BRIEF REPORT

Building mental health and resilience: regional and global perspectives from the inaugural Syrian American Medical Society Mental Health Mission Trip (July 2 to July 7, 2019)

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ABSTRACT

The Syrian conflict has resulted in the most significant refugee crisis since World War II. Current estimates suggest there are over 13.5 million Syrians in need of comprehensive humanitarian assistance as a direct result of the conflict. These humanitarian needs include mental health services to address the elevated rates of psychiatric disorders in this population. Towards this end, the Syrian American Medical Society conducted its inaugural mental health mission trip to Lebanon and Jordan from June to July 2019 to advance the state of mental health care for displaced Syrians. Following two weeks of trainings by international experts in trauma psychology, the mission concluded with a two-day scientific symposium, identifying two key elements for the advancement of humanitarian mental health care: 1) the need for community-based mental health services, and 2) the importance of transitioning from a crisis-response model in humanitarian mental health towards a model of resilience and post-traumatic growth.

Key words: Resilience, Human Devastation Syndrome (HDS), PTSD, Syrian refugees

Since March 2011, the Syrian conflict has led to the most significant refugee crisis since World War II. This protracted crisis has resulted in over 5.5 million registered Syrian refugees worldwide, with estimates from the host governments suggesting this number exceeds 7 million total refugees.[1] In addition, there are over 6.4 million internally displaced persons (IDPs) in Syria—a number that is expected to grow given recent escalations in regional conflicts.[2] Together, these data suggest there are over 13.5 million Syrians in dire need of comprehensive humanitarian assistance.[1]

As indicated by their refugee or IDP status, each of these 13.5 million individuals has been exposed to trauma and is subsequently at greater risk of developing severe psychiatric disorders.[3-6] Recent estimates suggest more than 50% of Syrian refugees and IDPs have some form of mental illness.[7]

Moreover, the chronic psychological stress experienced by displaced individuals, from protracted financial and security concerns to a pervasive sense of helplessness and hopelessness,[8-10] has compounding impacts on long-term emotional and physical well-being.[11,12] Indeed, as the Syrian conflict continues into its eighth year, the extent of trauma experienced by Syrian refugees has manifested beyond contemporary knowledge of post-traumatic stress disorder and other trauma-related disorders. The amount of repeated trauma in this population has resulted in a "devastation of the human experience", a condition coined

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Human Devastation Syndrome by Dr. M.K. Hamza to provide a comprehensive description of Syrian refugees' unique psychological conditions.[10,13,14] Consequentially, the mental health and psychosocial needs of displaced Syrians should be placed as an utmost priority to host communities and nongovernmental aid organizations (NGOs).

Numerous barriers prevent the provision of such humanitarian aid; however, in 2018, the UN Regional Refugee and Resilience Plan received only 62% of funds required to meet the humanitarian needs of Syrian refugees in neighboring countries.[1] In Lebanon, this number was a stark 48%. Mental health and psychosocial support, in particular, are often overlooked in attempts to accommodate more basic needs (i.e., food, water, and shelter) and primary health concerns.[15-17] Although these basic needs are essential for immediate stabilization and crisis management, extant evidence suggests the incorporation of mental health care in a holistic humanitarian response improves functional outcomes and long-term rehabilitation.[18,19] Yet, specialized mental health resources are scarce in primary host countries such as Lebanon and Jordan. Refugees and host communities alike feel these effects, highlighting the universal need for improved access to mental health care.

To this end, the Syrian American Medical Society (SAMS) launched its inaugural mental health mission trip to Lebanon and Jordan, from June to July 2019, to advance the state of mental health care for refugees. In his keynote address for the mental health mission trip, Dr. M. K. Hamza, a medical and forensic neuropsychologist, professor of clinical mental health at Lamar University, and chairman of the Mental Health Committee at SAMS, called for an overhaul of the entire mental health system as we know it: a move from the traditional crisis-response system into a holistic, progressive, and future-oriented system. He emphasized the importance of addressing the long-term effects of the human devastation refugees have suffered by transitioning from traditional medical models to community-based models for psychosocial interventions, resulting in a shift in conceptualizations of mental health diagnosis and treatment. As Dr. M. K. Hamza noted, these shifts will require progressive mind-sets focused on the building of resilience by bridging the gap between humanitarian aid and professional mental health and creating clear, concrete, and coherent guides for improved mental health.

