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# ASSESSMENT OF PSYCHOLOGICAL PROBLEMS AMONG SYRIAN REFUGEES IN QUSHTAPA CAMPS–ERBIL GOVERNORATE

**A THESIS SUBMITTED TO THE COUNCIL OF THE COLLEGE OF NURSING AT UNIVERSITY OF SULAIMANI IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE MASTER DEGREE IN PSYCHIATRIC AND MENTAL HEALTH NURSING**

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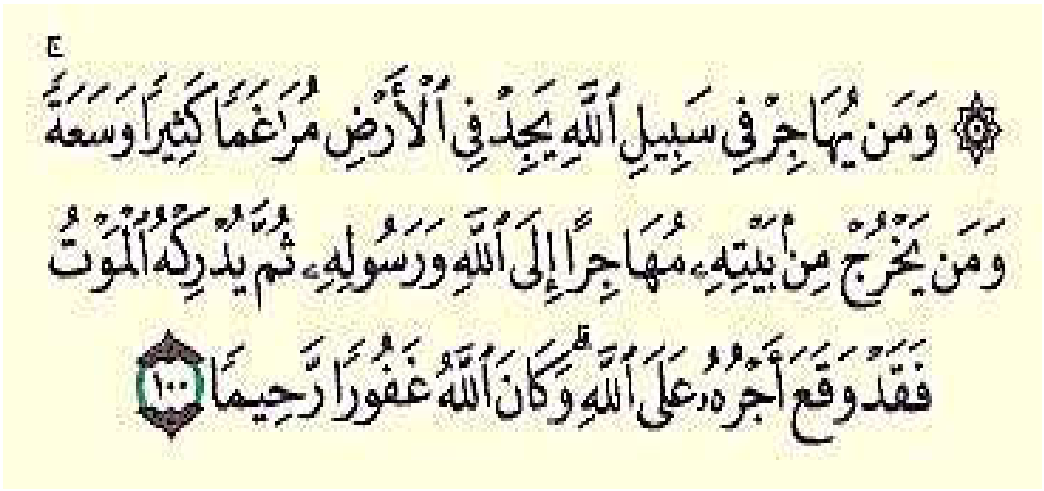
# Dedication

*The study is dedicated to my late father and mother who encouraged me to enter nursing against cultural norms and supported me with her prayers, and to my wife who was always there for me and sacrificed much for me to complete my project.*

*Great thanks for my supportive sisters and brothers and my bigger beloved family especially for my brother Ramazan who supported me in all stages of my life. Finally dedicate to my little baby Rahael I'm looking for him to have wonderful future*

*Mariwan*



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## ABSTRACT

**Background and Objective:** to assess the Psychological Problems among Syrian Refugees in Qushtapa Camps, that located southern of Erbil city.

**Methodology:** A descriptive study was conducted between 15th of November, 2015 till the 15thOctober, 2016. The community of Syrian refugees as of April 17th 2016, defined by the number of Syrian refugees registered were (6410). Randomly (300) subjects were selected to be a study sample. The Refugee Health Screener 15 (RHS-15) was designed by Pathways to Wellness agency was used as tools of the present study. The pilot study was carried out for the period from 25th, of May-10th of June, 2016. Reliability of the tool was determined through the use of test and retest approach and the interval period was two weeks. The Pearson correlation coefficient (***r)*** was computed. The result of reliability was (0.91).

**Results:** the study finding shows that (60.7%) of refugees had mild symptomatic of anxiety, and (38%) had moderate level, (62.7%) of refugees had moderate symptomatic of depression, and (36.3%) had mild level, (53%) of refugees had mild symptomatic of post-traumatic stress disorders, and (45.3%) had Moderate level, and 96.3% of them suffered from emotional distress.

**Conclusions and Recommendations:** the study concluded that the majority of refugees had symptomatic of anxiety, depression and post-traumatic stress disorders. approximately, all of Syrian refugees had emotional distress. finally, the study recommended that improve living conditions of Syrian refugees particularly in Qushtapa camp. fear of environmental threats and the need to improve living conditions were mostly acknowledged by Syrian refugees in these camp.

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## List of Abbreviation and Symbols

| | |
|---|---|
| APA | American Psychological Association |
| DF | Degree of freedom |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| EMPHNET | Eastern Mediterranean Public Health Network |
| ERC | Erbil Refugee Council |
| GAD | Generalized anxiety disorder |
| IMC | International medical group |
| MDD | Major depressive disorder |
| No. | Number |
| PTSD | Posttraumatic Stress Disorder |
| RHS | Refugee Health Scanner |
| SES | socioeconomic status |
| SD | Standard deviation |
| SPSS | Statistical package of social sciences |
| IASC | The Inter-Agency Standing Committee |
| IDPs | Internal displacement peoples |
| MHPSS | The Mental Health & Psychosocial Network |
| N.S | Not significant |
| UK | United kingdom |
| UNDP | United Nations Development Program |
| UNICEF | United nations international children's emergency fund |
| USA | United State of America |
| WHO | World health organization |
| & | And |
| % | Percentage |
| < | More than |
| > | Less than |
| U | Mann-Whitney test |
| $\sum$ | Summation |
| ± | Pulse/minus |
| $X^2$ | Chi- square |
| $X$ | Mean |

# CHAPTER ONE

# INTRODUCTION

# Chapter One
# INTRODUCTION

## 1.1. Introduction

Worldwide, the number of refugees defined, narrowly by the refugee convention as individuals who have been forcibly displaced outside their native countries, is estimated to be about 13 million plus a much larger number of former refugees granted citizenship in their new countries. Refugees could be at excess risk of psychiatric morbidity because of forced migration, traumatic events, and resettlement in unfamiliar environments. The relevant epidemiological evidence is, however, generally sparse, scattered, and apparently conflicting, and its interpretation has been complicated by the use of different sampling and assessment methods. For example, estimates of the prevalence of post-traumatic stress disorder in adult refugees have ranged from 3% to 86% and those for major depression have ranged from 3% to 80% (Lavik *et al*.,1996).

It was report a systematic review of interview-based psychiatric surveys of unselected refugee populations based in economically developed western countries. The continuing psychological impacts of trauma experiences prior to resettlement have been a longstanding focus of the refugee literature. Exposure to trauma may lead to a range of psychological reactions, including Posttraumatic Stress Disorder (PTSD). (Steel *et al*.,2002)

Persons experiencing the psychological effects of trauma may report feelings of fear, sadness, guilt and anger. Psychological sequelae include depression, anxiety and substance misuse. Trauma related syndromes include significant distress or impaired functioning, often involving intrusive thoughts and emotions about the traumatic events, avoidance, emotional numbing and/or hyper-arousal. Consistent and strong links have been made between pre-migration trauma and mental health in resettlement (Silove, *et al*., 2009).

It found prevalence rates for PTSD of 9% and for major depression of 5% among adults (sample size = 6,743; from 20 studies) and for PTSD among children of 11% (sample size = 260; 5 surveys). The authors point out that research to date on prevalence of psychiatric illness among refugees has been idely variable. The studies differ dramatically in terms of the populations studied, sample size, recruitment strategy, and the quality of the research design. In general, they point out that larger studies have lower prevalence rates (Fazel *et al*., 2005).

Another meta-analysis by Porter and Haslam (2005) combined pre- and post-displacement factors over 56 studies to provide additional insights into the overall trends within those data. They were found that refugees had worse outcomes than their non-refugee control comparisons (weighted mean effect size = 0.41). They also found that refugees (a) who were in institutional accommodation and had restricted economic opportunity, (b) who were displaced internally within their own country (i.e. had not been resettled in another country), and (c) whose initiating conflict in their country of origin was unresolved, had worse outcomes. In addition, those who were from rural backgrounds, with higher levels of

education, and higher pre-displacement socioeconomic status had worse outcomes. Importantly, they found that post-displacement factors moderated outcomes. That is, the situations in which refugees were living after they were displaced affected the relationship between their pre-displacement experiences, e.g., trauma, SES, and their post-displacement outcomes.

Post-migration difficulties may also be a result of the particular refugee's compatibility with the host culture and the nature of the resettlement program. The nature of the Australian humanitarian program may interact with various individual characteristics and circumstances to affect refugee responses in resettlement. Colic-Peisker and Tilbury (2003) suggest that active ('achievers' and 'consumers') versus passive ('endurers' and 'victims') approaches to resettlement by the refugees may interact with host community reactions to refugees. They suggest that medicalisation of the refugee experience in Australia may encourage refugees to take on a passive role which may decrease the likelihood of positive post-migration outcomes. The interaction between person and environment in resettlement cannot be overlooked. This interaction is also manifest in the access and utilisation of various community services across ethnic groups. Several writers suggest that the lack of cultural fit between traditional western psychotherapy and refugee beliefs about mental health and psychological disorders are among the most significant barriers to traditional mental health programs when such programs are available (Miller, 2009; Kemp, 2006; Steel *et al*., 2005).

Accordingly, refugees tend to rely more on the medical system than on mental health services for relieving symptoms of psychological distress (Brainard and Zaharlick, 2009).

Adjustment to geographical and cultural relocation requires considerable attention and energy from refugees in the beginning stages of resettlement. Almost overnight, individuals find themselves confronted by, amongst other things, a new language, cultural values and worldviews, foods and traditions, paperwork and systems of business and currency. Particularly with recent changes in the countries of origin for refugees entering Australia's humanitarian program, the "cultural gap" between Australian society and incoming refugees has grown even larger. That is, refugees now entering Australia tend to be even more disparate in cultural norms and lifestyle when compared to earlier waves of refugees, such as those from Eastern Europe. Individuals and ethnic minority groups vary in the extent to which they maintain their cultural and ethnic heritage and in the degree to which they interact with the larger society when entering a new country. (Berry *et al*., 2002)

According to models of acculturation individuals and minority ethnic groups are considered to integrate, assimilate, separate, or to be marginalised within the larger society. Literature with immigrants and refugees suggests that newcomers who integrate into mainstream society have better outcomes than those who approach resettlement differently (Young, 2006;Valtonen, 2004).

However, these studies have largely been done within societies that encourage newcomers to integrate into the mainstream society, which may confound these results. For refugee children and adolescents in Australia, those who had the most positive attitudes toward both their culture of origin and Australian culture had the highest ratings of self-worth and peer social acceptance (Kovacev, 2004).

When adapting to Australia, refugees are faced with a sudden loss of identity and subsequent demands to reconstruct themselves within the new context (Colic-Peisker and Walker, 2003).

Individuals, family members and cultural groups vary in the rate and degree to which the new identity changes to become more similar to norms that apply within mainstream Australian culture (Sonderegger and Barrett, 2004).

This can be a major source of tension and conflict for families, communities and service providers. Families, just like individuals, must reconstruct themselves, with individuals taking on new social roles and responsibilities. Children and adolescents frequently become language brokers as their English skills often advance more rapidly than those of adults. Parental roles change and cultural differences in family structure and discipline may be at odds with Australian norms. Where refugee families are considered to be at risk of domestic violence, partly because of their experiences in forced migration and differences in behavioural norms, culturally appropriate interventions are a necessity (Pan *et al*., 2006).

Particular emphasis has been placed on the psychological vulnerabilities of child refugee claimants who have been held in immigration detention. Thomas and Lau (2002) conducted an extensive review of local and international research into the mental health status of children and adolescents who were refugees or were detained in the course of claiming refugee status. Thomas and Lau concluded that symptoms of post-traumatic stress are common amongst child and adolescent refugees.

The studies they reviewed also offered evidence for a direct relationship between the level of premigration trauma to which young people were subjected and their levels of post-migration post traumatic stress. Children who were separated from parents or other caregivers were more likely to exhibit symptoms of depression.

Thomas and Lau (2002) found evidence in the reported research for an inverse linear relationship between the time since the traumatic events occurred and young people's level of post traumatic stress symptoms. Symptoms of traumatic stress decreased over time. However, they noted evidence in the research they reviewed which suggested that parents and other caregivers may underestimate young people's levels of psychological stress and distress, and that young people's levels of psychological dysfunction were related to levels of psychological dysfunction within their families. Their literature review provided strong evidence for the existence of co-morbid physical and psychological symptoms amongst young refugee claimants and for family separations and unaccompanied arrival having a negative influence on young detainees' physical and psychological health and wellbeing.

Finally, the inquiry concluded that "the education available to children in detention fell significantly short of the level of education provided to students with similar needs in the community that "on-site detention centre schools failed to develop a curriculum suited to the needs and capabilities of children in immigration detention and that "Children were inadequately assessed as to their educational needs, and there was insufficient reporting of their educational progress".

## 1.2. Importance of the study:

The refugees have experienced trauma and that the choice to leave their home country was not their own. As a result of these traumatic events, which can occur before leaving home, during migration, or even after entering the host country, about half of refugees will arrive at their final destination with Psychological problems (Carballo, 2011). This study builds on previous research that The International Organization on Migration conducted the aim of assessing the mental health and Psychological needs and investigating the provision of services available in the camp. The scale of Psychological indicators used in the assessment correlated four social indicators (housing, schooling, employment and social life The majority of problems refugees experience in their new country as indicated by literature are isolation and solitude, language barriers, unemployment and challenges to integration (IOM, 2008; Laban, 2005). This situation can be worsened if refugees cannot access or lack information allowing them to approach the social support and assistance that may be available to them, particularly health and Psychological assistance. This could be due to unfamiliarity with the system, language difficulties, or insufficient insurance coverage (Laban *et al*., 2007). For example, health services available to Iraqis are much more limited in Syria and Jordan than those found in welfare- based European countries such as Denmark and Sweden. Recently numbers of refugees increase in the Kurdistan region of Iraq, more than 1,000,000 refugees living in Erbil city camps. The researcher was motivated to carry out a study in this field and in this specific area.

## 1.3.The problem statement:

Assessment of psychological problems among Syrian Refugees in Qushtapa Camp-Erbil Governorate.

## 1.4. The objectives of the study:

1- To assess the Psychological Problems(Anxiety, Depression, PTSD and Emotional distress) among Syrian Refugees in Qushtapa Camps

2-To assess the factors that contribute to those Psychological Problems and their demographic characteristics such us (age, gender, education, home residency, financial support and losses of family members).

### 1.5. Definition of terms

**1.5.1.a Psychological problem ( Theoretical):** A psychological problem is a disorder of the mind involving thoughts, behaviors, and emotions that cause either self or others significant distress.(Franklin,2016)

**1.5.1.b Psychological problem (Operational):**The refugee's problems that facing them during displacement and effected their psychological statues and appeared as symptomatic of anxiety, depression, post traumatic depression as well as emotional distress.

**1.5.2.a Refugee (Theoretical):** Persons fleeing armed conflict or persecution. **(UNHCR,2016).**

**1.5.2.b. Refuges (operational):** persons who feels for refuge or safety, especially to a foreign country as in time of political upheaval and war.

**1.5.3.a Camp (Theoretical):**

A place where tents, huts, or other temporary shelters are set up, as by s oldiers, nomads, or travelers **(En.wikipedia,2016).**

**1.5.3.b Camp (Operational):** a place usually away from urban areas where tents or simple buildings (as cabins) are erected for shelter or for temporary residence (as for laborers, prisoners, or vacationers).

# CHAPTER TWO

# REVIEW OF LITERATURE

# Chapter Two
# Review of Literatures

## 2.1. Overview of problem:

The conflict in Syria between the government of Bashar al-Assad and various other forces, which started in spring of 2011, continues to cause displacement within the country and across the region. By the end of 2014, an estimated 7.6 million people were internally displaced and 3.7 million Syrians had fled the country since the conflict began (OCHA, 2014; UNHCR, 2015a). During 2014, more than one million Syrians were newly registered as refugees in neighboring countries, bringing the total number of registered refugees in the region to 3,688,402 by year-end (UNHCR 2014a; UNHCR, 2015a). As large as the number of newly registered refugees is, in a sense it underestimates the current crisis as it excludes the 117,590 Syrians who were awaiting registration at the end of 2014 (UNHCR, 2015a), and de facto Syrian refugees who were residing in the region but who were not formally registered or awaiting registration.

The Syrian conflict has placed enormous strain on its neighboring countries, with Jordan, Lebanon, and Turkey shouldering the largest burden. By the end of 2014, Lebanon, a country of approximately 4.8 million people before the onset of the Syrian refugee crisis, hosted 1,146,405 registered Syrian refugees, meaning that nearly one in every five people now living in Lebanon is a Syrian refugee (UNHCR, 2015a). As of December 31, 2014, Turkey hosted the largest Syrian population, with 1,552,839 registered refugees; Jordan housed the third largest population with 622,865 registered refugees (UNHCR, 2015b). In comparison, Iraq and Egypt accommodated a smaller yet substantial number of Syrians,

hosting 228,484 and 137,812 registered refugees, respectively (UNHCR, 2015c). María Eugenia Casar, undersecretary general and associate administrator of the United Nations Development Programme (UNDP), has reported that "countries hosting Syrian refugees are struggling with the massive impact on their economies, societies, and infrastructure threatening not only their stability but the stability of the entire region" (cited in UNHCR, 2014b). The scope and protracted nature of the Syrian conflict has made the situation for Syrian refugees and their host communities exceedingly difficult. Syrian refugees face tension among host community populations and struggle to secure basic needs like security, food, and shelter (Orhan and Ortun, 2014).

With the humanitarian situation caused by the Syrian conflict continuing to deteriorate, Syrians are increasingly seeking asylum in states outside the region. In 2013, Syria became for the first time the main country of origin of asylum seekers in 44 industrialized countries in Europe, North America, and the Asia Pacific region (UNHCR, 2014d). An estimated 56,400 Syrians requested refugee status in the 44 industrialized countries in 2013, more than double the number of Syrian asylum claims in 2012 (25,200) and six times the number in 2011 (8,500) (UNHCR, 2014e). In 2014, the number of Syrian asylum seekers in the 44 industrialized countries reached 149,600, the highest number recorded by a single group since 2002 (UNHCR, 2015h).

The refugee situation caused by the Syrian conflict is dire. Lebanon, Jordan, Iraq, Egypt, and Turkey host massive numbers of Syrian refugees, and Syrians are increasingly seeking protection outside these countries as well. This paper looks at the burdens and costs of the Syrian refugee crisis and considers how they have, or have not, been shared by the international community at large, and in particular by Germany, Sweden, the United

Kingdom, and the United States. These four states were chosen as a focal point because they accommodate relatively large numbers of asylum seekers annually and enjoy a positive reputation for providing refuge to those in need in times of crisis.

