi’ to describe feeling easily irritated, angry or tense, and associated it with ‘getting upset over little things’
- ‘Masseb’ (معصب) is used to describe a person who is currently nervous, in a temporary state
- ‘Mitwatter’ (متوتر, ‘I feel tense’) is used for tension due to a specific situation, such as waiting for the results of an exam or expressing or having an opposing opinion to someone else

Sadness and difficulty in adjustment to an acute stressor:

- ‘Hozon’ (حزن, ‘sadness’) and difficulty in the face of an acute or sudden stressor may be referred to as ‘al-hayat sawda’ (الحياة سودا, ‘a black life’). The concept of ‘hozon’ can also be used for a state of grieving
- ‘Iswadat al dounia fi ouyouni’ (إسودت الدنيا في عيني, ‘life has blackened in my eyes’)
- Somatic complaints may include feeling a burden or weight on the chest, resulting in pain in the chest area or inability to breathe and the need for air, as well as loss of appetite, pain in the abdomen and chest, and/or sleep disturbances

Depression:

- While ‘hazon’ may signify a state of depression, this is more directly referred to by laypersons and mental health practitioners alike as ‘halat ikti’ab’ (حالة إكتئاب, ‘condition of ikti’ab’). ‘Ikti’ab’ may hold complex concepts, such as brooding, darkening of mood, aches and a gloomy outlook, and may be accompanied by a variety of medically unexplained somatic symptoms and fatigue, as well as signs of social isolation.

Lack of resources and helplessness:

- Lack of resources and financial hardship is often referred to as ‘al ayn bassira wal yadd kassira’ (العين بصيرة و اليد قصيرة, ‘the eye sees but the hand is short or cannot reach’)
- Expressions often used by Syrians to express helplessness are:
- ‘mafi natija’ (مافي نتيجة) ‘there is no use’),
- ‘hasis hali mashlol’ (حاسس حالي مشلول, ‘I feel like I’m paralyzed’)
- ‘inshalit, ma a’d fini a’mel shi’ (إنشليت, ما عاد فيني أعمل شيء, ‘I am hopeless’ and ‘I cannot do anything anymore’)
- mou tali ‘bi’idi shi’ (مو طالع بإيدي شي, ‘nothing is coming out of my hands’, which refers to the inability to do anything to change an undesirable situation)
- ‘lhat’ (إحباط), which refers to a mix of depressive feelings, frustration, a sense of defeat, disappointment and loss of hope

Cognitive symptoms:

- Symptoms of loss of concentration and memory, expressed with terms such as ‘mou aader rakkezz’ (مو قادر ركز, ‘I can’t focus’ or ‘I can’t concentrate’)
- Anger and aggressive behavior:
 - Anger may be the feeling that Syrian men express in place of sadness and anxiety. Crying, fear and sadness can be associated with weakness.
- ‘Mashkalji’ (مشكلجي, ‘troublemaker’) was used in Jordan to indicate children and adolescents who were often getting into trouble with neighbors or friends complaining about his/ her behavior

Madness:

- ‘Majnoon’ (مجنون) which means ‘crazy’, ‘mad’ or ‘insane’. The symptomatic expression of ‘majnoon’ appears to overlap with the psychotic disorders category of mental disorders (such as schizophrenia), but not with disorders such as depression, anxiety, or posttraumatic stress disorder.
- The word ‘manjoon’ has strong negative connotations and can be used casually to describe someone who is behaving in an unexpected or strange way, but does not always specifically refer to a mental disorder.

Suicidality:

- Because of the shame and stigma that is associated with suicidal ideation and suicide attempts, Syrians may choose to use indirect expressions to describe this, such as ‘they wish they could sleep and not wake up’ (itmana nam ma fik (إنماني نام ما فيق).

2.3 Explanatory models for mental and psychosocial problems

The explanatory models described below can be useful for informing culturally appropriate programs and mental health care, however, it is critical to view this information as one of many tools that may be utilized by a client. Syrians may use multiple models in order to understand concepts of mental illness and to explain their situation (Hassan et al., 2015) and therefore these should not be used to overgeneralize populations.

As an awareness about mental health issues have increased in Syria over the past few decades, many individuals who receive services report that their mental health issues stem from stressors and challenges in their life, as well as traumatic experiences or grief (Hassan et al., 2015). Many Syrians view the soul and the body as interdependent entities, and will describe the experience of their mental distress in physical, somatic terms.

However, for many, their religious lens will impact their understanding of mental and emotional problems. In Islam, the heart is the focal point of emotional distress, and so mental health practitioners may hear descriptions of mental illness emanating from the heart rather than the head (Hassan et al., 2015). Christian Syrians may have similar explanatory models as Muslims, but possibly with resistance to sharing emotional and mental distress.

For the Druze, mental illness explanatory models may incorporate elements of reincarnation, in which an individual suffering from a mental illness is being punished from something done in a previous life (Hassan et al., 2015).

- In addition, the concept of evil spirits (“jinn”, جِنّ), the “evil eye”, and of magic may be used to explain mental illness. Elements of jinn are also influential within Islam, and clients may describe themselves as “possessed, attacked or slapped by jinn” (Hassan et al., 2015) in order to explain their experience of mental distress.

2.4 Concepts of the person

Culture and religion strongly influence the Syrian concept of self; individual identity will be understood mostly in relation to those central concepts (Hassan et al., 2015). In particular, within Islam, each individual operates on a “social dimension” with specific rules of behavior that must be followed; outside of that operates a “universal dimension” that is directed by the will of God. The concept of fate plays a large role on both of these dimensions, in that it is believed that submission to fate is in fact obedience to God’s will. Life is believed to be a “testing phase” before death and eternity; as a result, for some Syrians the difficulties in this life can be viewed as an opportunity to strengthen faith and to prove themselves (Hassan et al., 2015). In addition, although humans are viewed as weak, God is viewed as infinitely strong and thus the idea of resting in God’s will, even in the midst of catastrophe, may be comforting (Hassan et al., 2015).

2.5 Coping strategies

Coping mechanisms represent an imperative instrument in the management of psychological distress. Understanding these mechanisms allows clinicians and humanitarians to design initiatives that promote access and utilization of natural, healthy coping strategies. Supporting the Syrian community and individual’s means to manage daily stressors primes a path of resilience and growth, lessening the potential for exacerbated mental illness within a community.