With this in mind, the SAMS mental health mission trip consisted of mental health and psychosocial support trainings for local mental health and psychosocial support (MHPSS) staff from various government and NGOs. Provided by eight international experts in psychiatry, trauma psychology, and social work, these trainings covered a broad range of mental health topics, including the neurobiological response to psychological trauma, management of traumatic brain injuries, advancements in the assessment of suicide risk, dialectical behavior therapy, and mental health in primary care settings. Additional trainings such as reflective supervision and group therapy were provided to focus on advancing the practice of mental health care in humanitarian settings. These trainings were conducted to improve the accessibility and sustainability of high-quality mental health care for refugees and provide the initial foundation for the unity between humanitarian aid and professional mental health.

The mission then culminated with a two-day scientific symposium attended by government officials, international experts, and NGO representatives that addressed the regional to global transition of refugee mental health toward resilience. The symposium focused on advancing MHPSS services available to the Syrian refugee community with an emphasis on sustainable community-based resilience. This meeting of humanitarian actors, government officials, academics, and mental health professionals bridged humanitarian aid and mental health to create an international coalition devoted to the promotion and advancement of refugee mental health care.

Together, these two components of the 2019 SAMS mental health mission trip provided a preliminary assessment of the current status of mental health services available to Syrian refugees and generated a vision for future improvements in refugee mental health care in host communities worldwide. Here, we outline key outcomes from this inaugural SAMS mental health mission trip, including key recommendations from the scientific symposium. We hope these findings will justify the continued use of such missions and generate a model for future advancements in the international humanitarian response to refugee crises.

COMMUNITY-BASED MENTAL HEALTH: BENEFITS AND NEEDS

A core theme spanning the two domains of the mission trip was the emphasis on community-based mental health care. Established in 1996 to meet the overwhelming mental health needs following extensive community trauma, the base principles of community-based mental health focus on improving access to care through nonspecialized MHPSS services.[20,21] This is particularly relevant for low- to middle-income areas. The primary host communities for Syrian refugees, Jordan and Lebanon, have limited mental health resources. In Jordan, there are fewer than two psychiatrists

and less than one psychologist or social worker per 100,000 citizens.[22-24] In Lebanon, there are approximately two psychiatrists and fewer than three psychologists or social workers per 100,000 citizens.[24]

To remediate the imbalance generated by needs that outweigh available resources, community-based mental health seeks to generate population-based services that are sustainable and scalable to size.[25,26] This is accomplished by expanding mental health care from specialized settings to primary care settings, perhaps most notably promoted through the World Health Organization Mental Health Gap Action Program.[27] Moreover, nonspecialized psychosocial support (in contrast to specialized individual psychotherapy) circumvents the needs for mental health specialists and offers accessible programs that support general mental health and psychological well-being. Indeed, current provisions of mental health care for Syrian refugees by international actors, such as the International Medical Corps and Arabian Medical Relief, follow this model given the shortage of mental health specialists available in host communities. Yet, these models are unable to overcome the lack of awareness of MHPSS programs and mental health in general, with upward of 80% of Syrian refugees reporting no knowledge of psychosocial support programs in their community.[23,28] This is particularly relevant in the host country Turkey, where despite hosting more refugees than any other country, only 9.7% of refugees receive mental health care due primarily to a lack of knowledge about existing services.[29]