According to UNHCR's annual asylum trends reports of 44 industrialized states, between 2009 and 2013, Germany, Sweden, the United Kingdom, and the United States ranked among the top five states receiving asylum claims (UNHCR, 2014d). Each country has also demonstrated a significant commitment to alleviating the Syrian refugee crisis. The United States and the United Kingdom are the largest single-state bilateral donors of humanitarian aid for the Syrian crisis (Pierce, 2014), and Germany and Sweden have admitted the largest number of Syrian refugees among industrialized states outside the region.

Through a comparison of these four countries, this paper illustrates how some industrialized states have responded to the Syrian refugee influx and draws attention to differences and similarities in their responses. After comparing the contributions and responses of industrialized states to each other and to the contributions and responses of Syria's neighboring states, this paper puts forward two types of recommendations. First, to reduce the strain on neighboring countries, it recommends increasing the level of burden sharing by the international community as a whole as well as increasing the distribution of this burden among industrialized states. Second, to enhance the level of protection available for Syrians in states beyond the region, this paper recommends that states:

(1) increase refugee resettlement;

(2) allow refugees to seek protection through embassies in the region; and (3) facilitate family reunification and other legal avenues for

admission, such as private sponsorship, medical evacuation, humanitarian visas, academic scholarships, and labor mobility schemes.

The Syrian Refugee Crisis in Neighboring Countries The neighboring countries of Turkey, Lebanon, Jordan, Iraq, and Egypt have provided valuable protection to Syrian refugees since the conflict began in 2011. They have generally allowed Syrians access to their territories and have dedicated significant financial resources and social services to help them.27 For example, Turkey, by the start of December 2014, had invested USD 4.5 billion in direct assistance to Syrian refugees in their country (Guterres, 2014). As of mid-2014, Jordan and Lebanon had spent more than USD 1.2 billion and USD 1.6 billion, respectively (UNDP, 2014).

The central Iraqi government and regional Kurdistan government also contributed to the Syrian refugee response by providing core relief items, cash assistance, and essential services (such as free access to health care) (UNHCR, 2015f).

The burden placed on these countries is immense and has had adverse social and economic costs on the host communities. More than 80 percent of registered Syrian refugees in neighboring countries live in communities and cities rather than designated refugee camps. The influx of large numbers of refugees to urban settings has dramatically shifted the demographic composition in some areas and strained basic social services like water, sanitation, food, health care, housing, and electricity (UNDP, 2014).

The Report of 2014 United Nations Development Program (UNDP) described the refugee influx as a large-scale “de facto acceleration of urban growth” which has not been matched by increases in housing, service provision, infrastructure, and market capacity adequate to meet the requirements of the increased population (ibid). The areas and communities

that were already among the poorest prior to the crisis (i.e., the northern region in Jordan and in Lebanon along the Syrian border) have been particularly hard hit. They have had to absorb some of the largest numbers of refugees, yet have less resources and wealth than towns and cities located farther away from the Syrian border (ibid.).

In Lebanon, a country with major development challenges that pre-dated the Syrian refugee crisis, the impact has been particularly devastating. Lebanon now has the highest per capita rate of refugees worldwide (Inter-Agency, 2015a).

Since the start of the Syrian conflict in March 2011, the number of people residing in the country has increased by nearly 25 percent, and the people living under poverty has risen by nearly two-thirds. Public institutions struggle to cope with the added volume of demands for their services. Lebanese national health, education, and infrastructure services are overstretched, and in some areas demand for electricity, water, and waste collection far surpass the capacity to meet the needs (Government of Lebanon and OCHA, 2014).

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For Syrian refugees in Lebanon, shelter is a serious concern due to the absence of formal refugee camps and the lack of affordable housing. At the end of 2014, 55 percent of the 1,146,405 registered Syrian refugees lived in substandard shelter, mainly in informal settlements, garages, worksites, or unfinished buildings. The number of house evictions and dismantling of informal refugee settlements has also increased, and an estimated 29 percent of Syrians were unable to meet their basic needs (ECHO, 2015).

The situation in Jordan is also dire. In 2014, 84 percent of the 622,865 registered Syrian refugees lived in urban and rural areas across the

country rather than in official refugee camps. Around two-thirds of the population outside camps in 2014 lived below the Jordanian absolute poverty line (USD 96 per month), and one-sixth were below the abject poverty line (USD 40 per month) (UNHCR, 2014e).

Among the Syrian households outside camps, 46 percent were without heating and two-fifths had poor sanitary conditions. In Turkey, tension has been rising in cities and towns bordering Syria due to the growing Syrian population, which reached 1,552,839 registered refugees at the end of 2014 (Amnesty International, 2014; UNHCR, 2014a). More than 70 percent of these refugees lived outside of government run refugee camps, often in overcrowded rental houses (InterAgency, 2014a).

Though camp settings provide basic services, many Syrians outside of camps struggle to secure basic needs like housing, health care, and education, and some live in abject poverty, often in unsanitary, even dangerous housing conditions (Amnesty International, 2014). For Syrian refugees in Iraq and Egypt, changes in the security and political landscape in each country have negatively impacted the refugees' living conditions. As the armed conflicts in Syria and Iraq have intensified and become intertwined, the situation for Syrians in Iraq has deteriorated. In particular, humanitarian agencies reported a deterioration of asylum space in 2013 in the Kurdistan region, especially in the Erbil governorate where the authorities temporarily discontinued assistance and issuance of residency permits to refugees in October 2013 (Inter-Agency, 2014b).

Although assistance and issuance of residency permits was reinstituted in 2014, the security situation remains tense in the central and northern region (Inter-Agency, 2015b). On top of the 228,484 registered Syrian refugees, two million Iraqis were internally displaced by violence in 2014 alone, overloading the resources of host communities who

accommodated both refugee and internally displaced populations (UNHCR, 2015f). In Egypt, despite the government's initial commitments to provide refugees with access to public health and education on equal footing with Egyptians, the protection available for Syrians has decreased due to a change in the political environment (Inter-Agency, 2014c). In July 2013, the Egyptian government altered its policy and introduced visa requirements for Syrians, who had previously been exempt from this regulation (Inter-Agency, 2014c).

The introduction of visa requirements has significantly limited access to the country (Ayoub and Khallaf, 2014). Additionally, hostility toward Syrian refugees has increased, particularly following the government regime change in July 2013 (Inter-Agency, 2014c).

## 2.2. The Mental Health Impact upon Refugees

Whilst the sequelae of the refugee experience encompasses and affects many areas of psychosocial functioning such as individual functioning, community structure, education, economics, and politics this section will be restricted to a review of the literature investigating the prevalence of mental health outcomes in refugee populations, in particular adults, children, and families. Research has singled out mental health as of special concern in refugee populations, leading to an extensive body of literature in this area (Heptinstall *et al*., 2004).

This literature is important to health professionals not only because of the large number of people who are adversely affected by the refugee experience, but because many of these individuals will require access to, or be confronted by mental health services from outside their cultures of origin. Therefore, the development of a knowledge base which will help to

inform more culturally appropriate practice to help promote optimal outcomes is essential (Keyes, 2000).

The number of studies investigating the prevalence of psychological disorders in refugees is extensive, but the majority of these studies have focused on posttraumatic stress disorder (PTSD) and depression (Turner *et al*., 2003), with some studies also investigating disorders such as psychotic illnesses, anxiety disorders, and alcohol abuse (e.g., Bhui *et al*., 2007; Fazel *et al*., 2005; Steel et al., 2009).

**2.3. Posttraumatic Stress Disorder**

The current edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) describes PTSD as an anxiety disorder which follows a direct, personal experience of a traumatic event. The traumatic event must involve actual or threatened death or injury to the person or to others, and to which the person responds with intense fear, hopelessness, or horror. The traumatic event is usually described as being outside the range of usual human experience, such as exposure to military combat, violent assault, torture, rape or natural disasters.

The person must then display persistent symptoms that fall into three broad categories:

(a) re-experiencing of the trauma (e.g., through intrusive recollections or dreams of the trauma);

(b) avoidance and numbing symptoms (e.g., avoiding places that remind them of the trauma or diminished interest in activities), and;

(c) increased arousal symptoms (e.g., hyper-vigilance or sleeping difficulties). Although these are typical and expected reactions following a traumatic event, for a person to be diagnosed with PTSD, the re-experiencing, avoidance and arousal must occur for longer than one month

after exposure to the trauma, and these symptoms must cause significant distress, and/or impairment in important areas of the person‟s functioning. The criteria for PTSD are slightly different for children. Instead of responding with intense fear, hopelessness or horror, the response in children must involve disorganized or agitated behavior (APA, 2000).

PTSD is one of the most disabling of the anxiety disorders and causes significant impairment in occupational and social functioning, high rates of suicidality, and is associated with more medical illness (Marshall *et al*., 2001). However, the exact burden of disability arising from PTSD in refugee populations is unknown because most surveys do not record the functional impairment associated with the disorder (Fazel *et al*., 2005).

## 2.4. Depression

Most people experience sadness in their life in response to experiences of loss, failure and stress. However, clinical depression is a much more intense and longer lasting mood disturbance that significantly interferes with one's day-to-day functioning. Major depression is characterized by chronic feelings of sadness, irritability, anger and hedonia. It involves cognitive symptoms, such as thoughts of worthlessness, diminished ability to think, and suicidal ideation. It is also characterized by physical symptoms, such as changes in appetite, sleeping patterns, tension and fatigue (APA, 2000). Currently, major depression is the world's third leading cause of burden of disease and it is expected to rise to first place in 2030 (WHO, 2008). However, the application of Western mental health diagnoses such as PTSD and depression to non-Western refugee individuals has generated much controversy. As such, it is pertinent to present an overview of this debate.

## 2.5.Controversy surrounding psychiatric diagnoses with refugee populations

The application of psychiatric diagnoses to non-Western refugee populations has generated much debate and has proved very controversial in the refugee field (Ehntholt and Yule, 2006; Rousseau, 2005). Some researchers have argued that applying psychiatric diagnoses to refugees is inappropriate because these diagnostic labels cannot account for or do justice to the pervasive effects of the refugee experience, such as the disintegration of a community‟s social and cultural fabric (Rousseau, 2005).

Others also argue that assigning psychiatric labels to trauma survivors unnecessarily pathologises and medicalizes normal responses to abnormal experiences (e.g., Summerfield, 2009). However, in response to these criticisms, cross-cultural researchers and clinicians argue that these labels allow for, and encourage those in authority to allocate the resources required to take action, offer help, and alleviate the person‟s distress (Ehntholt and Yule, 2006).

Nicholl and Thompson (2004) provide an excellent summary of other controversial issues specific to PTSD. In this summary, Nicholl and Thompson highlight that non-Western populations place different values and meanings on PTSD symptomology and in doing so put the validity of the PTSD construct into question. For example, in some cultures, rather than being unwanted re-experiencing of the traumatic event, dreams of the dead are perceived as positive and comforting. Nicoll and Thompson also highlight Bracken‟s (2001) controversial proposition that PTSD is a socially constructed syndrome based on Western notions of individuality, and as such, may not be valid in collectivist cultures. In addition, the current construct of PTSD ignores collective traumatization even though

entire ethnic groups are traumatized through acts such as genocide (Weine *et al*., 2008). However, Nicholl and Thompson state that despite these controversies, the majority of cross-cultural researchers and clinicians acknowledge that PTSD symptomatology is applicable to refugees.

There is less controversy surrounding the cross cultural application of depression compared with PTSD. In a World Health Organization (WHO) sponsored cross-cultural study on the symptomatology of depression in 573 individuals from Canada, Iran, Japan, and Switzerland, the results indicated that more than 76% of depressed people reported a common pattern of depressive symptoms (WHO, 2008).

These symptoms included sadness, absence of joy, loss of interest, anxiety, tension, lack of energy, reduced concentration, and a sense of inadequacy.

However, other cross-cultural studies have reported a variation in the expression of this disorder. For example, Phan and Silove (2007) provide an excellent examination of the disparities between Western and Vietnamese expression of depression. In this article they highlight the fact that Vietnamese language does not have a word for depression and conversely, that there are no accurate English translations or meaningful English idioms for a number of familiar Vietnamese medical terms describing depressive-like expressions. For example, the English equivalent of *suy yeu than kinh, suy nhuoc than sac,* and *xao tron tam than* include "weakness of the nerves", "debilitated appearance" and "disturbed mental state" respectively.

Although most researchers in the refugee field accept that PTSD and depression can affect refugees and that many of their symptoms are universal, the literature also indicates that the expression and course of these illnesses are culturally determined. Culture-specific symptoms may

lead to the under-recognition or to the misidentification of psychological distress, which may lead to inappropriate, or no treatment at all. As a result, cross-cultural experts advocate that clinicians develop the following cultural competencies: a sound knowledge of the concepts of mental health and illness of both cultures; that they adopt an open, interested, and respectful attitude towards the non-Western individual's expression of distress; and to consider this expression within their social and cultural backdrop (Kirmayer, 2001; Phan and Silove, 2007).

**2.6. Prevalence of Mental Health Issues in Adults Refugee**

As previously mentioned, the majority of studies have focused on PTSD and depression, but other disorders such as other anxiety disorders, substance abuse, psychotic illnesses, and somatic complaints have also been investigated. Therefore, Part I of this chapter will present a review of this mental health prevalence research specific to adult refugee populations.

**2.7.PTSD in adult refugees.**

The majority of studies investigating the mental health outcomes in refugee populations have focused on PTSD (Watters, 2001). This is not unexpected given that trauma is a necessary precursor to PTSD, and that refugees are generally exposed to multiple traumas, much of which is usually outside the realm of usual human experience (Fazel *et al*., 2005). Indeed, it has been estimated that between 5% and 35% of refugees have experienced extreme forms of trauma such as torture and other human rights abuses (Baker, 2002).

One of the first investigations of PTSD in refugees was conducted by Kinzie, and others (2000). In this seminal study, 13 Cambodian refugees who had survived between two and four years in a Pol Pot labour camp and who had resettled in the United States were interviewed by Kinzie and his colleagues. The sample was composed of five males and seven females

who were drawn from an adult refugee psychiatric clinic. These individuals were interviewed because their symptoms were more persistent and severe compared with other Cambodian refugees attending the clinic. Kinzie et al. (2000) reported that all 13 individuals met DSM-III criteria for PTSD and noted that their symptoms were very similar to those seen in European concentration camp survivors. This study was important because it was one of the first to provide cross-cultural validity for PTSD as a diagnosis, which was the aim of the study.

According to Kinzie et al. (2000) study, PTSD has been documented in refugees in various phases of dislocation and resettlement, and from all over the world including: South-East Asian countries (Mollica *et al*., 2003; Steel *et al*., 2002), the Balkans ( Favaro *et al*., 2009; Momartin *et al*., 2004), the Middle-East (Gorst-Unsworth and Goldenberg, 2008; Laban *et al*. 2005), and Africa (Kamau *et al*., 2004; Schweitzer *et al*., 2006).

These findings add further support for the cross-cultural validity of PTSD. However, PTSD prevalence rates reported in these studies have varied widely and appear to be influenced by the phase of dislocation and resettlement that they are in, the level of traumatic exposure, and their country of origin, but this is not always the case. For example, PTSD prevalence rates for refugees residing in refugee camps have ranged between 0.8% for refugees in Kakuma refugee camp (Kamau *et al*., 2004), to 50% for former-Yugoslavian refugees living in a refugee camp for an average of 3.5 years (Favaro *et al*., 2009). Variations in PTSD prevalence rates have also been reported for refugee populations who have resettled in the West. For example, Steel, Silove, Phan and Bauman (2002) reported a PTSD prevalence of 4% in a population-based study of 1161 Vietnamese refugees who had been living in Sydney for an average of 11.2 years, while Carlson and Rosser-Hogan (2001) reported a PTSD prevalence rate of 86%

in a randomly selected community sample of 50 Cambodian adults who had been living in North Carolina for an average of 3.5 years. Although one could infer from these studies that an inverse relationship exists between time in resettlement and PTSD prevalence rates, other studies contradict this observation. For example, Laban et al. (2004) determined that the PTSD prevalence rate increased from 31.5% to 41.7% in a group of Iraqi asylum-seekers who had resided in The Netherlands for less than 6 months, and for more than 2 years respectively. Although, it has been hypothesised that asylum-seekers may unconsciously endorse higher levels of distress and psychiatric symptoms in order to obtain refugee status (Hollifield *et al*., 2002) however, it is also crucial to remember that uncertain asylum status is a well-known stressor shown to exacerbate mental health problems (Silove, *et.al*, 2007).

Unfortunately, there are drawbacks to such extreme variation in prevalence data. These include: (a) that PTSD estimates at the lower end may contribute to the neglect of refugee mental health and conversely, (b) that PTSD estimates at the higher end may stigmatize refugees and fuel assumptions that refugees are riddled with psychiatric illness and are not resilient ( Fazel *et al*., 2005). Therefore, in an attempt to determine a more reliable prevalence estimate for PTSD in refugees, and to explore the potential sources that may explain this variation, Fazel *et al*., (2005) and Steel *et al*., (2009). conducted two of the most extensive meta-analyses of the refugee mental health literature to date.

While Fazel *et al*., (2005) calculated an overall weighted PTSD prevalence estimate of 9% from 17 refugee surveys with data comprising a total of 5,499 refugees, Steel *et al*., (2009). calculated a much higher overall weighted PTSD prevalence estimate of 30.6% from 145 surveys, comprising a total of 64,332 refugee and conflict-affected individuals.

Differences in the inclusion criteria used in each meta-analysis and the greater proportion of individuals with a history of torture in the Steel *et al*., (2009). analyses is the most likely reason for the significantly different PTSD estimates produced.

Although it may be important to determine which PTSD prevalence estimate is the most accurate, either estimate is still too high. Both estimates indicate that refugees suffer from much higher rates of PTSD compared with Western civilian populations. For example, the 12-month PTSD prevalence rate in Australia is estimated at 1.3% ( Creamer *et al*., 2001). Similarly, in Europe, this estimate is 1.1% (Darves-Bornoz *et al*., 2008).

An important finding to also emerge from these meta-analytic reviews is that PTSD prevalence rates are significantly affected by methodological issues related to sample size, sampling method, instruments used, and use of interpreters rather than same-language interviewers. However, results are also shown to significantly depend upon risk factors and the characteristics of the refugees under investigation including the type and severity of trauma experienced, ethnic group, age, duration since displacement, host-country, and post-settlement stressors.

Although limited by the number of studies published, a review of the longitudinal refugee adult literature demonstrates that PTSD symptoms can abate, become exacerbated, and even emerge some-time after resettlement ( Boehnlein *et al*., 2004; Hauff and Vaglum, 2004; Weine et al., 2008). These observations are consistent with PTSD symptoms in Western civilian populations, where PTSD has also been shown to run a variable longitudinal course (McFarlane, 2000). These studies indicate that approximately 30% of Western individuals with PTSD generally continue to suffer from chronic PTSD symptoms, and about 80% will also meet

criteria for at least one other DSM-III-R disorder (Kessler *et al*., 2005). Therefore, these findings suggest that traumatised refugees will most likely remain a vulnerable group even after their resettlement to a safe country.