A strong social support network is one of the primary positive coping strategy among Syrians, however, the dynamics of displacement and conflict can disrupt these networks, undermining collective healthy coping mechanisms. When positive coping mechanisms are unavailable or disintegrated, individuals may then depend on unhealthy or less effective strategies. Some of these strategies can promote anger or aggressive tendencies, leading to an increase in family violence, the use of substances to numb symptoms, and social isolation (Hassan et al., 2015).

General coping strategies

Coping mechanisms identified throughout Syrian refugee populations are listed below, as identified by Hassan et al., (2015) and the report “Mental Health/Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za’atari Refugee Camp (2013). These include both healthy and unhealthy strategies that are employed by women, men, adolescents, and children.

Some of the overall strategies that were listed include praying, listening to music, watching TV or drawing. Social strategies included seeking the companionship of family and friends, engaging in social activities, attending a community event, visiting a school, or talking with a trusted person (Hassan et al., 2015). While many of the coping strategies reported are positive, refugees report also frequently utilizing negative coping mechanisms such as withdrawing, smoking, obsessively watching the news, worrying, or “doing nothing” (Hassan et al., 2015). Syrians have described utilizing some of these passive coping mechanisms because they feel helpless, or like there is little else for them to do (Displaced Syrians in Jordan: A Mental Health and Psychosocial Information Gathering Exercise, 2012).

Social support networks

Numerous studies found that social support networks serve as the primary vehicle for employing healthy coping strategies. In times of severe and ongoing distress, people rely on “collective cultural systems of knowledge, values and coping strategies to make meaning in the face of adversity”. For refugees, “providing culturally safe environments for respectful dialogue and collaborative work can help Syrians construct meaning from suffering and finding adaptive strategies to cope with their situation” (Hassan et al., 2015). This is further supported by findings in the 2015 IMC report, Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis, which emphasizes the importance of building capacity among Syrian refugees by engaging them in building their skills through community-level activities that promote resilience and a sense of community.

Implications for future programing: developing initiatives that foster social cohesion among displaced populations in a culturally appropriate manner, taking into consideration the different ways in which women and men utilize support networks for coping, can promote the collective engagement of effective ways to manage distress (Hassan et al., 2015).

Coping strategies among women

Coping strategies that women describe using include prayer, talking to family and friends, utilizing social networks, organizing charity and support groups, going to shops, leaving the home to work together, or distracting themselves by keeping busy (for example, cleaning the home). These active coping mechanisms can be contrasted with passive coping mechanisms, which tend to occur when the living situation – like as living in a camp setting – does not promote pre-displacement daily routines, such as performing household chores, working, or going out. Passive coping strategies that were reported include sleeping, crying, smoking or seeking time alone/withdrawing (Hassan et al., 2015).

Implications for future initiatives: reinforcing women's social networks and developing opportunities to actively cope within her household and community increases her overall well-being and ability to employ healthy, resilient coping strategies.

Coping strategies among men

Syrian men reported that the coping mechanisms in Syria and which they feel they are still able to use after displacement include praying or spending time alone. Coping mechanisms that they stated they could no longer utilize after arriving in a refugee camp setting included working, visiting friends and family, or going out. Due to cultural norms regarding masculinity and the expectation that men should not acknowledge weakness, men may not seek out social coping mechanisms, resulting in a more individualistic, potentially less effective approach to coping. Some of these include sleeping, crying, smoking or 'getting angry' (Hassan et al., 2015).

Implication for future initiatives: providing men with gender and culturally appropriate opportunities for social activities within his community may prompt utilization of healthier coping strategies.

Coping strategies among adolescents

Coping mechanisms that are often used by Syrian adolescents, as reported by Hassan et al. and in the report "Mental health Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan" (2014):

- Talking to friends and parents
- Listening to music
- Finding things to do
- Reading the Quran
- Joining school or community centers
- Playing with friends
- Withdrawal
- Thinking of former good times in Syria
- Crying
- Watching TV
- Sleeping
- Playing with friends
- Eating
- Drawing
- Distracting themselves

Syrian adolescents reported 'talking to friend and parents' as their primary coping tool (Hassan et al., 2015). The role of parents and caretakers serves as a critical avenue for diffusing the emotional distress of displacement and offers a healthy coping strategy for dealing with their distress. However, when parents are struggling to cope with their own emotional distress and turn to maladaptive coping strategies – such as beating their child or isolating themselves – youth must seek other support, potentially turning to unhealthy coping strategies.

An assessment on mental health and psychosocial well-being of displaced Syrian children in Za'atari refugee camp, completed by IMC and UNICEF, founded that in a sample of 255 adolescents, the top coping mechanisms reported were withdrawing (71% of responders), crying (38%), finding things to do (31%) and going to parents (31%) (IMC & UNICEF, 2013). The main risky behaviors that Syrian adolescents identified they used to cope with their own emotional distress included smoking (4%), stealing (4%) and beating others (8%) (IMC & UNICEF, 2013).

A 2015 field study report conducted by World Vision and Columbia University evaluated Child Friendly Spaces for Syrian refugee children and found a number of key implications for future programming enhancements. Recommendations included better addressing the needs of older children through different forms of programming, such as vocational and life skills training.

Implications for future initiatives: utilize positive coping mechanisms that adolescents naturally turn to. It also remains paramount that parents and caregivers simultaneously be supported since positively-coping parents will provide the first-line of healthy coping for their children. Consider also incorporating vocational and social activities into interventions.

Coping strategies among children

The report, "Insights into Syrian Refugee Children's Mental Health Status and Coping Mechanisms" found that family environment are a strong influence in children's coping and well-being. Syrian children seem to be resilient if the social and home environments are positive and conducive to forming friendships. The report found that livelihood opportunities for parents play a significant role in the well-being of the entire family: "Children whose families, particularly their father, were unemployed showed higher levels of mental health symptom profiles, indicating that the stability and support offered through livelihood and employment opportunities not only provide benefits to the adult employed but also for the children in their household" (Caritas Lebanon Migrants Center, 2015).