To address this gap in awareness and accessibility, the SAMS mental health mission advocated for the expansion or modification of this community-based model beyond primary care settings into community-based providers, termed "peer leaders." These peer leaders are embedded within their communities to provide nonspecialized MHPSS care that is highly visible and accessible by all.[21,30] This model follows recent advancements in the operationalization of community-based mental health, which call for community services that are cognizant of the systemic influences on mental health, including socioeconomic contexts and cultural influences.[31,32] This can be accomplished by utilizing multiple levels of community (i.e., family, social networks, and surrounding organizations) and placing providers with firsthand experience of the reported hardships directly in the primary setting.[30,32]

Specifically, the use of peer leaders creates MHPSS providers that are not only more readily accessible and suitable for scaling services up to size, but also have an intimate understanding of the underlying context from which mental illness emerges in a refugee population. This knowledge is essential to progressing the system of mental health from the current medical model to a more holistic and progressive system that accounts for the pervasive, long-term effects of repeated, sustained trauma experienced by refugees and IDPs.[13] The extent of trauma experienced by Syrians reflects a human devastation that extends beyond our current understanding of trauma-related psychopathology.[10,14] This misconceptualization may account in part for the relatively low prevalence of trauma-related disorders in Syrian refugees,[10] as the clinical manifestation of the human devastation experienced by Syrians may not fit with existing categorical diagnoses.[33,34] To this end, additional research is needed to generate diagnostic criteria for Human Devastation Syndrome to more accurately index their trauma symptomatology and generate novel interventions tailored to their unique experiences.[13,14]

The complexities of these cases are further reflected by the reported need from community MHPSS providers for greater supervision and case consultation. Although community-based mental health services provide increased access to care for beneficiaries, the MHPSS providers are often left with suboptimal specialized support to manage more difficult cases. Approximately 72% of MHPSS providers, both specialized and nonspecialized, who attended the SAMS mental health trainings reported a need for more continuing education opportunities and resources for case consultation and supervision. This report was echoed by providers in refugee camps, where there is very limited access to mental health specialists. These findings highlight a gap in extant models of nonspecialized community-based mental health, which needs to be filled through continued training opportunities such as those provided by the SAMS mission trip, greater collaboration across the spectrum of providers as shown at the SAMS scientific symposium, and extensions of existing telepsychiatry models to include case consultations and specialized supervision.

Overall, there is a need for an interdisciplinary approach to provide adequate specialized support for community-based providers and improve case conceptualizations and diagnostics of mental illness within a Syrian refugee population. This can be accomplished by bridging the gaps between humanitarian aid, professional mental health, and academia through improved data sharing and the expansion of education opportunities for community MHPSS providers through academic institutions.[35,36] To this end, the SAMS scientific symposium called for the formation of a joint committee consisting of Ministries of Development, Health, and Planning, affiliated academic institutions, and NGOs. These branches will provide the necessary specialized support and resources to promote

the development and implementation of evidence-based community mental health practices. This provides a blueprint for future collaborative initiatives promoting community-based models of mental health care in international humanitarian settings.

MOVING FORWARD: RESILIENCE AND GROWTH

An additional theme spanning the mental health trainings and scientific symposium was the promotion of resilience and a transition away from a pure crisis management model of mental health. As the Syrian crisis extends into its eighth year, the mental health needs of the refugee community are proving to be long-standing, requiring a sustainable response that promotes growth and rehabilitation. The concept of building resilience has been positioned as a critical means to address such long-standing psychological stressors and burdens of mental illness.[37,38] However, to date, the construct of resilience has yet to be operationalized, preventing the development of adequate methodologies to foster resilience in an individual and their community.

The concept of resilience operates on the idea of one's ability to defy challenges placed on them by their predispositional traits, circumstances, or environments.[39] Individuals subjected to severe trauma are often confronted with profound and lasting psychological and physical sequelae.[6] Moreover, as seen in the refugee experience, these traumas can be prolonged and repeated over time, exposing an individual to protracted states of psychological trauma that has lasting effects.[40] An individual's response to these subsequent stressors is explained, in part, by their prior reactions or adjustment attempts to trauma.[41] Resilient individuals are able to apply effective coping strategies to overcome their adversity and move forward in life effectively and productively.