**2.8.Depression in adult refugees.**

Studies investigating the presence of depression in refugee populations are relatively sparse in comparison to those investigating PTSD (Lindert *et al*., 2009). Nevertheless, depression prevalence rates are available for refugee populations in various phases of dislocation and resettlement, and from all over the world including: South-East Asia (Hubbard *et al*., 2005), the Balkans ( Favaro *et al*., 2009; Turner *et al*., 2003), Africa (Kim *et al*., 2007), and the Middle-East ( Jamil *et al*., 2007; Laban *et al*., 2004). However, as observed with PTSD, the prevalence data for depression also varies significantly from study to study.

For example, prevalence rates for depression in refugees residing in camps range between 31% in a random sample of 1121 internally displaced Sudanese women (Kim *et al*., 2007). to 85.5% in a random sample of Sierra Leonean refugees. Lower prevalence rates for refugees in resettlement are generally reported, yet study results infer that as length of time in resettlement increases, the prevalence of depression may also increase. For example, (Hinton *et al*., 2003). found a depression prevalence rate of 5.5% in 201 Vietnamese refugees upon their arrival to San Francisco, while Schweitzer *et al*., 2006). reported that 16% of adult Sudanese refugees met criteria for depression up to 2 years after their resettlement to Queensland. Further, (Laban et al., 2004). reported that the prevalence rate of depression increased from 25.2% in Iraqi asylum-seekers residing in The Netherlands for less than 6 months, and up to 43.7% in those who had been living there for more than 2 years.

With such wide variations also reported in prevalence rates for depression, Fazel *et al*., 2005) and Steel *et al*., 2009). also endeavoured to determine a more reliable prevalence estimate for depression in refugee populations. From 14 refugee surveys with data comprising a total of 3,616 adult refugees, (Fazel *et al*., 2005). calculated an overall weighted prevalence estimate for depression of 5%. In contrast, a 30.8% prevalence estimate for depression was calculated by (Steel *et al*., 2009). from 117 surveys and 57,796 refugee and conflict-affected individuals. Although the depression estimate calculated by (Fazel *et al*., 2005). is very similar to the 4.1% prevalence rate for major depression in Australia (Australian Bureau of Statistics, 2007) and the 6.6% prevalence rate in the United States (Kessler *et al*., 2003). the method employed by (Fazel *et al*., 2005). to calculate their estimate has been criticised for underestimating and undervaluing the distress and difficulties experienced by refugees ( Miller *et al*., 2005).

Again, the meta-analytic studies conducted by Fazel *et al*., 2005). and Steel *et al*., (2009) highlight that prevalence rates for depression can vary for the same reasons that PTSD prevalence rates do – as a result of factors related to study design and sample characteristics. Taken together, these findings underscore the need for more accurate and systematized measurements of health outcomes in refugee populations (Hollifield, 2005).

**2.9.Other disorders in adult refugees.**

Although the human suffering caused by the refugee experience commonly manifests with symptoms of PTSD and depression, other disorders are also frequently found in refugee adults including anxiety disorders, substance use, psychosis, and somatic complaints. In addition, co-morbidity between these disorders is also commonly reported. The refugee literature pertaining to these disorders are briefly described in turn. (Fazel *et al*., 2005)

**2.10.Generalised anxiety disorder and panic disorder.**

In their meta-analytic review, (Fazel *et al*., 2005). identified five studies reporting the prevalence rate for generalised anxiety disorder (GAD). The studies identified provided data for a total of 1,423 adult Vietnamese, Cambodian, Hmong, Cuban and Haitian refugees. The prevalence of GAD in these studies ranged from 1% (Westermeyer, 1988) to 21% (Hubbard *et al*., 2005). but the overall weighted prevalence for GAD estimated by Fazel and colleagues was 4%. Some research suggests that panic disorder is highly co-morbid amongst refugees from Vietnam and Cambodia with a PTSD diagnosis. For example, 60% of Cambodian refugees (Hinton, *et al*., 2000). and 50% of Vietnamese refugees with PTSD (Hinton, *et al*., 2001) were suffering from panic disorder. These results are consistent with investigations in non-refugee populations, such as Vietnam veterans, who also have a high rate of co-morbidity between PTSD and panic disorder (Mellman, *et al*., 2002).

**2.11Anxiety in general.**

Although the study of PTSD has dominated the anxiety research field in refugee populations, a large proportion of studies have utilised questionnaires such as the Hopkins Symptom Checklist-25 (HSCL-25) to investigate the prevalence of clinical levels of anxiety. For example, Cardozo, *et al*., 2004). reported a 42% prevalence rate for clinical anxiety in Karenni refugees living in a Thai refugee camp, as they scored above the cut-off on the HSCL-25‟s anxiety subscale. Similarly, Hermansson, and others (2002) reported an anxiety prevalence rate of 43% using the HSCL-25 in a sample of war-wounded refugees, 8 years after their arrival in Sweden.

Keller, et al., 2006). found a much higher level of anxiety in their convenience sample of refugees from a variety of cultural backgrounds

who were seeking treatment in a torture treatment program, with 81.1% obtaining scores above the questionnaires cut-off.

**2.12.Substance use and abuse.**

Substance use has been shown to be a commonly reported co-morbid disorder in people with a history of trauma. For example, up to 75% of combat veterans with lifetime PTSD have been shown to meet criteria for alcohol abuse or dependence (Jacobsen, *et al*., 2001). and up to 80% of women seeking substance abuse treatment report histories of sexual and/or physical assault (Hien, *et al*., 2004). However, the literature generally indicates that substance misuse is relatively uncommon in refugee populations, even in refugees who have been living in the West for over 10 years. For example, low rates of substance-use disorders of between 1% and 4% have also been found in Vietnamese and Cambodian refugee community samples living in Australia and the United States for between 10 to 20 years ( Marshall *et al*., 2005). Steel *et al*., 2002). Even in a clinical sample, Boehnlein *et al*., 2004). found no cases of alcohol or substance abuse in 23 Cambodian refugees who had initial diagnoses of co-morbid PTSD and major depressive disorder. However, the base rate for alcohol abuse disorders is generally lower in Asian populations compared with Western populations which may account for the low prevalence of substance misuse (Au and Donaldson, 2000). Nevertheless, some studies indicate that substance and alcohol abuse may be a problem for some refugees resettled in the West. For example, Bhui *et al*., 2007). found that the use of Qat, a leaf which is chewed like tobacco and with amphetamine-like properties, was common in a community sample of adult Somali refugees living in the UK. Qat was used by 40% of this sample, which is higher than the 31.3% rate of Qat use found in an epidemiological sample living in Somalia (Odenwald *et al*., 2005).

In addition, Farias (2001) reported that alcohol abuse was a prominent problem amongst 31% of traumatised male Salvadoran refugees seeking assistance in the United States.

Taken together, the literature indicates that substance abuse in refugee populations warrants our attention, even though these issues may not be as common in traumatised refugees as in other traumatised populations.

**2.13.Psychotic illness.**

Disorders and problems that do not necessarily stem from refugee experiences but may be adversely affected by them include psychosis (de Anstiss *et al*., 2009). In the aforementioned meta-analytic review of serious mental disorders in refugee populations, Fazel *et al*., (2005) identified only two studies reporting on psychotic illness ( Hauff and Vaglum, 2005; Westermeyer, 1988). These two community sample studies provided a total of 226 adult Vietnamese and Hmong refugees resettled in the West, with an overall weighted psychotic illness prevalence rate estimated at 2%. However, a much higher prevalence rate for psychotic symptoms has been reported in a random sample of 180 Somali refugees living in the community in London. For example, Bhui *et al*.,2003). found that nineteen men (21%) and sixteen women (18%) had at least one active symptom of psychosis, and that experiences of being lost, kidnapped, or a lack of shelter or water was associated with probable psychosis.

Studies investigating psychotic illness in refugee camps and in clinical populations have also returned high prevalence rates. For example, Kamau *et al*., 2004). reported that 12.3% or 227 individuals attending a community mental health service in Kakuma refugee camp presented with psychotic illnesses (schizophrenia and bipolar disorder) over a three year period. This represented 0.25% of the total camp population. And finally, a

high prevalence of psychotic symptoms in clinical samples has also been reported. For example, Kinzie and Boehnlein (2000) found a prevalence rate of 7% for schizophrenia and schizoaffective disorder in their clinical sample of 100 highly traumatised Cambodian refugees seeking treatment for PTSD and major depressive disorder. These researchers observed that although individuals with and without psychosis were similar in terms of demographics, trauma history and family history of psychosis, they hypothesised that vulnerability to post-traumatic psychosis may be caused by a specific neurophysiological vulnerability, which when coupled with developmental and environmental factors may cause gross impairment in reality testing.

**2.14.Somatic complaints.**

The presence of somatoform disorders in survivors of torture have been well documented ( Priebe and Esmali, 2010). Somatoform disorders are defined by the presence of physical symptoms which suggest a medical problem, but cannot be explained by a medical cause (APA, 2000). Given that many refugees have also had experiences of torture, the presence of somatoform disorders has been investigated by some refugee researchers. For example, van Ommeren *et al*.,2001). compared 418 tortured and 392 non-tortured Bhutanese refugees living in camps in Nepal. These researchers found that tortured refugees were more likely to report persistent somatoform pain disorder (51% vs. 28%) and dissociative disorders (18% vs. 3%) compared with non-tortured refugees respectively. Laban *et al*., 2004). also compared the prevalence of somatoform disorders in two groups of Iraqi asylum-seekers. Those who had resided in The Netherlands for less than 6 months returned a prevalence rate of 4.9%. However, asylum-seekers who had been residing in the Netherlands for more than two years returned a significantly higher prevalence rate of

13.2%. This result was significantly different even after adjusting for sex, age, and adverse life events. The finding by Laban and colleagues suggests that post-migratory stressors (such as the process of proving an asylum claim) may interact with experiences of torture to exacerbate somatic complaints. Given that somatoform disorders contribute considerably to the burden of health problems and influences help seeking behaviour, more attention to somatoform symptoms than is currently afforded to refugee populations may be warranted (Laban *et al*., 2004).

**2.15.Co-morbidity.**

Co-morbidity, or the presence in an individual of more than one psychiatric disorder at the same time has also been studied in refugee populations. The general trauma literature highlights a substantial co-morbidity between PTSD and other psychiatric diagnoses, including depression, anxiety disorders, and substance use (McFarlane, 2000). However, co-morbidity between PTSD and depression in refugee populations is the most widely studied. For example, Momartin *et al*., 2004). reported that 40% of Bosnian refugees had co-morbid PTSD and depression. Favaro *et al*.,2009). also found that 65% of former-Yugoslavian refugees suffered with co-morbid PTSD and depression. Higher rates of co-morbidity have also been reported by Marshall et al. (2005) who reported that 71% of Cambodian refugees with PTSD also met criteria for major depression, and that 86% of those with major depression also met criteria for PTSD. Finally, in the aforementioned meta-analysis conducted by Fazel *et al*., 2005). the researchers calculated that 71% of those diagnosed with major depression also had a diagnosis of PTSD, and that 44% of those diagnosed with PTSD also had a diagnosis of major depression.

Research indicates that having more than one psychiatric diagnosis at the same time confers a significant risk to one‟s ability to function in day to day activities. For example, Mollica *et al*., 2009). reported that refugees with co-morbid psychiatric diagnoses were five times more likely to be functionally impaired that those diagnosed with PTSD alone. Karam (2007; cited in Momartin *et al*., 2004). also reported that those with co-morbid conditions displayed greater symptom severity by a factor of three to five times greater than those with PTSD alone. More research is required to establish co-morbidity between other psychiatric diagnoses, but when working with traumatised refugees, it would be prudent to assess for conditions other than those relating to PTSD and depression, especially in light of emerging evidence that those suffering from co-morbid conditions stand out as a group because of their substantial level of psychosocial impairment (Momartin *et al*., 2004).

Syrian Refugee's Stress, Emotional Distress, and Coping Strategies According to the current research of Helen Verdeli, professor of clinical psychology at Teachers College, Columbia University, the most common stressor experienced by Syrians living in refugee camps is worry about the well-being of their relatives who have dispersed to other refugee camps, moved to other countries, or remained in Syria and might have been tortured or killed (Eastern Mediterranean Public Health Network (EMPHNET), 2014). Another stressor is fear about interpersonal violence (EMPHNET). Although refugees residing inside the camps are protected from military violence, inside the camps they are vulnerable to physical violence, torture, sexual assault, and rape (EMPHNET). Most adults and children have been victims of or witnessed multiple acts of violence. Major threats, stressors, and realities such as these represent some of the daily life

struggles of Syrian refugees. Continuous exposure to violent incidents, or their threat, compromises any positive effects resulting from protective factors, such as family and community support. Many refugees report experiencing a variety of psychological symptoms in reaction to the stressors. Between three and 30 percent of Syrian refugees experience clinical depression and between 50 and 57 percent experience Post-Traumatic Stress Disorder (PTSD) (EMPHNET, 2014). In comparison, the rate of PTSD in the general American population is estimated to be between five and 12 percent (EMPHNET). Dr. Verdeli is currently researching psychological interventions to treat depression and PTSD among Syrian refugees in the Za'atari Camp (Global Mental Health Lab, 2015). Respondents to mental health surveys reported "most or all of the time" to the following statements:

(1) Feeling unable to perform essential activities for daily living .

(2) Feeling severely upset about the Syrian conflict (EMPHNET, 2014). Additionally, many reported feeling so hopeless that they did not want to continue living while others reported feeling loss of interest in things they used to like and feeling so angry that they felt out of control. The symptoms of emotional distress are suggestive of the severity of daily dysfunction experienced by refugees. The coping strategies of Syrian refugees were also examined (EMPHNET, 2014). The most reported coping strategy was "Nothing;" forty-one percent reported they did nothing to cope. Other coping strategies, in descending order of percentage, include the following:

- Socializing: 15%
- Praying or reading the Quran: 13%

- Fighting and getting angry: 11%
- Crying: 6%
- Walking or going out: 5%
- Sleeping: 5%
- Smoking: 3% These employed coping strategies consist of positive and maladaptive, or unhealthy tactics.

Psychological Interventions In order to alleviate the significant emotional distress and mental illness experienced among Syrian refugees, immediate attention from mental health professionals is necessary. Psychologists and aid workers must be trained to treat emotional distress and mental illness within a cultural and religious context. It is essential that mental health professionals implement interventions that de-stigmatize mental illness. This might be accomplished by using local idioms and religious terms in treatment. The goal for mental health professions, such as Dr. Verdeli, is to develop culturally appropriate treatments for depression and PTSD that employ positive, culturally-based coping strategies. Other interventions include culturally sensitive outreach to refugees. One component of outreach consists of promoting early detection of mental illness and emotional distress by using adequate and culturally sensitive screening tools, as well as improving access to mental health services. Research on the mental health of Syrian refugees (EMPHNET, 2014; UNHCR, 2015b) also suggests that promoting safety and security within the camps and expanding access to recreational areas, especially for children, are necessary protective factors to support resiliency.

## 2.16. Previous Studies:

Several assessments and reports were conducted by various humanitarian actors to assess the situation of Syrian refugees in Jordan. Summarized below are some of the relevant assessments conducted: - In 2012, CARE Jordan carried out a baseline assessment to provide information on the needs and gaps in services available to Syrian refugees living in the urban areas of Amman. The assessment utilized the "UNHCR Tool for Participatory Assessment in Operations". A main finding was that Syrians in Amman suffered significant hardships in securing basic life necessities. Psychosocial activities for adults and children were found to be inadequate. The assessment recommended carrying out an in-depth analysis of psychosocial needs, risks, and coping strategies in particular for women and girls11- In 2012, the United Nations Children's Fund (UNICEF) and IMC carried out a Rapid Mental Health and Psychosocial Support assessment to describe related problems and gaps in services among Syrian refugees in Jordan. The assessment also aimed to examine current and potential coping strategies, resources, and support needed. In presenting the most compelling problems, the report identified worry, camp conditions, aggressiveness, psychological distress, and boredom as the most common. Praying or reading the Quran, and talking to people were the most commonly identified coping mechanisms among participants of the study12. - In early 2013, CARE Jordan conducted another participatory assessment and baseline survey of Syrian refugee households Irbid, Madaba, Mafraq, and Zarqa. Results indicated that livelihoods and food security were areas of concern, and that Mafraq had the poorest households with the worst living conditions. The assessment also reported feelings of

isolation, increased feelings of depression and negativity, and increased levels of family violence (both verbal and physical).

An inter-agency assessment of gender-based violence and child protection issues among Syrian refugees, with special emphasis on early marriage, was carried out in early 2013. The purpose was to identify the risks that these families face in Jordan, and to describe the urban refugees' knowledge, attitudes, and practices towards gender-based violence and early marriage. The assessment reported high rates of early marriage (one-third of marriages below age of 18), in addition to a limited mobility of women and girls restricting their participation in work, social activities and receiving aid supplies. Also reported was that the majority of Syrian refugees did not know of any services available in their community for survivors of violence.

The International Rescue Committee undertook an assessment to support the development of a cash transfer program for Syrian refugees in Jordan, with specific focus on Ramtha and Mafraq. Among other findings, the assessment reported that economic hardships affect household members' psychological well-being, which could result in increasing verbal and physical violence, particularly against women and girls. Respondents expressed preference for cash over in-kind assistance because it provides them with an increased sense of independence and dignity.

In June 2013, UNICEF released an assessment presenting key challenges for Syrian children and women in Jordan in the areas of child protection and gender-based violence, education, water, sanitation, hygiene, nutrition, health, mental health, psychosocial support, and adolescent development and participation. The report concluded that the

situation of the Syrian children in Jordan is vulnerable and critical. In the domain of MHPSS, the report recommended the provision of basic services and security, increased support for families and communities as a means of reducing threats to their mental health and psychosocial well-being, improved quality of 'focused non-specialized support' for children and their families, and the provision of specialized assistance for girls, boys and women with ongoing anxiety, aggression, depression, or 'profound stress'.