Other coping mechanisms that the report found children utilize included:

- Spending time with family
- Spending time with friends
- Engaging in hobbies
- Using media (watching TV or listening to music)
- Retreating or staying alone
- Sleeping

Children reported the following improvements to help them better cope:

- Language classes
- Increased recreational activities
- Cultural/intellectual stimulation
- More friends

Implications for future initiatives: ensuring livelihood training and opportunities exist for Syrian families offer multiple levels of benefits at both individual and family levels. Encourage programs that support and help to build strong familial and social bonds.

Cultural norms in seeing out services

While historically, women in Muslim societies have had less presence in public settings, the current context of displacement and conflict have resulted in women, accompanied by their children, seeking mental health and psychosocial care. This increase is also likely due to presenting the provision of services by using less medical terms such as 'counseling' and offering the services as part of an overall health program package where women and children are provided safe spaces (Hassan et al., 2015). However, due to cultural norms regarding masculinity and the expectation that men should not acknowledge weakness, men may not seek out social coping mechanisms, resulting in a more individualistic, potentially less effective approach to coping (Hassan et al., 2015). While it is socially acceptable to show emotions publicly, even intense emotions, men are expected not to be as apparent with their feelings. Providing information, support, and resources through creative approaches that are integrated

into the natural activities of the community may be useful in gaining more participation from men (Hassan et al., 2015). Within Syrian culture there is also some stigma associated with the clinical labels that accompany psychological distress – casing “shame, fear, or embarrassment” (Hassan et al., 2015), which may decrease help-seeking behavior from mental health professionals.

2.6 Role of religious and culture-specific healing practices

Cultural and religious-specific value systems can influence the presentation and understanding of psychological problems. Treatment approaches can incorporate these value systems, contributing to sustainable adherence of treatment plans. Some Syrians simultaneously access religious or supernatural healing practices while also seeking psychosocial support services for mental illness. Religious groups such as Alawites, Sufis, and Christians, may have visited holy sites or shrines where saints are buried to ask for help with an illness, although access to many of these types of sites is no longer possible for displaced Syrians.

For Syrian Muslims,

“Common types of religious based, traditional and spiritual treatments in Syria, and other countries in the region, include rukyah (رُكْيَة) and hijab (حِجَاب). Rukyah involves reading Quranic verses or prayers, followed by al naft (النفث), ‘blowing a puff of air’ on the wound or ill body part. A religious leader usually performs this kind of treatment, but a family member can also perform rukyah. The hijab are amulets containing Quranic verses and written prayers, often produced by a katib (كاتب), a male healer, and worn on the body to ward off evil spirits. In both types of treatment, a sheikh (شيخ), a religious or spiritual leader, will choose the verses or prayers he sees as appropriate for the type of ailment concerned. Traditional healers are also generally called sheikh.” (Hassan et al., 2015)

While Islam prohibits the use of magic, some Syrians view it as an alternative to dealing with illnesses and can be used in conjunction with other healing practices, including traditional medicine. Collaboration with traditional healers can serve as a cultural bridge to including traditional medical and psychological interventions as part of a healing or treatment plan (Hassan et al., 2015).

3. TURKISH MENTAL HEALTH CARE SYSTEM

Recent improvements in the last few decades to Turkey’s health system are attributed to the Health Transformation Programme (HTP), which has been implemented in Turkey since 2003 (WHO, Country Cooperation Strategy, 2013). This Programme was established to improve the access, quality, sustainability, and efficiency of health services, with the overarching purpose of keeping these services “human centered” (Strategic Plan, 2013-2017). Overall improvements to infrastructure, equipment, supplies and expanding training of staff has brought significant improvements to health indicators in the country (WHO, Country Cooperation Strategy, 2013). Under the HTP, the 2010-2014 Strategic Plan was the first iteration of a plan for developing Turkey’s health care system.

Improvements to Turkey’s health system has in turn pushed progress in the mental health field, increasing both the accessibility and quality of services (Universal Health Coverage in Turkey, 2013). Most recently, the Turkish government has been implementing a second phase of health reforms that built off of the first Strategic Plan, which are presented in the Strategic Plan, 2013-2017. This second iteration of reform focuses on the “governance, efficiency, and quality of the health sector” (WHO, Country Cooperation Strategy, 2013). It reflects a new organizational structure of the Turkish governing body responsible for health care, the Ministry of Health (MoH). This Strategic Plan includes four strategic goals:

1. To protect the individual and the community from health risk and foster healthy life styles
2. Provide accessible, appropriate, effective and efficient health services to individuals and the community
3. To respond to the health needs and expectations of individuals based on human-centered and holistic approach
4. To continue to develop the health system as a means to contributing to the economic and social development of Turkey and to global health

By establishing specific development goals, and making changes both at a policy level and at an infrastructural level, Turkey is making progress towards comprehensive care for those with mental illness.

3.1 Mental health policy, legislative framework and leadership

Mental health services in Turkey are overseen by the Turkish Government's Ministry of Health (MoH). Statutory Degree No. 663 establishes the "organization, duties, mandate and responsibilities" of the MoH, which includes the planning and establishment of both private and public healthcare institutions (Strategic Plan 2013-2017).

There are numerous policies in place within the Turkish Constitution that are designed to protect the rights of those with mental illnesses. Article 56 of the Constitution states that it is the responsibility of the State to ensure all individuals can sustain physical and mental health (Munir et al., 2006), stating that the State "shall regulate the central planning and function of the healthcare services" (Strategic Plan, 2013-2017). This Article gives the State responsibility for supervising both public and private healthcare (Strategic Plan, 2013-2017). Article 61 of the Constitution ensures that individuals with mental illness are not ostracized or secluded, establishing that "the State shall take measures for protection of the disabled and to promote their social integration" (Munir et al., 2006). In addition, Article 61 protects mentally ill within work situations, stating that "children, women and physically and mentally disabled persons shall be under special protection in terms of working conditions" (Munir et al., 2006).

Significant changes were initiated by the Health Transformation Programme. In 2011, the MoH was restructured with the purpose of "enhancing its role in health system policy development, planning, supervision of implementation, monitoring and evaluation" (WHO, Country Cooperation Strategy, 2013). These changes include emergency management, preventative services, development of health services and research. Under the new structure, health services are organized from a central governmental level, down to each consecutive level of government. There are 81 provinces in Turkey, and in each provinces health services are overseen by the Public Health Director and a Deputy Public Health Director. Distinct types of health services are broken down into twenty-one separate units, one of which is the Mental Health Programme Unit. At the district level, the District Health Director oversees additional units of private and public health services (Strategic Plan, 2013-2017).