Although psychological resilience is often discussed as a fixed, trait-like quality, there is accruing evidence to suggest psychological resilience is malleable and can be developed over time.[39] This includes building, among other qualities, (1) self-efficacy and hardiness, (2) the ability to tolerate and overcome emotional distress, (3) a positive acceptance of change (i.e., progressive, growth mind-set), (4) a perception of control and agency, (5) spirituality, and (6) positive coping skills. This can be accomplished by empowering individuals with skills that are necessary to feel capable of overcoming adversity, including both distress tolerance and emotion regulation skills as well as practical occupational and life skills.[42,43] Under the principles of self-determination theory,[44] building resilience improves therapeutic outcomes and generates sustained growth post-intervention by increasing self-efficacy, self-agency, and the ability to cope with and overcome emotional distress, positioning it as an essential component to facilitate long-term success in adaptation and later reintegration or repatriation efforts.

Indeed, the topic of resilience and related principles of positive psychology were popular among community MHPSS providers. Approximately 66% of responding trainees reported a desire for more training opportunities on resilience and psychotherapeutic interventions promoting positive psychology. More nonspecialized, positive psychology therapy groups were among the most reported needs from MHPSS providers in surveyed refugee camps. However, to date, there are limited evidence-based interventions to build resilience, specifically in the context of refugee mental health and humanitarian response. As the extent of trauma, which these individuals have experienced, extends far beyond current models of trauma-related disorders, novel conceptualizations and advancements in the understanding of their psychological trauma are needed to generate adequate and sensitive interventions to build resilience.