In July 2013, IMC conducted a mental health/psychosocial and child protection assessment for Syrian adolescents in Za'atari refugee camp. Supported by UNICEF, the assessment aimed at identifying MHPSS problems and coping strategies among adolescents in the camp, and provided recommendations to guide MHPSS interventions. Results indicated that the main MHPSS concerns among this group were grief and fear. Withdrawal was the most commonly expressed coping strategy. The assessment concludes with a set of concrete recommendations guided by the IASC Guidelines on MHPSS16. (Fazel *et al*., 2005)

# CHAPTER THREE

# METHODOLOGY

# Chapter Three
# Methodology

## 3.1 Administrative Arrangement

This thesis was approved by the Research Ethical committee at school of Nursing/university of Sulaimani. Prior to data collection, official permission was obtained from Erbil Refugee Council (ERC), to carry out the study. Ethical issue was obtained from all subject and only who agree to participate in the study they are included. (Appendix A).

## 3.2 Design of the study

To achieve the objectives of the present study, a quantitative descriptive study was applied for the period from the 15th of November 2015 until the 15th October, 2016.

## 3.3 Setting of the study:

The present study was conducted at Qushtapa Camp, Erbil governorate, Kurdistan Region, Iraq. It was established by Kurdistan region government in August, 2013. The camp involves nine sectors (A-B-C-D-E-F-G-H and I), each sector included between (144-265) families. Kurdistan government provided the camp with Primary Health Care Center to provide free medical and counseling services, Primary and secondary school, and small shopping center.

## 3.4 Study Population

Syrian refugees in (Qushtapa) camp, Erbil, Kurdistan Region, Iraq, are the populations captured in this assessment. The population of Syrian

refugees defined by the number of Syrian refugees registered were (6410).

### 3.5 Sample of the study

The quantitative part of this assessment used a multistage cluster random sample, proportionate to the size of population in each area of interest.

**A.** Qushtaba Camp: The camp is divided into 8 districts. The number of clusters per district is proportionate to the population number (estimated) in each district. Five clusters were randomly selected from the camp, and each cluster contained between (144-265) families which were systematically selected. Assessment started their interviews from the main road, and continued toward the end of the lanes in the camp until the targets were reached. Every other tent in the lane was interviewed. If the number of tents in the lane did not meet the survey target, the interviewers then continued to the next lane.

**B.** The sample size for Qushtapa camp was calculated with an assumption that the total population of refugees in the camp was (6410) out of them 1360 were aged above 18 and Married ; the prevalence was 50%, precision 5%, confidence interval 95%, and a design effect. Using Epi Info, the sample size for the quantitative study calculated for Qushtapa was 300. They After adding a 20% to cover the non-response rate, the total number of families required to be interviewed from each of the clusters from within the camp was determined to be 30 families from each cluster .

**C.** Randomly (300) subject were selected to be a study sample. Both married male and female were participated in the study, and any

subjects with previous mental disorders, or refused to participated in the study were excluded.

### 3.6. Study tool:

A. The Refugee Health Screener 15 (RHS-15) was designed by Pathways to Wellness to address a deficit in efficient screening tools to assess for anxiety, depression, post-traumatic stress and emotional distress across refugee populations. Pathways to Wellness and other supporters of the refugee screening tools believe that integrating early detection and support for mental health problems into the refugee resettlement, paired with culturally appropriate and effective treatment, reduces resettlement stress and accelerates healing.

*Current Languages Available via the RHS-15:* Arabic, Kurdish Amharic, Burmese, English, French, Karen, Nepali, Spanish, Swahili.

### 3.7. Scoring system:

RHS-15 consisted of 15-question screener consists of two sections. The first 14 questions are rated on a scale from 0 (not at all) to 4 (extremely), with variably full jars of sand representing these numbers. A total score 12 on the first 14 questions is a positive screen. Question 15 comprises the second section, which is a distress thermometer, in which individuals can mark their distress from 0 (no distress) to 10 (extreme distress). A distress thermometer score 5 is a positive screen. An individual only has to score positive on one of these two sections to warrant a positive screen (Pathways to Wellness, 2011).

### 3.8 Pilot Study:

The pilot study was carried out for the period from 25th of May, 2016 till the 10th of June, 2016. Ten families were selected randomly for this purpose and (20) couples were assessed

**The pilot study aimed to:**

1- Identify the barriers that may be encountered during data collection.

2- Estimate the time required for data collection.

3- Be sure of the accuracy of the scales.

4- Determine the reliability of the study scales.

### 3.8.a Validity of the study scale :-

To ensure the validity of the scale, method and procedure proposed to be carried out during the study, 15 experts of different specialties related to the field of the present study were chosen. Six of them were professors, five of them were assistant professors and four of them were lecturers. They were asked to review the scale format for clarity and adequacy in order to achieve the present study objective.

Those experts were six faculty members from School of Nursing/ University of Sulainani, Three faculty member from College of Nursing/ Hawler Medical University, Three faculty member from College of Nursing / Mosul University, Two faculty member from College of Nursing / University of Baghdad, One faculty member from /College of Nursing/ University of Karbala.

Most of them had agreed that the scales were clear, relevant and adequate. Certain modifications were employed based on the expert's recommendations and suggestions(Appendix C).

### 3.8.b Reliability of the study Tool:-

Reliability of the scales was determined through the use of test and retest approach and the interval period was two weeks. The Pearson correlation coefficient (***r)*** was computed .The result of reliability was (0.91)

### 3.9 Data collection period:

The data were collected from the 4th of July 2016 to 25th of August 2016.

### 3.10. Limitations of study:

1. Unfortunately, conducting research as part of a university Master program means that limited resources are available to student researchers.
2. In addition, because the researcher was a novice, this may have affected the quantity and quality of the discussions. It has been reported that novice moderators tend to ask questions that are confusing, complex, and difficult to analyse, and vary in their ability to direct discussion, and monitor verbal and non-verbal responses.
3. As with any self-report measure, the focus group interview is also subject to self-report bias. Some research participants may intentionally or unintentionally “fake good”, or present themselves in a good light.

4. Three hardened refugee represent only a small sample of the total refugee parent population in Kurdistan region and therefore, this limits the generalisability of the findings. However, qualitative methods place less emphasis on generalisability, and instead aim for richness and depth of information by exploring the quality of participant experiences through meaning and process.

## 3.11 Statistical Analysis

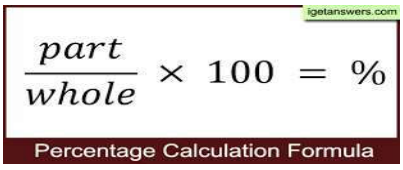
Data were prepared and entered into a computer files; Statistical Package for the Social Science (SPSS, version 20) was used for data analysis. Data were analyzed through the application of two approaches:

### 3.11.a. Descriptive data analysis approach

This approach was applied through the measurement of the following:

1.Frequencies. (F)

2.Percentages.




Means of scores. (MS)

$$\overline{X} = \frac{\sum_{i=1}^{n} X_i}{n}$$

3.Standard deviation.

$$SD = \sqrt{\frac{\sum (x - \bar{x})^2}{n}}$$

### 3.11.b.Inferential statistical data analysis

(Chi – Square):

$$X^2 = \sum \frac{(f_O - f_E)^2}{f_E}$$

c.Mann Whitney :

$$U_a = n_a n_b + \frac{n_a(n_a + 1)}{2} - \sum R_a$$

*and*

$$U_b = n_a n_b + \frac{n_b(n_b + 1)}{2} - \sum R_b$$

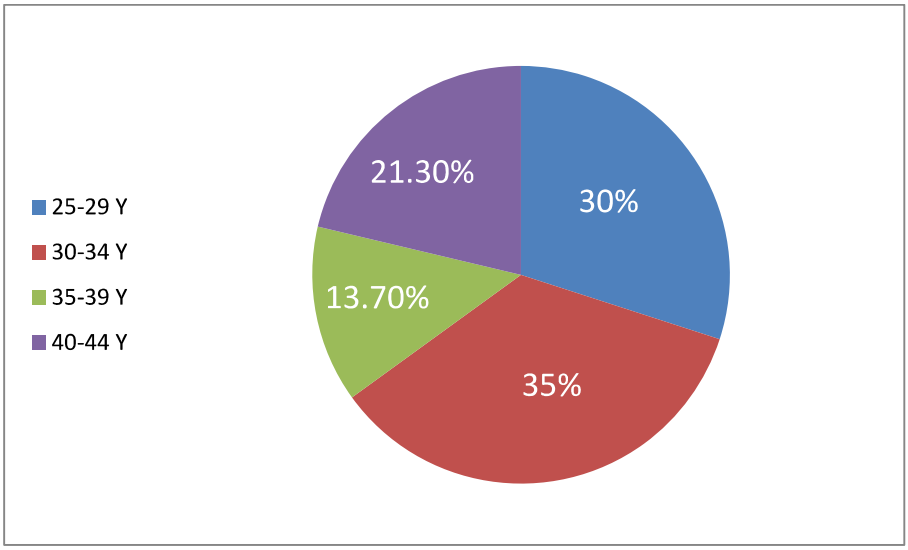
# CHAPTER FOUR

# RESULTS

# Chapter Four

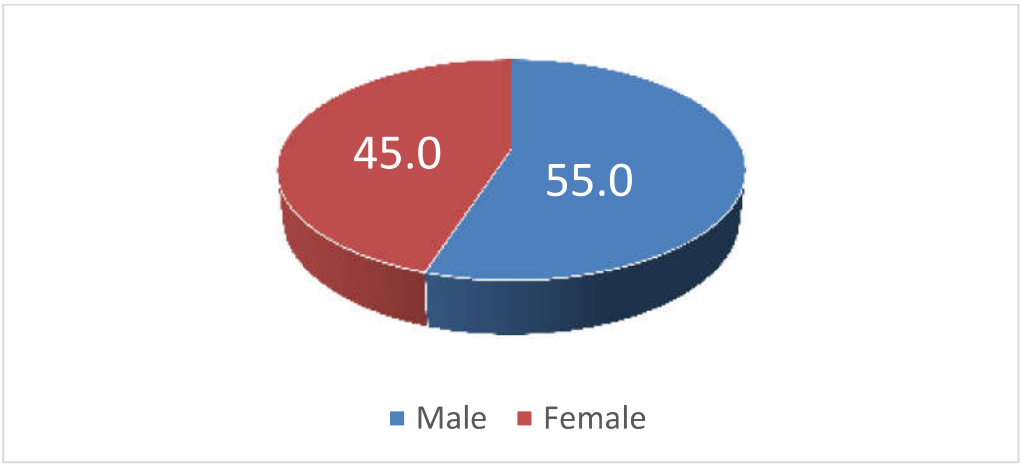
# Results

**Figure (4:1): Distribution of study subject by age**



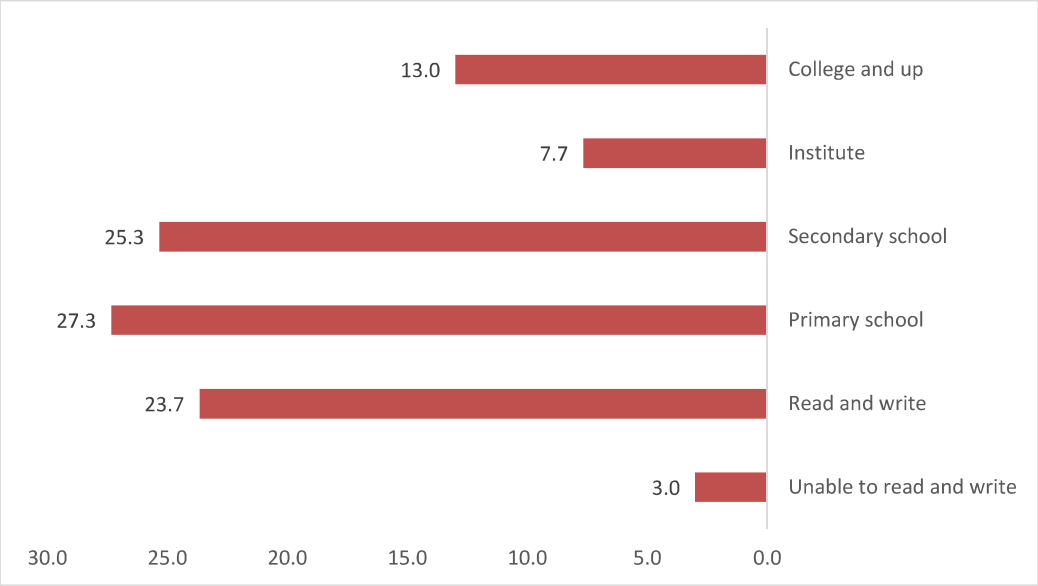

This figure shows that most of the sample in age groups bewteen (20-29 years) and (30-34years) with percent of (30%),(35%) respectivly

**Figure (4:2):Distribution Of Study Subject By Gender**



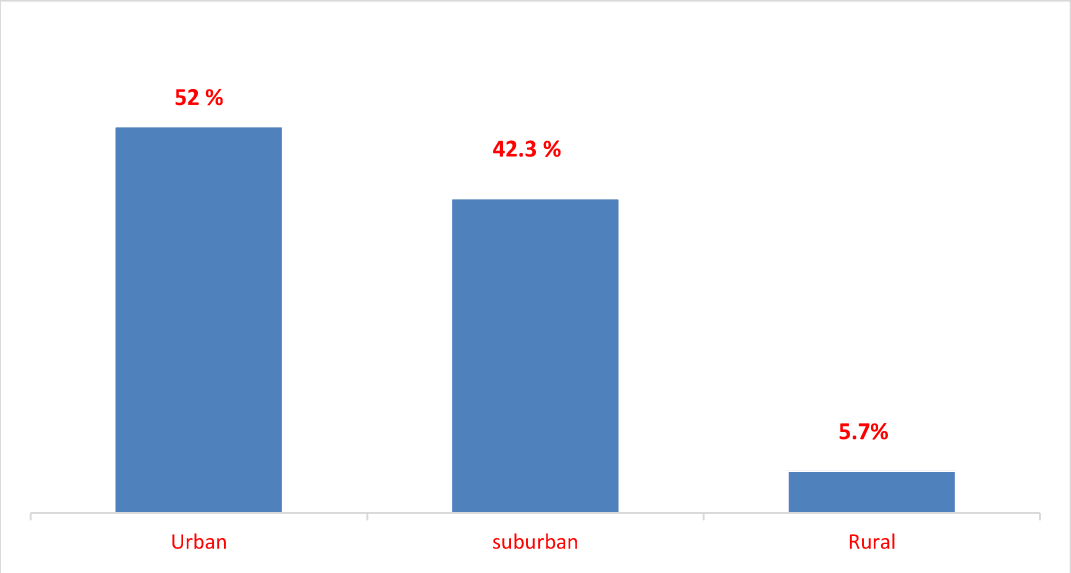

This figure shows that (55%) of sample were male and (45%) of them were female

**Figure (4:3): Distribution of Study Subject By Educational Level .**



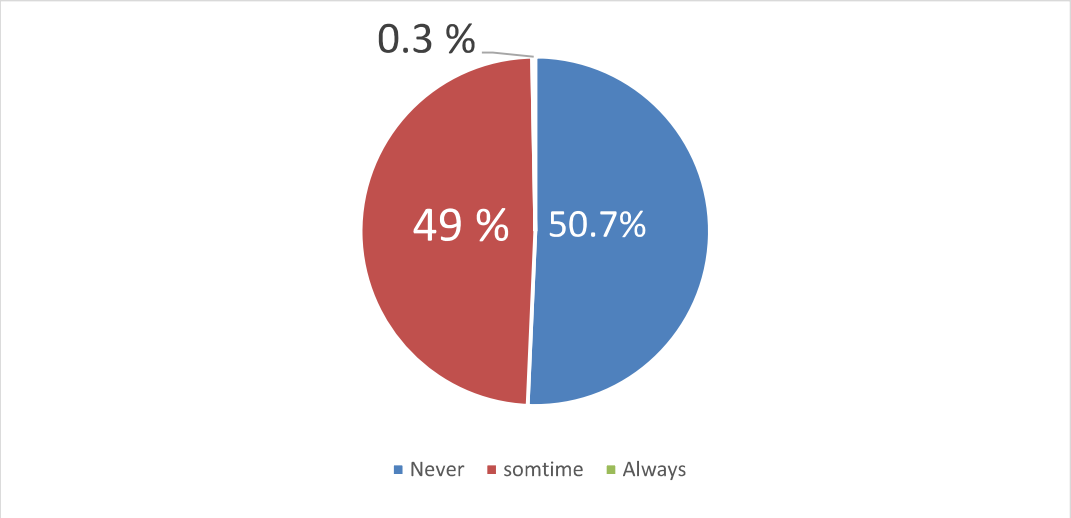

This figure shows that the majority of sample were under secondary school graduated and only (20.7% were graduated from institution or college)

**Figure (4:4): Distribution of Study Subject by Residency**




This figure shows that (52%) of sample from urban and (42.3%) from suburban and only (5.7%) from rural area

**Figure (4:5): Distribution of Study Subject by Financial Support**




This figure shows that (50.70%) of study subject do not received any economic support.

**Table (4:1): Symptomatic and severity of Anxiety among refugees**

| Anxiety | | Frequency | Percent |
|---|---|---|---|
| Severity | Normal | 2 | 0.6 |
| | Mild | 182 | 60.7 |
| | Moderate | 116 | 38.7 |
| | Total | 300 | 100.0 |

This table shows that (60.7%) of refugees had mild symptomatic of Anxiety, and (38.7%) had Moderate level.

**Table (4:2): Symptomatic and severity of Depression among refugees**

| Depression | | Frequency | Percent |
|---|---|---|---|
| Severity | Normal | 3 | 1.0 |
| | Mild | 109 | 36.3 |
| | Moderate | 188 | 62.7 |
| | Total | 300 | 100.0 |

This table shows that (62.7%) of refugees had Moderate symptomatic of Depression, and (36.3%) had Mild level.

**Table (4:3): Symptomatic and severity of PTSD among refugees**

| PTSD | | Frequency | Percent |
|---|---|---|---|
| Severity | Normal | 5 | 1.7 |
| | Mild | 159 | 53.0 |
| | Moderate | 136 | 45.3 |
| | Total | 300 | 100.0 |

This table shows that (53%) of refugees had Mild symptomatic of PTSD, and (45.3%) had Moderate level.

**Table (4:4): Symptomatic of emotional distress among refugees**

| DISTRESS | | | |
|---|---|---|---|
| NORMAL | | DISTRESS | |
| No | % | No | % |
| 11 | 3.7 | 289 | 96.3 |

This table shows that (96.3%) of refugees had symptomatic of emotional distress, and only (3.7%) had Normal level.