Improvements to health care coverage were also made, including the Green Card Programme that provides coverage for low-income individuals (Strategic Plan, 2013-2017). The "Law Concerning Covering Medical Expenses of the Green Card Holders by the State who are Unable to Make Payments" also makes access to health services attainable for citizens who otherwise would not have these services (Munir et al., 2006). Between 2002 to 2011, those covered by the Universal Health Insurance was increased from 69.8% to 98.2%, and the coverage in the Green Card Programme was expanded to include outpatient healthcare services and pharmaceuticals (Strategic Plan, 2013-2017, pg 26). As the National Mental Health Policy explains, "[c]onsidering the fact that persons with severe and persistent mental disorders are frequently hospitalized due to lack of sufficient care or availability of sufficient treatment systems within the community" the Green Card Programme is "highly important" (Munir et al., 2006).

Laws related to supporting the health costs for persons with mental illness have been initiated in Turkey. Insured Turkish citizens who are unable to work because of a chronic illness or disability – including mental illness – may receive a pension (Munir et al., 2006). Recent changes in the Turkish health policy also provide insurance for individuals who would not otherwise be able to afford it. The "Law on Paying Pension Wages to Needy, Unprotected and Destitute Turkish Citizens over 65" provides pensions to individuals as long as they have an identified diagnosis (Munir et al., 2006). Individuals under the age of 65 are covered under Article 1 of this law and are eligible for the same pension amount, as long as they are unable to "sustain their lives without the support of others" or are employed in job that is not appropriate for their situation (Munir et al., 2006).

Suicide is not illegal under Turkish law. The Criminal Code Law number 5237 establishes that assisting, encouraging or helping in suicides is punishable with a prison sentence (Criminal Code Vol 1: General Provisions). Forcing or threatening an individual to complete suicide is considered a felonious homicide, which is particularly significant regarding honor killings. The Strategic Plan, 2013-2017 establishes a number of preventative services directed towards suicide reduction.

3.2 Relative roles of government, private sector, NGOs, and traditional healers in providing mental health care

Information presented here reflects data from the National Mental Health Plan, published in 2011 and the World Health Organization's 2011 Mental Health Atlas report. Unfortunately, more recent literature on Turkey's mental

health system could not be found through this literature review; this should be taken into consideration while reviewing the information presented here.

According to the National Mental Health Plan, in 2011 the MoH was largely responsible for mental health service provision in Turkey. 27.2% of psychiatric beds in Turkey were within one of the MoH's general hospitals, 53.5% beds were within a MoH mental health and disorders hospital (Altaş et al., 2011). University and general hospitals had 13.1% of psychiatric beds in Turkey, and the private sector covered 6.2% (Altaş et al., 2011).

According to data presented in the National Mental Health Policy (2006), the majority of adults with mental disorders are referred to psychiatrists (39.2%), other mental health specialists (33.1%), and general practitioners (20.7%). A smaller category seek traditional services, with 3.6% seeking care from spiritual leaders and 3.4% reportedly seeking services from a category labeled as "other" (MHAP, 2006).

Over the past decades, demand for traditional healers has decreased. In a study completed in 1989 in southwest Turkey, participants were asked to rank what would be most helpful for mental health issues. Traditional healers were ranked as the least helpful, under mental hospitals and psychiatrists (Eskin, 1989). Two studies on mental health service utilization in Turkey found that traditional healers were providing less than 3% of mental health services in the cities of Ankara and Erzurum (Community Mental Health Services in Turkey: Past and Future, 2007). However, it appears that there has been growing acceptance towards alternative treatments in medical centers with the introduction of services such as acupuncture, hypnosis and chiropractic services within hospitals and clinics (Cetingulec, 2014). While Turkey has a history of alternative medicine – including music therapy that was used to treat individuals with mental disorders during the Seljuk and Ottoman eras (Cetingulec, 2014) – it appears that the demand for traditional medicine to treat mental health conditions has decreased.

3.3 Description of the formal mental health services

It is estimated that 18% of adults and 11% of children or adolescents in Turkey will experience a mental illness in the span of their lifetime (Altaş et al., 2011). However, according to data from 2011, only one in every six individuals with a mental illness were accessing mental health services (Altaş et al., 2011). According to the National Mental Health Plan, mental health services were especially low for risk groups such as young, elderly, or individuals with disabilities (Munir et al., 2006). Large differences in the health outcome between different socioeconomic groups (rich and poor) and geographic locations (east and west, rural and urban) were attributed to shortages and unequal distribution of human resources throughout the country (Atun et al., 2013). Responding to these gaps in mental health services required improving the breadth and accessibility of mental health services. To accomplish this, the Mental Health Action Plan proposed three areas for development: setting goals and deadlines for the implementation of a mental health plan, moving towards community mental health facilities and away from mental hospitals, and integrating mental health services into primary care (World Health Atlas, 2011).

While Turkey has clearly shown progress in improving the health care system, limited information available on the current capacity of the Turkish mental health system. In 2011, The World Health Organization (WHO) reported that there were 7,648 available psychiatric beds; 3,440 of these beds were located in mental hospitals and 4,208 were within general hospitals (Mental Health Atlas, 2011). The rate of admission into psychiatric hospitals was 70.59 per 100,000 population (World Health Atlas, 2011); 75% of individuals who stayed in mental health hospitals would be there for less than a year, 13% would be there for longer than one year but less than five years, and 12% of individuals admitted to psychiatric hospitals were staying for over (Mental Health Atlas, 2011).

Adopting a community-based mental health model has allowed Turkey to reduce the consolidation of psychiatric beds within central mental health clinics and to increase the mental health services available across the country in general hospitals (Altaş et al., 2011). The stated goal of the Strategic Plan, 2013-2017 was to increase the number of community centers to 300 by 2017, and to 400 by 2023. One study evaluating the progress and services at community centers found that there had been 106 centers opened by the end of 2015 (Bilge et al., 2016). Although that number was below goals set by the Strategic Plan, it was expected that the target number would be reached quickly (Bilge et al., 2016). 45 centers were interviewed, all of which were fulfilling their role in providing the community with consultation and counseling, training services, home visits and outpatient services (Bilge et al., 2016).