Toward this end, the scientific symposium further proposed an interdisciplinary approach to define resilience in the context of refugee mental health, with the direct goal of generating a clear and coherent guide for methodologies to build resilience. Attendees noted the importance of generating holistic and community-based interventions for resilience that account for the biopsychosocial influences underpinning the human devastation experienced by so many Syrians. This includes expanding services beyond standard clinical models of mental health care to include occupational skills training and provision of basic needs that empower and embolden the individual. This method can be seen in practice through the peer leaders program enacted by SAMS, which gives individuals the skills necessary to not only overcome their own adversities but teach others how to do so as well. This provides a model for psychosocial support programs that meet both the basic and psychological needs of individuals to prepare them for the future living of a satisfactory and functional life. Under these principles, resilience can provide the bridge between humanitarian aid and professional mental health, improving both psychological and functional outcomes. Eight years after the Syrian crisis, the time is now ripe to incorporate the concepts of a resilience model into current psychosocial interventions to move toward a progressive, growth mind-set and promote success in future reintegration and repatriation efforts.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. United Nations High Commissioner for Refugees. 2018. Regional Refugee and Resilience Plan. Annual Report. Available from: https://data2.unhcr.org/en/documents/download/68557. [Last accessed on 26 Aug. 2019.
2. United Nations Children's Fund. 2019. UNICEF Whole of Syria Crisis Situation Report: July 2019 Humanitarian Results. Available from: https://reliefweb.int/report/syrian-arab-republic/unicef-whole-syria-crisis-situation-report-july-2019-humanitarian. [Last accessed on 26 Aug. 2019].
3. Breslau N. Psychiatric morbidity in adult survivors of childhood trauma. Semin Clin Neuropsychiatry 2002;7:80-8.
4. Chu DA, Williams LM, Harris AW, Bryant RA, Gatt JM. Early life trauma predicts self-reported levels of depressive and anxiety symptoms in nonclinical community adults: Relative contributions of early life stressor types and adult trauma exposure. J Psychiatr Res 2013;47:23-32.
5. Copeland WE, Shanahan L, Hinesley J, Chan RF, Aberg KA, Fairbank JA, *et al*. Association of childhood trauma exposure with adult psychiatric disorders and functional outcomes. JAMA Netw Open 2018;1:e184493.
6. Kessler RC, Aguilar-Gaxiola S, Alonso J, Bromet EJ, Gureje O, Karam EG, *et al*.; WHO World Mental Health Survey Collaborators. The associations of earlier trauma exposures and history of mental disorders with PTSD after subsequent traumas. Mol Psychiatry 2018;23:1892-9.
7. El Arnaout N, Rutherford S, Zreik T, Nabulsi D, Yassin N, Saleh S. Assessment of the health needs of Syrian refugees in Lebanon and Syria's neighboring countries. Confl Health 2019;13:31.
8. Wells R, Steel Z, Abo-Hilal M, Hassan AH, Lawsin C. Psychosocial concerns reported by Syrian refugees living in Jordan: Systematic review of unpublished needs assessments. Br J Psychiatry 2016;209:99-106.
9. Hassan G, Kirmayer LJ, MekkiBerrada A, Quosh C, el Chammay R, Deville-Stoetzel JB, *et al*. 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. Geneva, Switzerland: UNHCR; 2015.
10. Syrian American Medical Society. 2018. Human Devastation Syndrome: The Impact of Conflict on Mental Health. Available from: https://www.sams-usa.net/wp-content/uploads/2018/11/Mental-health-report-17.pdf. [Last accessed on 26 Aug. 2019].
11. McEwen BS. Stress, adaptation, and disease. Allostasis and allostatic load. Ann N Y Acad Sci 1998;840:33-44.
12. McEwen BS. Mood disorders and allostatic load. Biol Psychiatry 2003;54:200-7.
13. Hamza MK. From rubbles to resilience. In: Kolia R, chair. Towards an Integrated Model of Refugee MHPSS. Symposium conducted at the Regional to Global Transition of Refugee Mental Health toward Resilience Scientific Symposium, Amman, Jordan, July 2019.
14. Ahmed SR, Mahmood SU, Waheed H. Rise of human devastation syndrome in Syria. Int J Commun Med Public Health 2018;5:1227-9.
15. Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies. Lancet 2004;364:2058-67.
16. Orcutt M, Rayes D, Tarakji A, Katoub M, Spiegel P, Rubenstein L, *et al*. International failure in northwest Syria: Humanitarian health catastrophe demands action. Lancet 2019;394:100-3.
17. Pant S, Eder B, Vračar A, Mosca D, Orcutt M. WHO'S global action plan to promote the health of refugees and migrants. BMJ 2019;366:l4806.
18. Epping-Jordan JE, van Ommeren M, Ashour HN, Maramis A, Marini A, Mohanraj A, *et al*. Beyond the crisis: Building back better mental health care in 10 emergency-affected areas using a longer-term perspective. Int J Ment Health Syst 2015;9:15.
19. Ventevogel P, van Ommeren M, Schilperoord M, Saxena S. Improving mental health care in humanitarian emergencies. Bull World Health Organ 2015;93:666-666A.
20. Hassan G, Ventevogel P, Jefee-Bahloul H, Barkil-Oteo A, Kirmayer LJ. Mental health and psychosocial wellbeing of Syrians affected by armed conflict. Epidemiol Psychiatr Sci 2016;25:129-41.
21. Macy RD, Behar L, Paulson R, Delman J, Schmid L, Smith SF. Community-based, acute posttraumatic stress management: A description and evaluation of a psychosocial-intervention continuum. Harv Rev Psychiatry 2004;12:217-28.
22. Abu Hassan H. MHPSS current status in Jordan: Challenges and implementation. In: Kolia R, chair. Towards an Integrated Model of Refugee MHPSS. Symposium conducted at the Regional to Global Transition of Refugee Mental Health towards Resilience Scientific Symposium, Amman, Jordan, July 2019.
23. International Medical Corps. 2017. Understanding the Mental Health and Psychosocial Needs, and Service Utilization of Syrian Refugees and Jordanian Nationals. Available from: https://data2.unhcr.org/en/documents/download/62036. [Last accessed on 26 Aug. 2019].
24. World Health Organization. World Health Statistics 2010. Geneva, Switzerland: World Health Organization; 2010.
25. Bogart LM, Uyeda K. Community-based participatory research: Partnering with communities for effective and sustainable behavioral health interventions. Health Psychol 2009;28:391-3.
26. Bond GR, Drake RE, McHugo GJ, Peterson AE, Jones AM, Williams J. Long-term sustainability of evidence-based practices in community mental health agencies. Adm Policy Ment Health 2014;41:228-36.
27. World Health Organization. MhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental Neurological and Substance Use Conditions in Humanitarian Emergencies. Geneva, Switzerland: World Health Organization; 2015.
28. Askgaard R, Hansen AKV, Abou-Diab D, Tortur DDIm, Dansk F. Needs and Barriers for Mental health and Psychosocial Support among Syrian Refugees in Lebanon: Perspectives for Future Intervention. Danish Refugee Council; 2018.
29. Kaya E, Karadag Caman O, Kilic C, Uner S. Need for and barriers to accessing mental health care among refugees in Turkey: A mixed methods study. Eur J Public Health 2018;28:cky213.453.
30. Kolia R. MHPSS community based services: Vision and trends. In: Granlund M, chair. Highlights on the Community-based Approach as Future Trend of Intervention in Crisis. Symposium conducted at the Regional to Global Transition of Refugee Mental Health towards Resilience Scientific Symposium, Amman, Jordan, July 2019.
31. Thornicroft G, Alem A, Antunes Dos Santos R, Barley E, Drake RE, Gregorio G, *et al*. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. World Psychiatry 2010;9:67-77.
32. Thornicroft G, Deb T, Henderson C. Community mental health care worldwide: Current status and further developments. World Psychiatry 2016;15:276-86.
33. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: APA; 2013.
34. World Health Organization. 2018. International Statistical Classification of Diseases and Related Health Problems. 11th Revision. Available from: https://icd.who.int/browse11/l-m/en. [Last accessed on 26 Aug. 2019].
35. Khader Y. Anticipated role of academic institutions in regulating and guiding refugee MHPSS: Curriculum development training. In: Kanawati Y, chair. Academic Challenges, Research and Data Management. Symposium conducted at the Regional to Global Transition of Refugee Mental Health towards Resilience Scientific Symposium, Amman, Jordan, July 2019.
36. Mansour A. Integrated mental health training in nursing and medical schools. In Kanawati Y, chair. Academic Challenges, Research and Data Management. Symposium conducted at the Regional to Global