**Table: 4.5: Mann Whitney U test result on the refugee's anxiety, depression and PTSD level with respect to their gender.**

| Ranks | | | | | |
|---|---|---|---|---|---|
| Gender | | No. | Mean Rank | Sum of Ranks | U |
| Anxiety | Male | 165 | 145.03 | 23929.50 | 10234.5 |
| | Female | 135 | 157.19 | 21220.50 | |
| | Total | 300 | | | |
| Depression | Male | 165 | 145.77 | 24051.50 | 10356.5 |
| | Female | 135 | 156.29 | 21098.50 | |
| | Total | 300 | | | |
| PTSD | Male | 165 | 146.01 | 24092.00 | 10397 |
| | Female | 135 | 155.99 | 21058.00 | |
| | Total | 300 | | | |

This tables shows that there are no significant differences in refugee's anxiety, depression and PTSD in relation to their gender

**Table (4:6): Comparison between refugee's distress in relation to their gender**

| Gender | DISTRESS | | | |
|---|---|---|---|---|
| | NORMAL | | DISTRESS | |
| | Count | Table N % | Count | Table N % |
| Male | 6 | 2.0% | 159 | 53.0% |
| Female | 5 | 1.7% | 130 | 43.3% |
| X2 =0.1 DF= 1 | | | | |

This tables shows that there are no significant differences in refugee's distress in relation to their gender.

**Table: 4.7: Kruskal-Wallis Test result on the refugee's Anxiety, Depression, and PTSD level with respect to their age.**

| Ranks | | | | | |
|---|---|---|---|---|---|
| Age group | | N | Mean Rank | $\chi^2$ | Sig |
| Anxiety | 25-29 y | 90 | 148.46 | 3.8 | N.S |
| | 30-34 y | 105 | 150.33 | | |
| | 35-39 y | 65 | 139.82 | | |
| | 40-44 y | 40 | 172.89 | | |
| | Total | 300 | | | |
| Depression | 25-29 y | 90 | 160.79 | 1.9 | N.S |
| | 30-34 y | 105 | 145.2 | | |
| | 35-39 y | 65 | 148.95 | | |
| | 40-44 y | 40 | 143.76 | | |
| | Total | 300 | | | |
| PTSD | 25-29 y | 90 | 152.68 | 0.4 | N.S |
| | 30-34 y | 105 | 149.58 | | |
| | 35-39 y | 65 | 145.65 | | |
| | 40-44 y | 40 | 155.89 | | |
| | Total | 300 | | | |

This tables shows that there are no significant differences in refugee's anxiety, depression and PTSD in relation to their age group

**Table (4:8): Comparison between refugee's distress in relation to their age group**

| age group | DISTRESS | | | |
|---|---|---|---|---|
| | NORMAL | | DISTRESS | |
| | Count | Table N % | Count | Table N % |
| 25-29 y | 7 | 2.3% | 83 | 27.7% |
| 30-34 y | 2 | .7% | 103 | 34.3% |
| 35-39 y | 1 | .3% | 64 | 21.3% |
| 40-44 y | 1 | .3% | 39 | 13.0% |
| $X^2$ =6.21 DF=3 | | | | |

This tables shows that there are no significant differences in refugee's distress in relation to their age group.

**Table 4.9: Kruskal-Wallis Test result on the refugee's Anxiety, Depression, and PTSD level with respect to their educational level.**

| Ranks | | | | |
|---|---|---|---|---|
| Educational level | | N | Mean Rank | $\chi^2$ |
| Anxiety | Unable to read and write | 9 | 170.72 | 1.9 |
| | Read and write | 71 | 152.96 | |
| | Primary school | 82 | 152.46 | |
| | Secondary school | 76 | 147.77 | |
| | Institute | 23 | 131.20 | |
| | College and up | 39 | 153.92 | |
| | Total | 300 | | |
| Depression | Unable to read and write | 9 | 148.11 | 3.6 |
| | Read and write | 71 | 162.58 | |
| | Primary school | 82 | 153.48 | |
| | Secondary school | 76 | 136.37 | |
| | Institute | 23 | 157.59 | |
| | College and up | 39 | 146.17 | |
| | Total | 300 | | |
| PTSD | Unable to read and write | 9 | 161.17 | 2.1 |
| | Read and write | 71 | 151.01 | |
| | Primary school | 82 | 142.16 | |
| | Secondary school | 76 | 149.88 | |
| | Institute | 23 | 150.22 | |
| | College and up | 39 | 166.01 | |
| | Total | 300 | | |

This table shows that there are no significant differences in refugee's anxiety, depression and PTSD in relation to their educational level.

**Table (4:10): Comparison between refugee's distress in relation to their educational level**

| Educational level | DISTRESS | | | |
|---|---|---|---|---|
| | NORMAL | | DISTRESS | |
| | No | % | No | % |
| **Un able to Read and Write** | 0 | 0.0% | 9 | 3.0% |
| **Able to read and write** | 5 | 1.7% | 66 | 22.0% |
| **Primary school** | 3 | 1.0% | 79 | 26.3% |
| **Secondary school** | 2 | .7% | 74 | 24.7% |
| **Institute** | 1 | .3% | 22 | 7.3% |
| **College** | 0 | 0.0% | 39 | 13.0% |
| X2 = 4.3 DF=5 | | | | |

This tables shows that there are no significant differences in refugee's distress in relation to their educational level.

**Table 4.11: Kruskal-Wallis Test result on the refugee's Anxiety, Depression, and PTSD level with respect to their home residency.**

| Home Residency | | N | Mean Rank | $\chi^2$ | Sig |
|---|---|---|---|---|---|
| Anxiety | Urban | 156 | 150.70 | 0.85 | N.S |
| | Suburban | 127 | 152.69 | | |
| | Rural | 17 | 132.29 | | |
| | Total | 300 | | | |
| Depression | Urban | 156 | 149.04 | 0.56 | N.S |
| | Suburban | 127 | 150.25 | | |
| | Rural | 17 | 165.74 | | |
| | Total | 300 | | | |
| PTSD | Urban | 156 | 154.25 | 0.67 | N.S |
| | Suburban | 127 | 147.07 | | |
| | Rural | 17 | 141.76 | | |
| | Total | 300 | | | |

This tables shows that there are no significant differences in refugee's anxiety, depression and PTSD in relation to their residency.

**Table (4:12): Comparison between refugee's distress in relation to their home residency**

| Residency | DISTRESS | | | |
|---|---|---|---|---|
| | NORMAL | | DISTRESS | |
| | Count | Table N % | Count | Table N % |
| Urban | 3 | 1.0% | 153 | 51.0% |
| Suburban | 6 | 2.0% | 121 | 40.3% |
| Rural | 2 | .7% | 15 | 5.0% |
| X2 =4.9 DF=2 | | | | |

This tables shows that there are no significant differences in refugee's distress in relation to their home residency.

**Table 4.13: Kruskal-Wallis Test result on the refugee's Anxiety, Depression, and PTSD level with respect to their Financial support.**

| Financial support | | N | Mean Rank | $\chi^2$ | Sig |
|---|---|---|---|---|---|
| Anxiety | Never | 152 | 163.86 | 7.5 | N.S |
| | Sometimes | 147 | 136.70 | | |
| | Always | 1 | 148.50 | | |
| | Total | 300 | | | |
| Depression | Never | 152 | 156.90 | 1.7 | N.S |
| | Sometimes | 147 | 143.88 | | |
| | Always | 1 | 150.50 | | |
| | Total | 300 | | | |
| PTSD | Never | 152 | 161.61 | 5.1 | N.S |
| | Sometimes | 147 | 139.11 | | |
| | Always | 1 | 136.00 | | |
| | Total | 300 | | | |

This tables shows that there are no significant differences in refugee's anxiety, depression and PTSD level in relation to their financial support.

**Table (4:14): Comparison between refugee's distress in relation to their receiving Financial support.**

| Economic support | DISTRESS | | | |
|---|---|---|---|---|
| | NORMAL | | DISTRESS | |
| | Count | % | Count | % |
| **Never** | 5 | 1.7 | 147 | 49.0 |
| **Sometimes** | 6 | 2.0 | 141 | 47.0 |
| **Always** | 0 | 0.0 | 1 | .3 |
| X2 =0.171 DF=2 | | | | |

This tables shows that there are no significant differences in refugee's emotional distress level in relation to their financial support.

**Table 4.15: Kruskal-Wallis Test result on the refugee's Anxiety, Depression, and PTSD and distress level with respect to their losses of Family members.**

| Losing | | N | Mean Rank | $\chi^2$ | Sig |
|---|---|---|---|---|---|
| Anxiety | Father | 29 | 79.29 | 2.1 | N.S |
| | Mother | 16 | 89.91 | | |
| | Brother | 72 | 77.03 | | |
| | Sister | 15 | 75.13 | | |
| | Son | 22 | 69.25 | | |
| | Total | 154 | | | |
| Depression | Father | 29 | 79.47 | 3.1 | N.S |
| | Mother | 16 | 92.38 | | |
| | Brother | 72 | 76.17 | | |
| | Sister | 15 | 79.07 | | |
| | Son | 22 | 67.39 | | |
| | Total | 154 | | | |
| PTSD | Father | 29 | 85.22 | 4.1 | N.S |
| | Mother | 16 | 91.31 | | |
| | Brother | 72 | 76.04 | | |
| | Sister | 15 | 70.30 | | |
| | Son | 22 | 66.95 | | |
| | Total | 154 | | | |
| DISTRESS | Father | 29 | 78.00 | 6 | N.S |
| | Mother | 16 | 78.00 | | |
| | Brother | 72 | 78.00 | | |
| | Sister | 15 | 78.00 | | |
| | Son | 22 | 74.50 | | |
| | Total | 154 | | | |

This tables shows that there are no significant differences in refugee's distress in relation to their losing of family members.

# CHAPTER FIVE

# DISCUSSION

# Chapter Five
# Discussion

The purpose of this Study is to examine the level psychological problems namely (symptomatic anxiety, Depression, PTSD as well as emotional Distress among Syrian refugees due to Syrian war in Qushtapa camp in Erbil City, Kurdistan of Iraq.

## 5.1: Part one: socio-demographic characteristics of study subject

### *a. Age*

As shown in Figure (4:1), (35%) of people in Syria are between 30 and 34 and (30 %) are between 25 and 29 years, (21.7%) between 35 and 39 years, (31.3%) between 40 and 44 years old. Comparatively, refugees who have resettled to Canada had similar numbers. Of the Syrian refugees resettled to Canada in 2014, 34 % were under 15 years old, 15 % were between 15 and 24 years old, and 48 % were between 25 and 64 years old. (Citizen and Migration Canada,2015)

### b. Gender:

As shown in Figure (4:2), (45%) of study subject were Female and (55%) of them were Male

Since late 2011, the civil war in Syria and the resultant outpouring of more than 2 million Syrians has grown to threaten the stability, infrastructure, and security of its surrounding neighbors. In comparison to other humanitarian crises in recent history, “more people have fled their homes in Syria than fled the genocide and its aftermath in Rwanda or the ethnic cleansing in Bosnia.” As in previous and similar scenarios, women and children make up the vast majority of Syrians seeking shelter in Turkey, Jordan, Lebanon, Iraq and Egypt. Out of all the countries that are

host to refugees, Turkey is the only country that has thus far rebuked UN offers to oversee and manage camp affairs, choosing instead to lead – and pay for – internal efforts to care for Syrians seeking safety. ( International Labour Organization. (2013)

***c. Education***

In this study, (51%) participants' educational status was primary school education. (25.3%) participants' educational status was of secondary school education. (20.7%) participants' educational status was of university and institutional education. Figure (4:3)

Access to Education in pre-conflict Syria, high rates of primary school attendance were achieved due to free public education. However, rates of primary school attendance in rural areas were significantly lower than the national average, and there were high dropout rates at the secondary school level, especially among girls. Furthermore, the Ba'ath party used Syria's education system as a tool to indoctrinate children with party ideologies, and teachers were generally not permitted to express ideas that opposed government policy. According to the Cultural Orientation Resource Center, 72 % of Syrians of secondary school age were enrolled in school before the uprising. The current conflict situation has taken a severe toll on the education system, with school attendance rates down to 6 % in some areas due to general insecurity, damaged buildings and a lack of teachers. Prior to the conflict, a combination of public and private universities existed to provide higher education access to men and women in Syria. However, as with primary and secondary school, restrictions on academic and political freedom were largely present. According to the World Bank, post-secondary school enrollment steadily increased over the

years prior to the conflict and in 2010, 26 % of the population in the five-year age group following secondary school had enrolled in post-secondary education. It is highly likely that enrollment has dropped by a large percentage since then. ( United Nations High Commissioner for Refugees. (2013)

***d. Residency***

As shown in Figure (4:4), approximately (52%) of Syria's population resided in urban areas prior to the conflict, particularly in Damascus, Aleppo, Hama, and Homs, which are the country four largest cities. Drought and demographic shifts resulting from a rural exodus have been identified as key reasons behind the start of protests and the onset of the crisis.

***e. economic support***

In this study (50.7%) participants had Never received economic support. (49%) of them sometimes received economic support and (0.3%) of them always received economic support. (Figure 4:5).

## 5.2. Part two: Discussion of anxiety

The overall prevalence of Anxiety among Syrian refugee was (60.7%) of them had mid anxiety, 38.7% of them had moderate anxiety Table (4:1)

Prevalence of anxiety reported by studies conducted on refugees varies considerably. In a systematic review (Hollifield et al., 2002), the prevalence of anxiety was reported as 48.6%. These figures were 18.5% for Bosnian refugees (Vukovic *et al*., 2014).

For Iraqi refugees living in western countries, this rate varied between 28.3 and 75% for anxiety (Slewa-Younan, *et al*., 2001).

In post-conflict communities of Algeria, Cambodia, Ethiopia, and Palestine, the rates of anxiety were between 15.837.4% and 5.222.7%, respectively (De Jong *et al*., 2002).

In an adult population directly exposed to war in the Balkans, the prevalence of anxiety was between 10.635.4% and 10.937.3%, respectively (Priebe *et al*., 2010).

Tufan and Esmil (2013) reported the prevalence of anxiety and depression in refugees living in Turkey as 55.2 and 55.2%, respectively.

In another study conducted among Syrian refugees in Turkey (Alpak *et al*., 2015). the prevalence of anxiety was 33.5%. Thus, the few currently existing studies on populations displaced into Turkey reported rates close to each other.

Among others, this may be due to the homogeneity of the displacement duration among studied populations. Indeed, the recent crisis at the borders of Turkey and the subsequent massive displacement happened in a relatively short time period. The differences among symptoms between women and men with anxiety are rather consistent in fitting certain patterns of posttraumatic response. Namely, women reported flashbacks, hypervigilance, and intense psychological Emotional Distress due to reminders of trauma more frequently than men. Men reported feelings of detachment or estrangement from others more frequently than women. Thus, women tended to respond to traumatic stress by under modulation and men tended to respond by over modulation of emotions (Lanius *et al*., 2010).

## 5.3. Part three: Discussions of Depression

The overall prevalence of depression among Syrian refugee was (62.7%) of them had moderate depression and (36.3%) had mild depression Table (4:2).

Not different prevalence rates found among Guatemalan refugees in Mexico and Karenina refugees. Our finding was lower than the prevalence of depression among Internally Displaced peoples (IDPs) and refugee in Southern Sudan and amongst internally displaced persons in northern Uganda which was 49.9 % and 67 % respectively (Roberts et al.2008; Roberts, *et al*.,2009). The higher prevalence among refugees could be due to ongoing feeling of insecurity among refugee's community and also might be due to difference in instrument. The elevated risk for depression could be explained by negative attitudes towards women, lack of acknowledgement for their work, fewer opportunities for them in education and employment, and greater risk of domestic violence. It also explained by hormonal changes during menstruation in women (Bejamin and Sadock, 2007). This finding agrees with study among Vietnamese refugee in United States which showed that being divorced is consistent risk factor for depression (Buchwald, *et al*.,2003). The finding implies the unstable marital relationship and the loss of partner which increases the risk of having depression episodes. This study was consistent with the study conducted among Guatemalan refugees in Mexico (Sabin, *et al*.,2003). In this study, being exposed to 8 or more out of 16 traumatic events was significantly associated with the outcome of depression. The dose–response relationship between exposure to traumatic events and depression is also similar with other studies of displaced population (Onyut, *et al.*, 2009; Roberts, *et al.*,2009; Andrew, *et al*.,2012). Exposure to multiple war

stressors may lead to hopelessness and respondents who had experienced a high frequency of traumatic events were also more vulnerable to depression. This study also showed that lack of basic social goods such as house or shelter had a significant association with outcomes of depression. This could be due to lacking basic needs like shelter make to have low self-esteem which leads to loss of interest in every activity and hopelessness. There was strong association between forced displacement as refugee previously and depression. This was similar with the findings of the study conducted in Northern Uganda (Roberts, *et al*.,2009). Possible reason could be repeated exposure to trauma event and confronting with adverse situations and ongoing stressors in different camp, which substantially impact their mental health. So that, the finding of this study had a good argument back ground and evidence based to find out more or less similar prevalence rate compared to other community based studies.

### 5.4. Part Four: Discussion of PTSD

Our data analysis suggests that about (35%) of adult Syrian refugees in Qushtapa camp has mild post-traumatic stress disorder, about (45.3%) had moderate PTSD.(Table 4:3)

Brady, *et al*., 2000). has major depression, and about (30-50%) has a generalized anxiety disorder, with the probability that these disorders overlap in many people.

These prevalence estimates are much lower than some frequently cited claims based on less reliable estimates than ours,(Carlson and Rosse-Hogan,2001;Watters,2001) especially in relation to major depression, for which the overall prevalence rates in refugees are similar to those in several general western populations.(Ports, *et al*.,2002;Robins and Regier,2001).

Refugees based in western countries could be about ten-times more likely than the age matched general American population to have

posttraumatic stress disorder.( Portes, *et al*., 2002). This disorder is a potentially disabling condition characterized by traumatic flashbacks, hyper vigilance, and emotional numbing that might be a risk factor for substance abuse and suicide.(Brady, *et al*.,2000).

U S committee for Refugees (2003)Data in the present meta-analysis (about two-thirds of which are derived from the USA) suggest that roughly 50 000 of about 500 000 current refugees living in the USA have post-traumatic stress disorder, with even larger numbers probably affected of the 2·5 million former refugees settled there between 1975 and 2002. The exact burden of disability implied by such numbers is, however, unknown because many surveys did not record the functional impairment (or treatment needs) associated with the disorder in refugees in whom triggering factors (Watters, 2001; Kroll, 2003) psychiatric comorbidity, and long-term consequences of non-treatment have been reported to differ from those of other groups with posttraumatic stress. (Favaro, *et al*., 2009; Silove *et al*.,2007; Malekazi, *et al*.,2006; Locke, *et al*.,2006; Hubbard, *et al*.,2005; Sack, *et al*.,2004; Hinton, *et al*.,2003; Turner, *et al*., 2003; Sack, *et al*.,2003; Steel, *et al*.,2002).