In addition to making mental health services more accessible, the community centers are intended to provide more consistent care for individuals with severe mental disorders such as schizophrenia and bipolar disorder. In 2011, 95% of individuals with severe mental disorders were living with their families in Turkey – compared to 50% in Europe (Altaş et al., 2011). The Strategic Plan, 2013-2017 outlines a goal to increase the percentage of individuals with schizophrenia and bipolar disorder who are receiving services from a community center to 80% by 2017, and 90% by 2023.

It is not just *djinn*s and the dead who have supernatural powers to harm, but also some of the living. Belief in sorcery is common in Guinea. Sorcerers are distinguished by their selfishness in the pursuit of power or wealth, and suspicions of sorcery sometimes fall on those who appear reclusive or accumulate rather than share what they have, thus failing to fulfill their social obligations. Belief in sorcery thus expresses core values of egalitarianism and community [46], and provides a way of making sense of how some individuals in the modern world seem to enrich themselves very suddenly while most remain poor. Sorcerers may send harm to others through magical means. [23, 31]

Mental Health Services for Refugees

Refugee rights in Turkey are overseen by the Law on Foreigners and International Protection, as well as the Temporary Protection Regulation. Refugees who have registered and received their Temporary Protection Identification are able to access secondary and tertiary health services with a fee comparable to one paid by Turks (Regional Refugee & Resilience Plan, Turkey, 2016-2017). A Temporary Protection Identification is necessary for receiving services, otherwise refugees may only access health care when they first arrive in the country or in emergency situations (Regional Refugee & Resilience Plan, Turkey, 2016-2017).

Supporting the Syrian refugee community in this protracted crisis will require also providing comprehensive mental health services. The Disaster and Emergency Management Presidency of Turkey (AFAD Turkey) is the Turkish governmental arm responsible for supporting the safety and wellbeing of refugees. In addition to the AFAD, as of October 2015 there were reportedly 139 international non-governmental organizations (NGOs) in Turkey also working on behalf of refugees (Regional Refugee & Resilience Plan, Turkey, 2016-17). Working groups between these organizations include the Working Groups on Sexual and Gender Based Violence and Working Group on Mental Health, established in 2015. By 2016, there were reportedly 16 temporary health centers established in southeastern Turkey, which was expected to increase to 25-30 (Regional Refugee & Resilience Plan, Turkey, 2016-17). Forty outreach centers were created across the country – which included community centers, child friendly spaces and safe spaces for women (Regional Refugee & Resilience Plan, Turkey, 2016-17). A country map of Turkey with locations of those centers is included in Annex 2 (UNHCR, 2016).

Many local NGOs and religious groups have also stepped in to provide care for refugees, such as the Small Projects Istanbul. This Turkish NGO provides food, language classes, social events and even haircuts to Syrians in Istanbul. The Karam Foundation is a US-based nonprofit that is building a community center in Reyhanli, bringing educational and entrepreneurial opportunities to refugees in Southern Turkey.

Bahloul et al. (2015) found that there is a major gap in efforts towards recovery, resilience, the prevention of long-term manifestations of trauma and the impact of multigenerational trauma. To counteract this, they suggest that interventions should specifically “support individuals to restore relationships, build new, healthy patterns of interaction, and develop coping strategies.” The report suggests creativity-based programs that are “designed to attract people with social events, workshops, groups, and other recovery-oriented activities...” These programs would be providing culturally-sensitive psychoeducation around mental health, while utilizing “community and family-focused psychosocial interventions (i.e. vocational, counseling, supportive trauma-focused help)” (Bahloul et al., 2015).

Syrian children represent a large number of the refugee population in Turkey, with half of the refugees registered in Turkey under the age of 17 (Yaghmaian, 2016). Most displaced Syrian children in Turkey will not be able to accessing school, are at the risk of exploitation and pushed into child labor in order to support their families. Girls specifically are at risk for sexual exploitation, and child-marriages are reportedly increasing as an alternative to families having to support their daughters. A number of the provinces in Turkey have child-friendly spaces are

available, but with such a large vulnerable population there is a need to expand efforts to address the educational and mental health needs of displaced Syrian children.

4. CHALLENGES FACING SYRIAN REFUGEES IN ACCESSING MH SERVICES

Language barrier

As the conflict in Syria develops into a protracted crisis, there is a need for services that empower and strengthen Turkish efforts while advocating for the millions of refugees that now live in the country. Many barriers still exist to refugees being able to access mental health care. The language barrier in particular is an issue, with the sudden influx of Arabic-speaking Syrians into the Turkish health care system. A lack of service providers or translators available who can speak Arabic deters refugees from using these services (Regional Refugee & Resilience Plan, 2016-17). Turkey recently has taken steps to allow Syrian doctors and health professionals work in migrant health centers beginning first in areas more populated by Syrian refugees, however the extent to which mental health services will be included in this plan is currently unclear (Sikora, 2016).

Culturally-appropriate MHPSS Services

As previously discussed, the stigma related to mental illness and cultural norms around showing weakness, particularly among Syrian men, may make accessing services counterintuitive (Hassan et al., 2015). In addition, programming focusing on the vulnerabilities of women and children often neglect to recognize significant psychological trauma and vulnerabilities that even men experience. Men are reportedly more likely to be punished by authorities for “labor market violations” or to be refouled back to Syria (Turner, 2016). Recognizing the gaps that exist in MHPSS care for men, the International Organization for Migration (IOM) published a “Self-Help Booklet for Men facing crisis and displacement”, which is available in Arabic (2014). This booklet helps to normalize the feelings and experiences that displaced Syrian men may have.