Transition of Refugee Mental Health towards Resilience Scientific Symposium, Amman, Jordan, July 2019.
37. Norris FH, Tracy M, Galea S. Looking for resilience: Understanding the longitudinal trajectories of responses to stress. Soc Sci Med 2009;68:2190-8.
38. Sheerin CM, Lind MJ, Brown EA, Gardner CO, Kendler KS, Amstadter AB. The impact of resilience and subsequent stressful life events on MDD and GAD. Depress Anxiety 2018;35:140-7.
39. Joyce S, Shand F, Tighe J, Laurent SJ, Bryant RA, Harvey SB. Road to resilience: A systematic review and meta-analysis of resilience training programmes and interventions. BMJ Open 2018;8:e017858.
40. Herman JL. Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. J Traumatic Stress 1992;5:377-91.
41. Sheffler JL, Piazza JR, Quinn JM, Sachs-Ericsson NJ, Stanley IH. Adverse childhood experiences and coping strategies: Identifying pathways to resiliency in adulthood. Anxiety Stress Coping 2019;32:594-609.
42. Lee S, Mason M. Effectiveness of brief DBT-informed group therapy on psychological resilience: A preliminary naturalistic study. J Coll Stud Psychother 2019;33:25-37.
43. United Nations High Commissioner for Refugees. 2017. Resilience and Self-reliance from a Protection and Solutions Perspective. Available from: https://www.unhcr.org/en-au/58ca4f827.pdf. [Last accessed on 26 Aug. 2019].
44. Deci EL, Ryan RM. Self-determination theory in health care and its relations to motivational interviewing: A few comments. Int J Behav Nutr Phys Act 2012;9:24.