## 5.5. Part Five: Discussion of Emotional Distress

The finding of table (4:4) shows that (96.3) of study sample has emotional Distress.

According to the current research of Dr. Helen Verdeli, professor of clinical psychology at Teachers College, Columbia University, the most common stressor experienced by Syrians living in refugee camps is worry about the well-being of their relatives who have dispersed to other refugee camps, moved to other countries, or remained in Syria and might have been tortured or killed (Eastern Mediterranean Public Health Network

(EMPHNET), 2014). Another stressor is fear about interpersonal violence (EMPHNET). Although refugees residing inside the camps are protected from military violence, inside the camps they are vulnerable to physical violence, torture, sexual assault, and rape (EMPHNET). Many adults and children have been victims of or witnessed multiple acts of violence. Major threats, stressors, and realities such as these represent some of the daily life struggles of Syrian refugees.

## 5.6. Part Six: Discussion of Differences between Socio-demographic variables on Dependent Variables (Anxiety, Depression, PTSD and Emotional Distress)

### *a. Gender/Anxiety*

According to results presented in Table (4:5), there is no statistical significant difference between man and women in terms of gender/ *Anxiety*. This means that, both men and women almost gave similar responses to event questions. When we look at basic emotions such as fear, anger, disgust we can see that these are basic survival mechanisms occurring in response to a specific stimulus. For instance, when somebody faces pain or the threat of death showing and feeling fear is usual and common. Therefore, we can see the similarity of fear reaction among male and female in the results of this Study.

Women with anxiety reported guilt and worthlessness more frequently than men. Sar, *et al*., 2013). reported preponderance of feelings of guilt and worthlessness among women with dissociative depression compared with those without dissociation. Both dissociative depression and the dissociative subtype of PTSD are known to be related to chronic childhood trauma as seen in Complex PTSD (Sar, 2011). A number of studies have examined the dissociative experiences of refugees (Marmar, *et al*., 1994; Punama¨ki, *et al*.,2005). Marmar, *et al*., 1994), found a

relationship between peritraumatic dissociation and a PTSD diagnosis in male Vietnam theater veterans. In a sample of 316 Vietnam veterans, Waelde, *et al*., 2005). found a taxon of highly dissociative individuals. The preponderance of guilt and worthlessness may also be associated with the type of traumatic events.

***b. Gender/Depression***

According to results of Table (4:5), there is no statistical significant difference between men and women in terms of gender/depression. This means that males and females almost gave similar responses to depression questions. For instance, Researchers had observed that, many male and female Syrian refugees, act or feel like the events they had lived are still happening. They know, they are save in Kurdistan of Iraq and are safe. However, when they hear the sound of planes, they can easily become afraid. In addition, when they see Kurdish police or soldiers, they can experience panic and fear. Finally, many of them experience nightmares and physical problems such as pain, body tension and so on. The finding of a higher prevalence rate of depression among women than men in this study is similar to a pattern observed in different displaced population (Sabin, *et al*.,2003;Lopes,2004; Roberts, *et al*.,2008;Robersts, *et al*.,2009;Buchwald, *et al*.,2003;Andrew,*et al*.,2012;Marina, *et al*.,2011,Bastin, *et al*.,2013). However, this finding was opposite to the pattern observed in Ethiopian Immigrants and Refugees in Toronto (Fenta, *et al*., 2004). A number of significant associations of independent variables were found with outcomes of depression after adjusting for effects of other demographic and trauma exposure variables. Women are at particularly high risk of depression, as recorded in other studies on mental health of displaced populations (Sabin, *et al*.,2003;Lopes,2004; Robersts, *et al*.,2009.

***c. Gender/PTSD***

According to results Table (4:5), there is statistical significant difference between males and females on gender/PTSD in terms that females more often showed avoidance, Negative Interference and Associated Disturbance. The reason of females more often showing that might be withdrawal from social life. Therefore, many women lost their husband, they hold all burdens of family to their self. On the other hand, streets and outside world are not safe, because of these reasons many women stay at home. Finally, many women do not have social life, therefore, they experience detachment from others. Also the characteristic structure of women may be one reason in terms that females more often show avoidance. Generally, women are sensitive and establish an immediate link with their environment. However, if they face destruction of their environments or values, they might suffer from introversion, maintain their grief for a long time and show avoidance. On the other hand, men can or had to maintain their social life and connections with the outside world to work. Therefore, females might more often show avoidance. Exposure to multiple war stressors may lead to hopelessness and respondents who had experienced a high frequency of traumatic events were also more vulnerable to depression. This study also showed that lack of basic social goods such as house or shelter had a significant association with outcomes of depression. This could be due to lacking basic needs like shelter make to have low self-esteem which leads to loss of interest in every activity and hopelessness. There was strong association between forced displacement as refugee previously and depression. This was similar with the findings of the study conducted in Northern Uganda ( Robersts, *et al*.,2009).

***d. Gender/Emotional Distress***

According to results that presented in table (4:6), there is no statistical significant difference between males and females on gender/Emotional Distress. It means that, both male and female almost gave similar responses to Emotional Distress questions. Normally, responses and reactions to stress can change from one person to another. However, in this Study, the source of stress was war and because of the war conditions many Syrian refugees almost gave same responses to Emotional Distress questions. For instance, almost all males and females experienced concentration problems, difficulty falling or staying asleep or anger. Women and men are at risk for different types of stress-related disorders, with women at greater risk for depression and anxiety and men at greater risk for alcohol- use disorders (Kajantie and Phillips, 2005;Kessler *et al*., 2003). Although the specific basis for gender differences in prevalence of these disorders have not been well studied, it has been suggested that gender differences in emotional and craving responses to stress may underlie the differential risk for these psychological disorders (Kajantie and Phillips, 2005; Sinha and Rounsaville, 2002; Taylor, *et al*., 2006; Zahn-Waxler, 2000). Studies of subjective emotion experience find that women report greater sadness (Brebner, 2003) and anxiety/fear (Feingold, 1994; Fischer, *et al*., 2004; Ollendick, *et al*., 1995). than men.

***e.Age/ Anxiety***

According to results Table (4:7), there is no statistical significant difference among different age groups on age/ *Anxiety*. This means that five different age groups (25-29, 30-34, 35-39, 40-44 years) gave almost similar response to event questions. 74 Syrian refugees said: “Yes, we believed that the event could result in death or physical injury to us or others and we felt intense fear, helplessness or horror.” Even young, or

older Syrian refugees experienced similar things without age differences. Young adults have a higher prevalence of mental health symptoms than older subjects do. Nearly half of women and one third of men aged 18–34 years reported that they were moderately or extremely anxious or depressed. The prevalence of mental health symptoms decreased with age until the age of 70–74 years and increased again among those over 75 years. Many factors that have been shown to be associated with mental health symptoms in the present and other studies (such as unemployment, economic hardship and being belittled) are more prevalent among younger than older subjects.

***f.Age/depression***

According to results Table (4:7), there is no statistical significant difference among different age groups on age/negative interference. This means that almost all (300) participants showed symptoms of negative interference such as unwanted thoughts, images, nightmares and physical Emotional Distress. In this study, age is not seen a great influential factor. One factor that may contribute to the further development of depressive symptoms is the older age7,33,40,42-44.

***g.Age/PTSD***

According to results Table (4:7), there is no statistical significant difference among different age groups on age/avoidance. 89 Syrian refugees gave affirmative responses. As seen, from young generations to the old, many refugees experienced similar experiences and gave almost the same answers. Therefore, war conditions, many refugees had to drop or withdraw their social life and interactions with others. Generally young generation could not maintain their education and middle aged people could not maintain their jobs. War almost affected all the age groups.

***h.Age/Emotional Emotional Distress***

According to results of table (4:8), there is no statistical significant difference among different age groups on age/Emotional Distress. This means that people who are from 20 years old to 65 years old almost experienced similar experiences during war. Therefore, they almost gave similar responses to questions. It is thought that during the war emotional distress symptoms can be easily seen. Concentration problems, sleeping problems, emotional problems are very common. Therefore, age is not so much of big issues and important factors in this study.

***i.Education/ Anxiety***

According to results of table (4:9), there is no statistical significant difference among different educational statuses on educational status/event. This means that both educated people and uneducated people almost gave similar responses to event questions. In this Study, war issues were discussed as events. Therefore, affirmative responses to event questions are quite normal among educated or uneducated refugees.

***j. Education/Depression***

According to results table (4:9), there is statistical significant difference among different educational statuses on educational status/negative interference in terms of people who graduated from primary school more often show negative interference. Again we have stated before, education may be a protective factor for people. For instance, in this Study, many participants who are graduated from primary school suffered from negative interference symptoms. However, many educated participants can cope with negative interference symptoms. The prevalence of mental disorders was higher among those with lower levels of education, particularly for females. The prevalence of mental disorders was 24.9% for

those who did not complete school compared to 20.2% for those with school qualifications only and 19.5% for those with post-school qualifications.

***k.Education/PTSD***

According to results table (4:9), there is no statistical significant difference among different educational statuses on educational status/avoidance. participants said "Yes, we avoid thoughts or feelings about the experience". This means that, both educated and uneducated participants gave almost same responses to avoidance questions. Many people who are both educated and uneducated behave according to their nature and humans don not like to face dangerous situations. When danger is faced such as war, they may show reactions such as avoidance. This is normal at first. Education levels were found to have a higher affect as far as the degree of PTSD. Those who were educated were more influenced by the traumatic events than those who were less educated. Likewise, married participants seemed to be more affected by the traumatic events than single people. This may be due to their fear for their spouses and family members. Furthermore, people who experienced the traumatic events first hand or had been hurt in the traumatic events were affected more by the posttraumatic stress disorder than those who did not.

***l. Education/Emotional Distress***

According to results table (4:10), there is statistical significant differences among different educational statuses on educational status/Emotional Distress in terms that people who graduated from primary school more often showed Emotional Distress. When we look at this result, we can see the supportive side of education. So, education may be a protective factor. Generally, uneducated participants show symptoms of post-traumatic stress disorder in this Study. On the other hand, educated

participants show less symptoms of posttraumatic stress disorder. When Researchers had interviewed educated refugees, they realized that, educated refugees know how to cope with stressful events and produce solutions to their problems.

The effect of education on psychological Emotional Distress has proved to be inconsistent, as several previous studies have found an educational gradient, for example, in depressive symptoms (Belek, 2000, Fryers, *et al*., 2003, Fryers, *et al*., 2005, Lorant, *et al*., 2003), insomnia (Gellis et al., 2005) and chronic stress syndrome (Ahola, *et al*., 2006). but several studies have also found reversed or have failed to show any significant gradient (Aromaa and Koskinen, 2004, Meertens et al., 2003, Chen, *et al*., 2005, Molarius, *et al*., 2009, Lahelma, *et al*., 2006).

***m. Residency / Anxiety:***

The findings of the present study show that there are no significant differences between anxiety severity among Syrian refugees in relation to their address. (Table 4:11).

Previous findings of an association between urbanization and Anxiety were in agreement with some studies from the USA ( Blazer, *et al*, 2007; Neff and Husaini, 2007). A few studies from the Netherlands revealed higher urban than rural rates of psychosis ( Marcelis, *et al.*, 2008; van Os *et al.*, 2001, 2002).

***n. Residency / Depression:***

The findings of the present study show that there are no significant differences in depression severity among Syrian refugees in relation to their address. (Table 4:11).

According to Sundquist et al (2014) the main finding of their follow-up study was that a high level of urbanization was associated with increased incidence rates of psychosis and depression for both women and

men. This association remained after adjustment for age, marital status, attained level of education and immigrant status, and was more pronounced for psychosis than for depression. Moreover, the covariates living alone and low educational attainment were strongly associated with psychosis and depression, especially for men.

***o. Residency / PTSD:***

The findings of the present study show that there are no significant differences in PTSD severity among Syrian refugees in relation to their address. (Table 4:11).

Several previous studies have shown a relationship between PTSD, mood disorders, suicide attempts and poor social networks ( Amann, 2001; Johnsson Fridell, *et al.*, 2006; Cheng, *et al.*, 2000; Hirschfeld, *et al.*, 2000); thus, poor social networks might be a mediator between urbanisation and mental health.

***p.Residency / Emotional Distress:***

The findings of the present study show that there are no significant differences in emotional distress among Syrian refugees in relation to their address. (Table 4:12).

***q. Economic Support/ Anxiety***

According to results table (4:13), there is no statistical significant difference among different economic statuses on economic status/event. This means that, poor, middle and people of higher economical statuses gave almost similar responses to event questions. The reason to these similar responses may be the nature of war. Therefore, researchers recorded that; from poor participants to rich participants the disruptive effects of war were felt.

***r. Economic Support/Depression***

According to results table (4:13), there is no statistical significant difference between different economic statuses on economic status/avoidance. 39 poor participants answered yes to avoidance questions and 47 people who come from middle economic class answered yes to avoidance questions. As seen, economic status does not have great effects on the answers about avoidance. Both the rich and poor may experience avoidance such as detachment from others, forget important details of events and so on.

A meta-analysis spanning several different countries found that depression levels were consistently more often present in individuals from the lowest SES in varying cultures (Lorant, *et al*., 2003). Depression has also been found to be persistent across longitudinal studies in individuals from a disadvantaged socioeconomic background (Melchior, *et al*., 2013).

***s. Economic Support/PTSD***

According to results table (4:13), there is no statistical significant difference among different economic statuses on economic status/negative interference. This means that, from poor participants to rich participants the physical and psychological effects of war were seen. Both poor and rich participants suffer from nightmares, physical Emotional Distress, unwanted thoughts, and images and so on.

***t. Economic Support/Emotional Distress***

According to the results table (4:14), there is no statistical significant difference among different economic statuses on economic status/Emotional Distress. Again rich, middle economic status participants and poor participants answered almost the same way to Emotional Distress questions. When the subject is war, generally people experienced similar things. Many participants (poor-rich) felt Emotional Distress during the

war and many of them still experience it. Therefore we cannot say that rich people do not feel the destructive effects of war or poor people never feel Emotional Distress. In this study, economic status does not have a great effect on Emotional Distress questions. Previous research has suggested a higher prevalence of mental health problems in low SES communities (McLeod and Shanahan, 1993; Curtis, *et al*., 2001).

Income is a useful measure of socio-economic position because it relates directly to the wide range of material resources that may influence health (Galobardes, *et al*., 2006). Material circumstances that have direct implications for health include housing, food, clothing, transportation, medical care, child care, opportunities for leisure activities and a cleaner environment. Adequate income is a generalized resource that provides access to a larger variety and better quality of health enhancing goods and services. A graded relationship between income and health is no longer solely limited to material deprivation but also reflects social ordering (Schnittker, 2004a). Psychological Emotional Distress and mental health problems have been found to be generally more common among the lower income groups (Fryers, *et al*., 2003, Fryers, *et al*., 2005).

***u.Losses in Family/ Anxiety***

According to results of table (4:15), there is no statistical significant difference among different relationships according to losses in family/event. This means that, if refugees lost their close or distant relatives, they experienced intense fear, horror and helplessness. Therefore they answered yes to event questions.

***v.Losses in Family/depression***

According to results of table (4:15), there is no statistical significant difference between different relationships between according to losses in family/avoidance. Avoidance is a frequent symptom of posttraumatic stress

disorders. After traumatic events such as war, showing avoidance from social life or others is very common. Therefore losing close or distant loved ones does not have a great effect on refuges in this Study. Many of them answered yes to avoidance questions.

***w. Losses in Family/PTSD***

According to results of table (4:15), there is no statistical significant difference among different relationships between the lost people on losses in family/negative interference. This means that even refugees who have lost their close or distant loved ones experienced negative interference. The relationship refugees in terms of their loved ones does not have a great effect on negative interference questions in this Study.

***x. Losses in Family/Emotional Distress***

According to results of table (4:15), there is statistical significant difference among different relationships according to loss in family/ Emotional Distress in terms of people who lost their close relatives more often show Emotional Distress. According to the researchers note, people who have lost their close relatives more often experience concentration and sleep problem. They more often cry and think about them. They miss them, therefore they might have an increased probability in developing Emotional Distress symptoms.

# CHAPTER SIX

## CONCLUSIONS AND RECOMMENDATIONS

# Chapter Six
# Conclusions and Recommendations

## *6.1 Conclusions*

1. The majority of refugees had symptomatic of Anxiety, Depression and PTSD.
2. All refugees had emotional distress
3. No significant differences were found between Anxiety, Depression, and PTSD in relation to their gender, age, educational level and financial support.
4. The majority of refugees did not receive any finial support.
5. The refugees who loss closed family member are more susceptible to mental health problems

## *6.2 Recommendations*

1. ***Improve living conditions of Syrian refugees particularly in Qushtapa Camp:***

   Fear of environmental threats and the need to improve living conditions were mostly acknowledged by Syrian refugees living in Qushtapa camp. Almost every interviewee from the camp who lived in a tent expressed a need for having a caravan. Most of the needs were expressed in relation to improvement in basic necessities such as food, shelter, clothing, clean water, and sanitation. The following interventions are recommended in support of this recommendation:

   - Continuing efforts towards replacing tents with caravans.
   - Conducting health awareness sessions focusing on hygiene, waste management and other relevant topics

2. ***Ensure access to basic health and education services:***

   Increase coverage for health and education services in areas of need, and assess obstacles to accessing services in order to decrease these barriers. Ensure the availability of information on these services through various means and channels (pamphlets, leaflets, educational sessions, community initiatives and groups.

3. ***Meet the needs of refugees relevant to financial stability and food provision:***

   The expressed need for securing an income, together with the need for nutritional services, were highlighted in this study. Preoccupation with lack of income, unemployment and inability to secure basic necessities for the family can escalate mental health problems by affecting feelings of self-worth, guilt, shame, helplessness, anger, and despair. This particular recommendation

requires collaboration among different sectors with the following suggested interventions:

Provide appropriate vocational training and rehabilitation opportunities for women and men, promoting a sense of productivity and functioning.

- Facilitate the provision of appropriate opportunities for income generation for women and men.

**4. Distress and Coping**

As the assessment indicated community and family support as an important coping strategy adopted by the refugees, promoting initiatives that can capitalize and expand on these support structures is useful.

5. ***Develop community based interventions*** that focus on resilience, skill building, self-efficacy, and capacity building for refugees, and promote adaptive coping skills and strategies. Such interventions can increase motivation and hope, provide a sense of productivity, and replace negative coping behaviors with positive strategies that enhance wellbeing..
6. ***Support the development of community social support programs*** by encouraging interventions that build protective factors related to positive family and interpersonal relationships, and promote a sense of community, involvement and belonging. Such programs can provide opportunities to discuss common problems, express concerns and provide mutual support.
7. ***Support the strengthening of religious support services*** as a coping mechanism expressed by displaced Syrians. This can include self-help groups and religious ceremony “Wu’ath”.