This does not negate the specific vulnerabilities that women and children face of gender-based violence, domestic violence, forced early marriages, survival sex, isolation and other forms exploitation (Karasapan, 2016). Stigma affects women and children as well: in one pilot program treating posttraumatic stress disorder for refugees that was hosted at a kindergarten in Turkey, many of the participants reportedly “pretended to other refugees that they were just bringing their children to the kindergarten” (Hassan et al., 2015). It is important that MHPSS interventions are designed to appropriately educate against stigma, while also supporting confidentiality needs of clients. Although stigma still persists, some mental health practitioners have reported that as a result of “shared experiences of violence, loss and displacement”, the stigma associated with mental illnesses has been reportedly decreasing and Syrians are showing more acceptance towards participating in psychosocial programs (Hassan et al., 2015).

Accessibility

A few of the other barriers reported to refugees accessing mental health care in Turkey include the fact that mental health services are not covered by health care package (International Medical Corps, 2015). In addition, simply a lack of financial resources, even to cover indirect services costs such as transportation or medication deters some refugees from getting the care that they need (Hassan et al., 2015).

Other areas in need of improvement that have been noted include the need for a stronger referral system, and the need to increase psychosocial supports for refugees (Regional Refugee & Resilience Plan, 2016-17). As noted by Hassan et al., many refugees are living in very difficult and harsh circumstances, and as a result, mental health professionals may find that MHPSS interventions need to be designed holistically, to also respond to many of the non-mental health needs that refugees have (Hassan et al., 2015). However, many refugees are becoming “increasingly willing” to receive help from mental health professionals and rank MHPSS services as very important (Hassan et al., 2015).

5. RECOMMENDATIONS FOR FUTURE PROGRAMING

Preventative services

MHPSS programming for refugees in Turkey should take into consideration the long-term needs of this population. The daily stressors and challenges that displaced Syrians face will most certainly have an impact mental health and wellbeing. It is important that interventions are designed purposefully, with the longevity and sustainability of the program in mind – and while crisis-management services are essential, preventative mental health care that can support refugees in the long-term will also have a big impact (Hassan et al., 2015).

Support national mental health services

Mental health services sustained by aid organizations are a precarious system (Weissbecker & Leichner, 2015). It is essential that future programing does not work parallel to the national health system, but instead builds together with local efforts so that mental health services for refugees are not dependent on international aid (Weissbecker & Leichner, 2015). Advocating for policies that support the refugee population, ensuring that Syrian human resources are pulled into national efforts, and building capacity with local health care professionals to care for mental health needs of Syrians could help to ensure services are sustainable.

Language barrier

Support recent efforts to hire Syrian professionals for national health clinics, and advocate for Syrian mental health professionals to be included among those numbers. Translators can help support services when Arabic-speaking professionals are unavailable, so advocate for translators in hospitals and other clinics (International Medical Corps, 2015). In addition, when using interpreters, ensure they have been trained on trauma-informed practices (Hassan et al., 2015).

Stigma reduction

In order to reduce stigma, practitioners can avoid the use of clinical, psychological or psychiatric terms and labels while working with clients (Hassan et al., 2015). In addition, services can be offer in a neutral space – for example in primary health or community setting – in which the sole purpose of a visit is not immediately known as help-seeking for a mental health concern (Hassan et al., 2015). NGOs and national mental health professionals can also acknowledging and engaging with the Syrian refugees who are also addressing mental health and psychosocial well-being throughout their community. This can help to strengthen an organization's presence and validity within the community, but also helps to reduce stigma and improve referral stream for refugees in need of services but who may be hesitant to seek help outside of their community (Hassan et al., 2015).

Build of natural coping mechanisms

Interventions that utilize natural social support networks will help to foster social cohesion and encourage healthy coping strategies (Hassan et al., 2015). Recommendations for MHPSS programing include broad, inclusive mental health services that are connected well to other social supports, to ensure integrated and holistic care (Hassan et al., 2015). Livelihood opportunities serve as a key reinforcement of positive coping, that benefit both individuals and entire families (Escot, Mahfouz, Feghaly Saade, & Varady, 2015).

Child-specific recommendations

Focusing on future particularly an important intervention for adolescent refugees. To accomplish this, MHPSS programs can incorporate vocational and life-skills training for young adults. Language classes for adolescents and children will also help them to integrate into and navigate within their new environment (Escot et al., 2015). Family environment has a large impact on children, so MHPSS activities that ensure that parents have the skills to support the mental health of their children can be beneficial (Escot et al., 2015). For example, mothers' and fathers' groups can be an opportunity to offer trainings. In addition, mainstreaming mental health, recreation and social networks into all activities for children, including education and safe play spaces may support child refugee's wellbeing (Escot et al., 2015). On a broader spectrum within local spaces, awareness campaigns on the vulnerabilities and risks that are faced by refugee children are encouraged to help the public become more informed and potentially proactive against child exploitation (Escot et al., 2015).

Another recommendation is to ensure that Syrian and Turkish children are participating in activities together (Escot et al, 2015). Schools are a space where this can happen naturally, but it is also important that the space is monitored. Some recommendations specific to schools by Escot et al. include:

- Create and immediately implement a zero tolerance policy on discrimination and abuse in all schools.
- Design and implement tolerance courses or activities in schools immediately to reduce discrimination and stigmatization of Syrian refugee children by host country children.
- Ensure that teachers are trained on child protection concerns.
- Set-up mentoring mechanism at schools so teachers facing issues can obtain dedicated assistance.

6. CONCLUSION

In conclusion, there is a need for interventions that engage with Syrian refugees in a manner that is sensitive to specific cultural expressions of mental illness and emotional distress. MHPSS programs can be responsive to these cultural nuances, while still counteracting stigma and providing psychoeducation on the benefits of mental health services. Refugees have experienced or witnessed violence, danger, and significant loss; in addition to this, the daily challenges and vulnerabilities of life in Turkey can have detrimental mental health repercussions. MHPSS programs can act as preventative towards mental illness among refugees by including interventions that support the non-mental health related needs of refugees. Organizations working in Turkey have the opportunity to maximize their efforts and invest into sustainable programs by working alongside the Turkish mental health system and advocating for policies that will support refugees in the country in the long-term. By helping to reinstate refugees' natural coping mechanisms, encouraging individual independence and facilitating healthy communities, MHPSS programming can empower Syrian refugees who are rebuilding their lives in Turkey.

LIST OF RELEVANT REFERENCES REVIEWED

- Almoshmash, N. (2015). Exploring the Mental Health Needs and Suffering of Syrian Refugees. *Royal College of Psychiatrists TPSIG Newsletter* (London, England).
- Amnesty International. (2015). Syria: The worst humanitarian crisis of our time
Retrieved from <https://www.amnesty.org.nz/syria-worst-humanitarian-crisis-our-time>
- Altaş, G., Kahiloğulları, A., & Yanık, M. (2011). Ulusal Ruh Sağlığı Eylem Planı, 2011-2023.
- Atun, R., Aydın, S., Chakraborty, S., Sümer, S., Aran, M. Gürol, I., Nazlıoğlu, S., Özgülcü, Ş., Aydoğan, Ü., Ayar, B., Dilmen, U., & Akdağ, R. (2013). Universal Health Coverage in Turkey: Enhancement of Equity. *Lancet*, Vol 382, 65-99. doi: [http://dx.doi.org/10.1016/S01406736\(13\)61051-X](http://dx.doi.org/10.1016/S01406736(13)61051-X)
- Bilge, A., Mermer, G., Çam, M., Cetinkaya, A., Erdoğan, E., & Üçkuyu, N. (2016, May). Profile of Community Mental Health Centers in Turkey between 2013-2015 Years. *Journal of Health Sciences of Kacaeli University* Vol 2(2).
- Escot, R., Mahfouz, M., Feghaly Saade, I., & Varady, C. J. (2015). Insights into Syrian Refugee Children's Mental Health Status & Coping Mechanisms. *Caritas Lebanon Migrants Center*. Lebanon. Retrieved from <http://reliefweb.int/sites/reliefweb.int/files/resources/Final-Mental.pdf>
- Cetingulec, T. (2014). Turkey legalizes alternative medicine. Retrieved from <http://www.al-monitor.com/pulse/originals/2014/12/turkey-alternative-medicine-legalized.html>
- Criminal Code Vol. 1, General Provisions*. (2004). Official Gazette No. 25611.
- Eskin, M. (1989). Rural population's opinions about the causes of mental illness, modern psychiatric help-sources and traditional healers in Turkey. *International Journal of Social Psychiatry*, Vol 35(4).
- Gökalp, P., & Aküzüm, Z. (2007). Community Mental Health Services in Turkey: Past and Future. *International Journal of Mental Health, Psychiatry in Turkey* 36(3), 7-14.
Retrieved from <http://www.jstor.org/stable/41345221>
- Hassan, G., Kirmayer, L. J., & Mekki-Berrada, A. (2015). Culture, context and the mental health and psychosocial wellbeing of Syrians: a review for mental health and psychosocial support staff working with Syrians affected by armed conflict.
- Headington Institute. (2015). Questions to ask yourself before your next deployment. Retrieved from <http://www.headington-institute.org/blog-home/466/questions-to-ask-yourself-before-your-next-deployment>
- Hijazi, Z. & Weissbecker, I. (2015). Report: *Addressing Regional Mental Health Needs and Gaps in the Context of the Syria Crisis*. International Medical Corps.
- International Crisis Group. (2016, November). Report: Turkey's Refugee Crisis: the Politics of Permanence.
- International Medical Corps and UNICEF (2013). Mental Health/Psychosocial and Child Protection Assessment for Syrian Refugee Adolescents in Za'atari Refugee Camp, Jordan. Retrieved from <https://data.unhcr.org/syrianrefugees/partner.php?OrgId=17>

- Jefee-Bahloul, H., Barkil-Oteo, A., Pless-Mullooli, T., & Fouad, F. M. (2015). Mental health in the Syrian crisis: beyond immediate relief. *Lancet* 386(10003), 1531. London, England.
- Jordan Health Aid Society. (2012). Displaced Syrians in Jordan: A Mental Health and Psychosocial Information Gathering Exercise. Retrieved from: <http://jhas-international.org/?p=154>
- Karasapan, O. (2016). Syria's mental health crisis. Future Development. Retrieved from <https://www.brookings.edu/blog/future-development/2016/04/25/syrias-mental-health-crisis/>
- Munir, K., Ergene, T., Dağ, I., Erol, N., & Aker, T. (Eds.) (2006.) National Mental Health Policy. Ankara, Turkey.
- Multeci Der (2015). Türkiye'de Multecilerin Kabul Kosullari Hak ve Hizmetlere Erisimleri. Izmir, Turkey.
- Samari, G. (2015). The Response to Syrian Refugee Women's Health Needs in Lebanon, Turkey and Jordan and Recommendations for Improved Practice. Article, "*Knowledge & Action, Humanity in Action*."
- Sikora, R. (2016) Turkey improving medical services for refugees. Retrieved from http://orient-news.net/en/news_show/101804/0/Turkey-improving-medical-services-for-refugees
- Turner, L. (2016). Are Syrian Men Vulnerable Too? Gendering the Syria Refugee Response. SOAS, *University of London*. Retrieved from <http://www.mei.edu/content/map/are-syrian-men-vulnerable-too-gendering-syria-refugee-response>
- UNHCR. Partners, Community Centers and Refugee Outreach Volunteers Presence [Map]. (2016, November). In Syrian Regional Refugee Response. Retrieved from <https://data.unhcr.org/syrianrefugees/country.php?id=224>
- Weissbecker, I., & Leichner, A. (2015) Addressing Mental Health Needs among Syrian Refugees. Retrieved from <http://www.mei.edu/content/article/addressing-mental-health-needs-among-syrian-refugees>
- World Health Organization, Department of Mental Health and Substance Abuse. (2011). Mental Health Atlas, Turkey.
- World Health Organization. (2016, June). Report: 2.7 Million refugees Syrian refugees in Turkey receive public health advice. Retrieved from <http://www.euro.who.int/en/countries/turkey/news/news/2016/11/2.7-million-syrian-refugees-in-turkey-receive-public-health-advice>
- World Vision and Columbia University. (2015). Evaluation of Child Friendly Spaces: Jordan Field Study Report: A CFS Implemented by World Vision and Partners in Zarqa, Jordan.
- Yaghmaian, B. (2016, May). World Humanitarian Summit: Syrian Child Refugees in Turkey. Retrieved from: <http://www.theglobalist.com/world-humanitarian-summit-syrian-child-refugees/>