# REFERENCES

## References

القرأن الكريم \ سورة النساء الأية (100)

Ahola, K., Honkonen, T., Isometsä, E., Kalimo, R., Nykyri, E., & Koskinen, S. (2006). Burnout in the general population. *Social Psychiatry And Psychiatric Epidemiology*, *41*(1), 11-17.

Ahola, K., Virtanen, M., Honkonen, T., Isometsä, E., Aromaa, A., & Lönnqvist, J. (2011). Common mental disorders and subsequent work disability: A population-based Health (2000) Study. *Journal Of Affective Disorders*, *134*(1-3), 365-372.

Al-Hadethe, A., Hunt, N., Thomas, S., & Al-Qaysi, A. (2014). Prevalence of traumatic events and PTSD symptoms among secondary school students in Baghdad. *European Journal Of Psychotraumatology*, *5*(0). http://dx.doi.org/10.3402/ejpt.v5.23928

Alpak, G., Unal, A., Bulbul, F., Sagaltici, E., Bez, Y., & Altindag, A. et al. (2014). Post-traumatic stress disorder among Syrian refugees in Turkey: A cross-sectional study. *International Journal Of Psychiatry In Clinical Practice*, *19*(1), 45-50.

Amann, G. (2001). Social network and social support deficits in depressed patients: A result of distorted perception?. *European Archives Of Psychiatry And Clinical Neuroscience*, *241*(1), 49-56.

Başoğlu, M., Livanou, M., Crnobarić, C., Frančišković, T., Suljić, E., Đurić, D., & Vranešić, M. (2005). Psychiatric and Cognitive Effects of War in Former Yugoslavia. *JAMA*, *294*(5), 580. http://dx.doi.org/10.1001/jama.294.5.580

Bastin, P., Bastard, M., Rossel, L., Melgar, P., Jones, A., & Antierens, A. (2013). Description and Predictive Factors of Individual Outcomes in

## References

a Refugee Camp Based Mental Health Intervention (Beirut, Lebanon). *Plos ONE*, *8*(1), e54107.

Belek, I. (2000). Social class, income, education, area of residence and psychological distress: does social class have an independent effect on psychological distress in Antalya, Turkey?. *Social Psychiatry And Psychiatric Epidemiology*, *35*(2), 94-101.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*, *7*(1).

Blazer, D. (2007). Alcohol Abuse and Dependence in the Rural South. *Archives of General Psychiatry*, *44*(8), 736.

Brady, K. (2001). Comorbid Posttraumatic Stress Disorder and Substance Use Disorders. *Psychiatric Annals*, *31*(5), 313-319.

Brainard, J., & Zaharlick, A., (2009). Changing health beliefs and behaviors of resettled Laotian refugees: Ethnic variation in adaptation. *Social Science & Medicine*, *29*(7), 845-852. http://dx.doi.org/10.1016/0277-9536(89)90083-x

Brebner, J., (2003). Gender and emotions. *Personality And Individual Differences*, *34*(3), 387-394. http://dx.doi.org/10.1016/s0191-8869(02)00059-4

Buchwald, D., Manson, S., Dinges, N., Keane, E., & Kinzie, J. (2003). Prevalence of depressive symptoms among established vietnamese refugees in the united states. *Journal Of General Internal Medicine*, *8*(2), 76-81. http://dx.doi.org/10.1007/bf02599987

Cardozo, B., Talley, L., Burton, A., & Crawford, C. (2004). Karenni refugees living in Thai–Burmese border camps: traumatic

## References

experiences, mental health outcomes, and social functioning. *Social Science & Medicine*, *58*(12), 2637-2644.

Carlson, E. & Rosser-Hogan, R. (2004). Cross-cultural response to trauma: A study of traumatic experiences and posttraumatic symptoms in Cambodian refugees. *Journal of Traumatic Stress*, *7*(1), 43-58. http://dx.doi.org/10.1007/bf02111911

Chen, Y. (2005). Can social factors explain sex differences in insomnia? Findings from a national survey in Taiwan. *Journal Of Epidemiology & Community Health*, *59*(6), 488-494.

Cheng, A. (2000). Psychosocial and psychiatric risk factors for suicide: Case--control psychological autopsy study. *The British Journal Of Psychiatry*, *177*(4), 360-365. http://dx.doi.org/10.1192/bjp.177.4.360

Darves-Bornoz, J., Alonso, J., de Girolamo, G., Graaf, R., Haro, J., & Kovess-Masfety, V. et al. (2008). Main traumatic events in Europe: PTSD in the European study of the epidemiology of mental disorders survey. *Journal Of Traumatic Stress*, *21*(5), 455-462. http://dx.doi.org/10.1002/jts.20357

de Jong, J. & Komproe, I. (2002). Closing the gap between psychiatric epidemiology and mental health in post-conflict situations. *The Lancet*, *359*(9320), 1793-1794. http://dx.doi.org/10.1016/s0140-6736(02)08729-9

de Jong, J., Komproe, I., & Van Ommeren, M., (2003). Common mental disorders in postconflict settings. *The Lancet*, *361*(9375), 2128-2130. http://dx.doi.org/10.1016/s0140-6736(03)13692-6

Ehntholt, K. & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced

## References

war-related trauma. *Journal Of Child Psychology And Psychiatry*, *47*(12), 1197-1210.

Favaro, A., Maiorani, M., Colombo, G., & Santonastaso, P. (2009). Traumatic Experiences, Posttraumatic Stress Disorder, and Dissociative Symptoms in a Group of Refugees from Former Yugoslavia. *The Journal Of Nervous & Mental Disease*, *187*(5), 306-308.

Fawzi, M., Pham, T., Lin, L., Nguyen, T., Ngo, D., Murphy, E., & Mollica, R. (2007). The validity of posttraumatic stress disorder among vietnamese refugees. *Journal Of Traumatic Stress*, *10*(1), 101-108. http://dx.doi.org/10.1002/jts.2490100109

Fazel, M., Doll, H., & Stein, A. (2009). A School-Based Mental Health Intervention for Refugee Children: An Exploratory Study. *Clinical Child Psychology And Psychiatry*, *14*(2), 297-309.

Fazel, M., Reed, R., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, *379*(9812), 266-282.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, *365*(9467), 1309-1314.

Feingold, A. (2004). Gender differences in personality: A meta-analysis. *Psychological Bulletin*, *116*(3), 429-456.

Fenta, H., Hyman, I., & Noh, S. (2004). Determinants of Depression Among Ethiopian Immigrants and Refugees in Toronto. *The Journal Of Nervous And Mental Disease*, *192*(5), 363-372.

## References

First, M. (2013). Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, and Clinical Utility. *The Journal Of Nervous And Mental Disease*, *201*(9), 727-729.

Fischer, A., Rodriguez Mosquera, P., van Vianen, A., & Manstead, A. (2004). Gender and Culture Differences in Emotion. *Emotion*, *4*(1), 87-94. http://dx.doi.org/10.1037/1528-3542.4.1.87

Fryers, T., Brugha, T., Morgan, Z., Smith, J., Hill, T., & Carta, M. (2005). Prevalence of psychiatric disorder in Europe: the potential and reality of meta?analysis. *Social Psychiatry & Psychiatric Epidemiology*, *40*(1), 85-85.

Fryers, T., Melzer, D., & Jenkins, R. (2003). Social inequalities and the common mental disorders. *Social Psychiatry & Psychiatric Epidemiology*, *38*(5), 229-237.

Galobardes, B. (2006). Indicators of socioeconomic position (part 1). *Journal Of Epidemiology & Community Health*, *60*(1), 7-12. http://dx.doi.org/10.1136/jech.2004.023531

Gerritsen, A. (2006). Use of health care services by Afghan, Iranian, and Somali refugees and asylum seekers living in The Netherlands. *The European Journal Of Public Health*, *16*(4), 394-399. http://dx.doi.org/10.1093/eurpub/ckl046

Global Humanitarian Overview: (2015). Geneva: OCHA. https://docs.unocha.org/sites/ dms/Documents/GHO-FINAL-web.pdf.

Global Mental Health Lab. (2015). Mental health service provision for Syrian refugees in Jordan. Retrieved from http://www.tc.columbia.edu/gmhlab/

## References

Government of Lebanon & OCHA (United Nations Office for the Coordination of Humanitarian Affairs.2014). Lebanon Crisis Response Plan 2015-2016. https:// docs.unocha.org/sites/dms/CAP/2015-2016_Lebanon_CRP_EN.pdf.

Hinton, W., Du, N., Chen, Y., Tran, C., Newman, T., & Lu, F. (2004). Screening for major depression in vietnamese refugees. *Journal Of General Internal Medicine*, *9*(4), 202-206.

Hollifield, M., Warner, T., Lian, N., Krakow, B., Jenkins, J., & Kesler, J. (2002). Measuring Trauma and Health Status in Refugees. *JAMA*, *288*(5), 611.

Hubbard, J., Realmuto, G., Northwood, A., & Masten, A. (2005). Comorbidity of Psychiatric Diagnoses with Posttraumatic Stress Disorder in Survivors of Childhood Trauma. *Journal Of The American Academy Of Child & Adolescent Psychiatry*, *34*(9), 1167-1173.

Human Rights and Equal Opportunity Commission. (2004). A last resort: National inquiry into children in immigration detention. Retrieved from The Australian Human Rights Commission website: http://www.hreoc.gov.au/human_rights/children_detention_report/report/PDF/alr_complete.pdf

Inter-Agency. (2014a). (2014) Syria Regional Response Plan Turkey Mid-Year Update. UNHCR.

http://www.unhcr.org/syriarrp6/midyear/docs/syria-rrp6-myu-turkey.pdf.

Inter-Agency. (2014b). (2014)Syria Regional Response Plan Iraq Mid-Year Update.

## References

Inter-Agency. (2014c). (2014) Syria Regional Response Plan Egypt Mid-Year Update. UNHCR.

http://www.unhcr.org/syriarrp6/midyear/docs/syria-rrp6-myu-egypt.pdf.

Inter-Agency. (2015a). Regional Refugee and Resilience Plan 2015-2016: In Response to the Syrian Crisis, Strategic Overview. United Nations Population Division and UNHCR. http://www.3rpsyriacrisis.org/wp-content/uploads/2015/01/3RP-ReportOverview.pdf.

Inter-Agency. (2015b). Inter-Agency Operation Update – Syrian Refugees in Iraq, January (2015). UNHCR.

Jacobsen, L., Southwick, S., & Kosten, T. (2001). Substance Use Disorders in Patients With Posttraumatic Stress Disorder: A Review of the Literature. *American Journal Of Psychiatry*, *158*(8), 1184-1190. http://dx.doi.org/10.1176/appi.ajp.158.8.1184

Kajantie, E. & Phillps, D. (2006). The effects of sex and hormonal status on the physiological response to acute psychosocial stress. *Psychoneuro-endocrinology*, *31*(2), 151-178.

Kamau, M., Silove, D., Steel, Z., Catanzaro, R., Bateman, C., and Ekblad, S. (2004). Psychiatric disorders in an African refugee camp. *Intervention*, *2*(2), PP84-89.

Kemp, C. (2006). Refugee and immigrant health: Current issues. Paper presented at the Annual Arizona Refugee Resettlement Conference.

Kessler, R.., McGonagle K., Swartz M., Blazer D., Nelson C. (2003). Sex and depression in the National Comorbidity Survey. I: Lifetime prevalence, chronicity and recurrence. *J Affect Disord*, 29,85–96.

## References

Kessler, R., McGonagle K , Zhao S, Nelson CB, Hughes M, Eshleman S. (2004). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. *Arch Gen Psychiatry*, 51,8–19.

Kessler, R., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K., . Wang. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *JAMA, 289*(23), 3095-3105.

Kessler, R., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (2005). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048-1060.

Keyes, E., (2000). Mental health status in refugees: An integrative review of current research. *Issues in Mental Health Nursing,a21*, 397-410.

Kim, G., Rabih T., and Lynn L. (2007). Basic Health, Women's Health, and Mental Health Among Internally Displaced Persons in Nyala Province, South Darfur, Sudan, *Am J Public Health,*February, 97(2): 353–361.

Kimerling, R., ouimette, P., and wolfe, J. (eds.). (2002). Gender and ptsd. New york: the guilford press.

Kinzie, J. , Boehnlein, J. , Leung, P. , Moore, L. , Riley, C., and Smith, D. (2000). The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees. *American Journal of Psychiatry*, 147(7), 913-917.

Kirmayer, L., (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *The Journal of Clinical Psychiatry*, 62(s13), 22-28.

## References

Kroll J. (2003). Posttraumatic symptoms and the complexity of responses to trauma. *JAMA*, 290: 667–70.

Laban, C., Gernaat, H., Komproe I., van der Tweel, I., De Jong J. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *J Nerv Ment Dis*, 193(12): 825–32.

Laban, C. , Gernaat, H. , Komproe, I., Schreuders, B. , and De Jong, J. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *The Journal of Nervous and Mental Disease*, 192(12), PP843-851.

Lahelma, E., laaksonen, M., martikainen, P., rahkonen, O. and sarlio-lähteenkorva, S. (2006). multiple measures of socioeconomic circumstances and common mental disorders. *Soc sci med*, 63, 1383

Lanius, R. , vermetten, E., loewenstein, R., brand, B., schmahl, C., bremner, J. (2010). Emotion modulation in ptsd: clinical and neurobiological evidence for a dissociative subtype. *American journal of psychiatry,* 167(640–647.

Lavik, N., Christie, H., Solberg, O., Varvin, S. (2006). A refugee protest action in a host country: *possibilities and limitations of an intervention by a mental health unit. J Refugee Studies*, 9: 73–88.

Leavey, G., Hollins, K., King, M., Barnes, J., Papadopoulos, C., and Grayson, K. (2004). Psychological disorder amongst refugee and migrant schoolchildren in London. *Social Psychiatry and Psychiatric Epidemiology*, 39(3), 191-195.

## References

Lie, B. (2002). A 3-year follow-up study of psychosocial functioning and general symptoms in settled refugees. *Acta Psychiatrica Scandinavica*, 106, 415- 425.

Lindert, J., Von Ehrenstein, O. , Priebe, S., Mielck, A., and Brahler, E. (2009). Depression and anxiety in labor migrants and refugees: A systematic review and meta-analysis. *Social Science and Medicine*, 69, 246-257.

Lo newman, l. (2013). Seeking asylum—trauma, mental health, and human rights: an australian perspective. *Journal of trauma and dissociation,* 14(2), PP213–223.

Locke, C., Southwick, K., McCloskey, L., Fernandez-Esquer ME. (2006). The psychological and medical sequelae of war in Central American refugee mothers and children. *Arch Pediatr Adolesc Med*, 150: 822–28.

Locke, C., Southwick, K., McCloskey, L., Fernandez-Esquer ME. (2006). The psychological and medical sequelae of war in Central American refugee mothers and children. *Arch Pediatr Adolesc Med*, 150: 822–28. 26

Lopes Cardozo, B. (2004). Traumatic experiences, mental health outcomes, and social functioning of Karenina refugees living in Thai-Burmese border camps. Soc Sci Med, 58(12)2637–44.

LORANT, V., DELIEGE, D., EATON, W., ROBERT, A., PHILIPPOT, P. & ANSSEAU, M. (2003). *Socioeconomic inequalities in depression: a meta-analysis. Am J Epidemiol*, 157, 98-112.

## References

Lorant,V., Deliege, D., Eaton,W., Robert, A., Phili,ot, P. and Ansseau, M. (2003). *socioeconomic inequalities in depression: a meta-analysis. Am j epidemiol,* 157, 98-112.

Majka, L., & Mullan, B. (2002). Employment retention, area of origin and type of social su,ort among refugees in the Chicago area. International Migration Review, 26(3), 899-926.

Malekzai A, Niazi J, Paige S. (2006) . *Modification of CAPS-1 for diagnosis of PTSD in Afghan refugees. J Trauma Stress*, 9: 891–98. 25

Marcelis, M., Navarro-Mateu, F., Murray, R. ( 2008). Urbanization and psychosis: a study of 1942–1978 birth cohorts in The Netherlands. Psychological Medicine, 28, 871– 879.

Marina, L., Tanja, F., Metin, B. (2011) Factors associated with posttraumatic stress disorder and depression in war survivors displaced in *Croatia. Croat Med J*, 52:709–17.

Marmar, C. , Weiss, D. , Schlenger, W. , Fairbank, J. , Jordan, B. K., Kulka, R. (2004). Peritraumatic dissociation and posttraumatic stress in male vietnam theater veterans. *American journal of psychiatry*, 151, 902–907.

Marshall, G., Schell, T., Elliott, M., Berthold, S., Chun C-A. (2005) Mental health of Cambodian refugees 2 decades after resettlement in the United States. JAMA,294(5): 571–9.

Marshall, R., Olfson, M., Hellman, F., Blanco, C., Guardino, M., and Struening, E. (2001). "Comorbidity, impairment, & suicidality in subthreshold PTSD." *American Journal of Psychiatry*, 158, PP1467-1473.

## References

McFarlane, A., C. (2000). Posttraumatic stress disorder: A model of the longitudinal course and the role of risk factors. *The Journal of Clinical Psychiatry,* 61(S5), 21-23.

McLeod, J.D., & Shanahan, M.J. (2003). Poverty, parenting and children's mental health. American sociological review, 58 (3), 351-366.

Mcleod, Jack. ( 2001). "another look at the agenda setting function of the press" hillsdale, lawrence erlbaum associates, inc, 47-60

Meertens, V., Scheepers, P. & Tax, B. (2003). depressive symptoms in the netherlands 1975-2006: a theoretical framework and an empirical analysis of sociodemographic characteristics, gender differences and changes over time. Sociol health illn, 25, 208-31.

Melchior, D., FRYERS, T., JENKINS, R., BRUGHA, T., & MCWILLIAMS, B. (2013). Social position and the common mental disorders with disability: estimates from the National Psychiatric Survey of Great Britain. Soc Psychiatry Psychiatr Epidemiol, 38, 238- 43.

Mghir, R., Freed, W., Raskin, A., Katon, W. (2005) Depression and posttraumatic stress disorder among a community sample of adolescent and young adult Afghan refugees. J Nerv Ment Dis, 183: 24–30.

Miller, G. A., Elbert, T., & Rockstroh, B. (2005). Judging psychiatric disorders in refugees. The Lancet, 366, 1604-1605.