ANNEX 1

TABLE 1: COMMON EXPRESSIONS AND IDIOMS OF DISTRESS IN SYRIAN ARABIC

Arabic term or phrase	Transcription	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
منضايك كثير هالفترة حاسس حالي منضايك ضايح نفسى مخنوقة	- Meddayyek ketir hal fatra - Haassess haalii meddayyek - Dayej - Nafsi makhnouka	- I am very annoyed these days - I feel annoyed - To be cramped - My psyche is suffocating	- Rumination tiredness, physical aches, constriction in the chest, repeated sighing - Unpleasant feelings in the chest, hopelessness, boredom
حاسس روحي عم تطلع	- Hassess rouhi 'am tetla'	- I feel my soul is going out	- Dysphoric mood, sadness - Inability to cope, being fed up - Worry, being pessimistic
قلبي مقبوض انعمى على قلبي	- Qalb maqboud - In'ama 'ala kalbi	- Squeezed heart - Blindness got to my heart ¹	- Dysphoria - Sadness - Worry, being pessimistic
تعبان نفسيًا حاسس حالي تعب حالي تعب نفس تعبانه	- Taeban nafseyan - Hassess haalii ta3ban - Halti taebaneh - Nafs ta'bana	- Fatigued self/soul	- Undifferentiated anxiety and depression symptoms, tiredness, fatigue
ما قادر اتحمل الضغط على كثير مو قادر ركز من الضغوطات	- Ma ader athammel - El daght 'alayy ketiir - Mou kaader rakkezz men el doghoutaat	- Can't bear it anymore - The pressure on me is too much - Can't concentrate because of the pressure	- Feelings of being under extreme stress or extreme pressure - Helplessness
فرطت	- Faratit	- I am in pieces	- General state of stress, sadness, extreme tiredness, inability to open up and to control oneself, or to hold oneself together
و الله مو شايف قدامي	- Wallah mou shayef oddaamii	- By God, I can't see in front of me	- General state of stress, feelings of loss of options, loss of ability to project into the future, - Confusion, hopelessness
حاسس الدنيا مسكرة بوشي ما في شي عم يربط معي	- Hases eddenia msakkra bwishi - Ma fi shi 'am yizbat ma'i	- I feel the world is closing in front of my face - Nothing is working as planned with me	- Hopelessness, helplessness, state of despair
- شو بدى إحكى... الشكوى لغير الله مذه - الحمد لله	- Sho baddi 'ehki... el shakwa le gher allah mazalleh - Al hamdulillah	- What am I supposed to say... it is humiliating to complain to someone other than God. - Praise be to God.	- Reference to shame in asking for help - State of despair, surrender
ما يعرف شو بدى إعمل بحالي	- Maa ba'ref shou beddi a'mel be haalii	- I don't know what I am going to do with myself	- General state of distress - Feeling upset, edgy, helplessness - Hopelessness, lack of options
متوتر	- Mitwatter	- I feel tense	- Nervousness, tension
خيفان حاسس بالخوف مرعوب	- Khayfan - Hases bil khof Mar'oub	- I am afraid - I feel fear - Frightened, horrified	- Fear, anxiety - Worry - Extreme fear
مغضب	M3asseb	- I feel angry	- Anger, aggressiveness - Nervousness

Sources: This table is based on suggestions by Arabic speaking mental health professionals, including: Alaa Bairoutieh, Tayseer Hassoon, Ghayda Hassan, Maysaa Hassan, Hussam Jefe-Bahloul, and Mohamed el Shazli.

TABLE 2: EXPRESSIONS IN KURDISH (KIRMANJI DIALECT)		
Kurdish terms or expressions	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
<i>Bena mn tanga</i> <i>Nafasa mn tanga</i>	- My breath is short	- Low mood
<i>Chi béjim/ chi bikim vala ye</i>	- What am I supposed to say/to do without result	- Helplessness - Hopelessness - Loss of options
<i>Dunia lber mn tari buya</i> <i>Dunya li ber chavé min resh biye</i>	- The world became dark in front of me - The world is closing in front of my face	- Despair - Hopelessness - Helplessness - Depression
<i>Ez dihisim gu ezé bifetisim</i> <i>Béna min dichiki</i>	- I feel I am going to suffocate	- Restlessness - Loss of options, - Feeling constricted
<i>Dil shikestime,</i> <i>Dilé min déshe</i>	- My heart is broken - My heart is aching	- Tightness in the chest - Chest pain - Stress - Anxiety - Sadness
<i>Az taabima</i> <i>Nefsi/ westyame</i> <i>Pir westyame</i>	- I'm tired - Fatigued self - Fatigued soul	- Helplessness - Hopelessness - Fatigue
<i>Az nkarm bshughlm</i>	- I can't fulfil my duties or responsibilities	- Inability or loss of drive or motivation to perform activities
<i>Az galak dfkrm</i>	- I think a lot	- Excessive thinking /excessive worry - Could be associated with anxiety or depression
<i>Lashe mn grana</i>	- My body is heavy	- Fatigue
<i>Kharna mn tunaya</i>	- I have no appetite	- Loss of appetite that could be associated with grieving, anxiety, worry or depression
<i>Az ghaidm</i> <i>Az qahrma</i> <i>Az ejzm</i>	- I am sad - I feel sorrow - I feel incapable or impotent	- Low mood - Sadness - Incapacity - Feelings of injustice or of being defeated by unjust life circumstances
<i>Jisme mn sist dbit</i>	- My body becomes rigid	- Spasm of body parts which may occur in non-epileptic seizures and in epileptic seizures
<i>Tahamula mn kem buya</i> <i>Tahamula mn tunaya</i> <i>Nema tahmül dikim</i> <i>Ez feritime</i>	- I feel that my ability to bear things is reduced	- Excessive stress - Easily losing control over one's emotions - Difficulty coping, handling stress or pressures
<i>Ez nizanîm chi bi seré xwe bikim</i>	- I don't know what I am going to do with myself	- General distress - A state of confusion, loss of options and disappointment
Source: This table is made with expert input of Kurdish speaking mental health professionals: Rawisht Rasheed, Aram Hasan and Naz Baban.		

ANNEX 2

Turkey

UNHCR, Partners, Community Centers and Refugee Outreach Volunteers Presence

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