Miller, K. (2009). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy*, 29(4), 283- 304.

## References

Molarius, A., Berglund, K., Eriksson, C., Eriksson, H., linden-Bostrom, M., Nordstrom, E., Persson, C., Sahlqvist, L., Starrin, B. and Ydreborg, B. (2009). mental health symptoms in relation to socioeconomic conditions and lifestyle factors - a population-based study in sweden. Bmc public health, 9, 302.

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2003). Dimensions of trauma associated with posttraumatic stress disorder (PTSD) caseness, severity & functional impairment: a study of Bosnian refugees resettled in Australia. Social Science & Medicine, 57(5), 775-781.

Momartin, S., Silove, D., Manicavasagar, V., & Steel, Z. (2004). Comorbidity of PTSD & depression: Associations with trauma exposure, symptom severity & functional impairment in Bosnian refugees resettled in Australia. *Journal of Affective Disorders*, 80(2-3), 231-238.

Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D., & Brooks, R. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Medical Journal of Australia*, 185(7), 357- 361.

Neff, J., A. & Husaini, B., A. ( 2007). Urbanicity, race & psychological distress. *Journal of Community Psychology*, 15, 520– 536.

Nicholl, C., & Thompson, A. (2004). The psychological treatment of post traumatic stress disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health*, 13(4), 351-362.

## References

Norris, f. , foster, j. , & weisshaar, d. (2002). The epidemiology of sex differences in ptsd across developmental, societal, & research contexts. In r. Kimerling, p. Quimette, & j. Wolfe (eds.), gender & ptsd, 3–42 Guilford, ny: the guilford press.

OCHA (United Nations Office for the Coordination of Humanitarian Affairs).(2014).

Ollendick, T., Yang, B., Dong, Q., Xia, Y., Lin, L. (2005). Perceptions of fear in children & adolescents: the role of gender & friendship status. *J Abnorm Child Psychol,* 23:439–452.

Onyut, L., Neuner, F., Ertl, V., Schauer, E., Odenwald, M., Elbert, T. (2009). Trauma, poverty & mental health among Somali & Rwandese refugees living in an African refugee settlement-an epidemiological study. Conflict Health, 3(6):90–107.

Orhan, Oytun. (2014). The Situation of Syrian Refugees in the Neighboring Countries: Findings, Conclusions & Recommendations. Ankara: Center for Middle Eastern Strategic Studies (ORSAM). http://www.orsam.org.tr/en/enUploads/Article/ Files/PP201452_189ing.pdf.

Pan, A., Daley, S., Rivera, L. M., Williams, K., Lingle, D., & Reznik, V. (2006). Understanding the role of culture in domestic violence: The Ahimsa Project for Safe Families. *Journal of Immigrant and Minority Health,* 8(1), 35-43.

Pierce, Karen. (2014). "Ministerial Pledging Conference on Resettlement & other forms of Admission for Syrian Refugees, 9th December 2014, Geneva." Statement delivered by Ambassador Karen Pierce on behalf of the British Government, December 10.

## References

Porter, M., and Haslam, N. (2005). Predisplacement and post displacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Journal of the American Medical Association*, 294(5), 602-612.

Portes, A., Kyle, D., Eaton, WW. (2002). Mental illness and help-seeking behavior among Mariel Cuban & Haitian refugees in South Florida. *J Health Social Behav*, 33: 283–98.

Priebe, S., Bogic, M., Ajdukovic, D., Franciskovic, T., Galeazzi, G. M, Kucukalic A. (2010). Mental disorders following war in the Balkans: A study in 5 countries. Archives of General Psychiatry, 67(5):518–528.

Punamäki, R. , komproe, I., quota, S., elmasri, M., and de jong, J. (2005). The role of peritraumatic dissociation and gender in the association between trauma & mental health in a palestinian community sample. *American journal of psychiatry*, 162(3), 545–551.

Rasmussen, A., Crager, M., Baser, R., Chu, T., & Gany, F. (2012). Onset of Posttraumatic Stress Disorder and Major Depression Among Refugees and Voluntary Migrants to the United States. *Journal Of Traumatic Stress*, *25*(6), 705-712. http://dx.doi.org/10.1002/jts.21763

Roberts, B., Damundu, E., Lomoro, O., & Sondorp, E. (2009). Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba. Southern Sudan BMC Psychiatry, 9(1):7.

Roberts, B., Ocaka, K., Browne, J., Oyok, T., & Sondorp E. (2008). Factors associated with post-traumatic stress disorder and depression

## References

amongst internally displaced persons in northern Uganda. BMC Psychiatry, 8(1):38.

Robins, L., Regier, D. (2001). Psychiatric disorders in America. New York: The Free Press,

Sabin, M., Cardozo, B., Nackerud, L., Kaiser, R., & Varese, L. (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. JAMA, 290(5):635–42.

Sack, Wh., Clarke, G., & Him, C. (2003). A 6-year follow-up study of Cambodian refugee adolescents traumatized as children. *J American Academic Child Adolescent Psychiatry*, 32: 431–37. 33 27.

Sack, WH., Clarke, GN., & Seeley, J. (2005). Posttraumatic stress disorder across two generations of Cambodian refugees. *Academic Child Adolescent Psychiatry*, 34: 1160–66.

Sack, WH., McSharry, S., Clarke, G., Kinney, R., Seeley, J., & Lewinsohn P. (2004). The Khmer Adolescent Project. I. Epidemiologic findings in two generations of Cambodian refugees. J Nerves Mental Disorder , 182: 387–95. 27

Sar, v. (2011). Developmental trauma, complex ptsd, & the current proposal of dsm-5. *European journal of psychotraumatology*, 2, 5662,

Sar, V., Akyüzü, G., Oztürk, E., & Alioğlu, F. (2013). Dissociative depression among women in the community. *Journal of trauma & dissociation*, 14(4), 423–438.

Schnittker, j. (2004a). education & the changing shape of the income gradient in health. J health social beaver , 45, 286-305. Schnittker, j.

## References

(2004b). psychological factors as mechanisms for socioeconomic disparities in health: a critical a,raisal of four common factors. Social biology, 51, 1-23.

Schwarz-Langer, G., Deighton, R., Jerg-Bretzke, L., Weisker, I., & Traue, H. C. (2006). Psychiatric treatment for extremely traumatized civil war refugees from former Yugoslavia. Torture, 16(2), 69-80.

Schweitzer, R., Melville, F., Steel, Z. (2006). Trauma, post-migration living difficulties & social su,ort as predictors of psychological adjustment in resettled Sudanese refugees. Australian & *New Zealand Journal of Psychiatry*,40(2):179–187.

Sharma, S. (2012). Psychological distress among Australians and immigrants: Findings from the (2007) National Survey of Mental Health and Wellbeing. *Advances In Mental Health*, *10*(2), 106-116. http://dx.doi.org/10.5172/jamh.2011.10.2.106

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar V, & Steel Z. (2007). Anxiety, depression & PTSD in asylum-seekers: associations with premigration trauma and post-migration stressors. Br *J Psychiatry*; ,170:351–57. 24

Silove, D., Steel, Z., McGorry, P., & Drobny, J. (2009). Problems Tamil asylum seekers encounter in accessing health & welfare services in Australia. Social Science & Medicine, 49(7), 951-956.

Sinha, R., Rounsaville, BJ. (2002). Sex differences in depressed substance abusers. *J Clin Psychiatry*,63:616–627.

Slewa-Younan S, Uribe Guajardo M. G, Heriseanu A, Hasan T. A. (2014). systematic review of posttraumatic stress disorder &

## References

depression amongst Iraqi refugees located in western countries. *Journal of Immigrant Minority Health*. 5:1–9.

Smith, P., Perrin, S., Yule, W., & Rabe-Hesketh, S. (2001). War exposure & maternal reactions in the psychological adjustment of children from Bosnia-Hercegovina. *Journal of Child Psychology & Psychiatry, 42(3), 395-404.*

Sonderegger, R., & Barrett, P., M. (2004). Patterns of cultural adjustment among young migrants to Australia. *Journal of Child & Family Studies,13(3), 341-356.*

Sondergaard, H. , Ekblad, S., & Teorell, T. (2001). Self-reported life event patterns & their relation to health among recently resettled Iraqi & Kurdish refugees in Sweden. *Journal of nervous & mental diseases,189, 838–845.*

Spasojevic, J., Heffer, R. , & Snyder, D . (2000). Effects of posttraumatic stress & acculturation on marital functioning in Bosnian refugee couples. *Journal of Traumatic Stress*,13(2), 205-217.

Statement of Mr Antonio Guterres: United Nations High Commissioner for Refugees. (2010). *International Journal Of Refugee Law*, *22*(1), 116-118. http://dx.doi.org/10.1093/ijrl/eeq004

Steel, Z., Silove, D., Phan, T., Bauman, A. (2002). Long-term effect of psychological trauma on the mental health of Vietnamese refugees resettled in Australia: a population-based study. Lancet, 360: 1056–62.

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture & other potentially traumatic events with mental health outcomes among populations

## References

exposed to mass conflict & displacement: a systematic review & meta-analysis. *Journal of the American medical Association*, 302(5), 537–549.

Steel, Z., Silove, D., Chey, T., Bauman, A., Phan, T., & Phan, T. (2005). Mental disorders, disability & health service use amongst Vietnamese refugees & the host Australian population. Acta Psychiatrica Scandinavica, 111(4),300-309.

Summerfield, D. (2009). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Soc Sci Med, 48: 1449–62.

Sundquist, J. & Johansson, S.E. ( 2002) Födelsel&ets betydelse: hälsan i olika invandrar grupper i Sverige [The Importance of The Country of Birth: Health in Different Immigrant Groups in Sweden]. Stockholm: Folkhälsoinstitutet.

Taylor, se., way bm, welch wt, hilmert cj, lehman bj, eisenberger ni .(2006). Early family environment, current adversity, the serotonin transporter promoter polymorphism, & depressive symptomatology. Biological psychiatry, 60:671–676

Teodorescu, DS., Heir, T., Hauff, E., Wentzel- Larsen, T., Lien L. (2012). Mental health problems & post- migration stress among multi- traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology*, 53(4):316–32.

Thomas, T., & Lau, W. (2002). Psychological well being of child & adolescent refugee & asylum seekers: Overview of major research

## References

findings of the past ten years. Sydney, NSW: Human Rights & Equal O,ortunity Commission, 359: 1793–94

Tran, T., Manalo, V., & Nguyen, V. (2007). Nonlinear relationship between length of residence & depression in a community-based sample of Vietnamese Americans. *International Journal of Social Psychiatry*, 53(1), 85-94.

Tufan, A., E., Alkin, M., Bosgelmez, S .(2013). Post-traumatic stress disorder among asylum seekers & refugees in Istanbul may be predicted by torture & loss due to violence. *Nordic Journal of Psychiatry,* 67:219–224.

Turner, S., Bowie, C., Dunn, G., Shapo, L., Yule, W. (2003). The mental health of Kosovan Albanian refugees in the UK. *Br J Psychiatry*, 184: 444–48. 29

UNDP (United Nations Development Programme). (2014). A Resilience-Base Development Response to the Syria Crisis. Amman: United Nations Population Division, Regional Bureau for Arab States.

UNHCR (United Nations High Commissioner for Refugees). (2011). UNHCR Resettlement Handbook. Geneva: UNHCR.

UNHCR. (2013). Asylum Trends .(2012): Levels & Trends in Industrialized Countries. Geneva: UNHCR.

UNHCR. (2014a). "Syrian Regional Refugee Response Inter-agency Information Sharing Portal: Regional Overview Datasheet, December 11,2014." Geneva: UNHCR

UNHCR. (2014b). "UN & Partners Launch Major Aid Plans for Syria & Region" Press Release, December 18. Berlin: UNHCR.

## References

http://www.unhcr.org/cgi-bin/texis/vtx/se
arch?page=searchanddocid=54929c676andquery=syria.

UNHCR. (2014c). "Governments Pledge to Take in Around 100,000 Syrian Refugees." Press Release December 9. Geneva: UNHCR. http://www.unhcr.org/print/548736336. html.

UNHCR. (2014d). Asylum Trends (2013): Levels & Trends in Industrialized Countries. Geneva: UNHCR.

UNHCR. (2014e). Living in the Shadows: Jordan Home Visits Report 2014. Amman: UNHCR.

UNHCR. (2015a). "Syrian Regional Refugee Response Inter-agency Information Sharing Portal." UNHCR.

http://data.unhcr.org/syrianrefugees/regional.php.

UNHCR. (2015b). Resettlement & Other Forms of Admission for Syrian Refugees, January 9. Geneva: UNHCR.

http://www.unhcr.org/52b2febafc5.pdf.

UNHCR. (2015c). "Resettlement." Geneva: UNHCR.

http://www.unhcr.org/pages/4a16b1676. html.

UNHCR. (2015d). "War Stokes Further Growth in Forced Displacement in First Half of 2014." Press release, January 7. Geneva: UNHCR. http://www.unhcr.org/54ac24226.html.

UNHCR. (2015e). "Syrian Regional Refugee Response Inter-agency Information Sharing Portal: Europe Syrian Asylum A,lications." UNHCR. http://data.unhcr.org/ syrianrefugees/asylum.php.

## References

UNHCR. (2015f) . "UNHCR Special Envoy Angelina Jolie Visits Iraq, Calls for International Leadership to End Suffering." Press release, January 25. Dohuk: UNHCR. http:// www.unhcr.org/54c5244d6.html.

UNHCR. (2015g). "Syria Regional Response Plan (2014).UNHCR Income as of 13 January 2015." UNHCR.

UNHCR. (2015h). Asylum Trends .(2014). Levels & Trends in Industrialized Countries. Geneva: UNHCR. The Syrian Refugee Crisis 279

UNHCR. (2015i). "UNHCR Resettlement Statistical Database." UNHCR. http://www. unhcrwashington.org/rststat.

United State Committee for Refugees (USCR). (2003). World Refugee Survey: an annual assessment of conditions affecting refugees, asylum seekers & internally displaced persons. Washington DC.

US Committee for Refugees. World Refugee Survey 2003: an annual assessment of conditions affecting refugees, asylum seekers & internally displaced persons. Washington DC, 2003.

Valtonen, K. (2004). The adaptation of Vietnamese refugees in Finland. Journal of Refugee Studies, 7(1), PP63-78.

Van der hart, o., nijenhuis, e. R. S., & steele, k. (2006). The haunted self: structural dissociation & the treatment of chronic traumatization. New york: norton.

Van, M., Sharma, B., Prasain, D., Poudyal, BN. (2001). Addressing human rights violations, in Trauma, War, & Violence: Public Mental Health in Socio-Cultural Context. Edited by de Jong JTVM. New York, Plenum, 259–283

## References

Van, M., de Jong, J., Sharma, B., Komproe, I., Thapa, S. B., & Cardena, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. Archives of General Psychiatry, 58(5), 475-482.

van , M., Sharma, B., Sharma, G. K., Komproe, I., Cardena, E., & de Jong, J. (2002). The relationship between somatic & PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety & depression. *Journal of Traumatic Stress*, 15(5), 415-421.

van , J., Hanssen, M., Bijl, R.V. (2001). Prevalence of psychotic disorder & community level of psychotic symptoms: an urban–rural comparison. Archives of General Psychiatry, 58, 663– 668.

van , J., Hanssen, M., de Graaf, R. (2002). Does the urban environment independently increase the risk for both negative & positive features of psychosis? Social Psychiatry & Psychiatric Epidemiology, 37, 460– 464.OpenUrl

Vuković I. S, Jovanović N, Kolarić B, Vidović V, Mollica R. F. (2014). Psychological & somatic health problems in Bosnian refugees: A three year follow-up. Psychiatria Danubina, 26:442–449.

Waelde, l., silvern, l., & fairbank, j. (2005). A taxometric investigation of dissociation in Vietnam veterans. *Journal of traumatic stress*,18, 359–369.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. Soc Sci Med 52: 1709–18.

Weine, S., Raina, D., Zhubi, M., Delesi, M., Huseni, D., Feetham, S. (2008). The TAFES multi-family group intervention for Kosovar

## References

refugees: A feasibility study. Journal of Nervous Mental Disorders, 191(2), 100-107.

Westermeyer, J., Neider, J., & Callies, A. (2009). Psychosocial adjustment of Hmong refugees during their first decade in the United States. A longitudinal study. *Journal of Nervous Mental Disorders,* 177(3), 132-139.

World Health Organization. (2008). The global burden of disease: 2004 update. Retrieved from the WHO website:

Young, M. (2006). Acculturation, identity & well-being: the adjustment of Somalian refugees. Sante Mental Que, 21(1), PP271-290.

Zahn-Waxler C. (2000) The development of empathy, guilt, & internalization of distress: implications for gender difference in internalizing & externalizing problems. In: Davidson RJ, editor. Anxiety, Depression, & Emotion. Oxford University Press; New York: 222–265.

# APPENDICES

# APPENDIX A

KURDISTAN REGIONAL GOVERNMENT
Council Of Ministers
Ministry of Higher Education & Scientific Research
University of Sulaimani Presidency
The Deanary of Faculty of Medical Science
School of Nursing

الخلاصة العربي.docx

حکومەتی هەرێمی کوردستان – عێراق
سەروەختایەتی زانکۆو‌مەتی وەزیران
وەزارەتی خوێندنی باڵا و توێژینەوەی زانستی
سەرۆکایەتی زانکۆی سلێمانی
ڕاگرایەتی فاکەڵتی زانستە پزیشکیەکان
سکوڵی پەرستاری

خوێندنی باڵا

No:
Date :

ژمارە ٤١١ ١٩ ٧
بکەوت: ٢٠١٦/ ٤ / ٢٢ زایینی
٢٧١٦ کوردی

بۆ پارێزگای هەولێر بەشی کوچ و کوچبەران

بابەت / ئاسانکاری

داواکارین لە بەڕێزتان ڕەزامەندی بفەرموون بە ئاسانکاری کردنی کارەکانی بەڕێز ( مەریوان قادر حمە ڕەش ) ، خوێندکاری خوێندنی باڵای کولێجەکەمان ( ماستەر ) بەمەبەستی کۆکردنی زانیاری وداتا توێژینەوەکەی کە بە ناونیشانی
(Assessment of Psychological Problems Among Syrian Refugees in QushtPA Camps – Erbil)

هاوکاریتان جێگەی ڕێز وسوپاس

د عطية كريم محمد
سەرۆکی سکوڵی پەرستاری

بۆ:
- خوێندنی باڵا
- خۆیی
- دۆسیەی دەرچوو

Iraq, Kurdistan Region, Sulaimani
University of Sulaimani
The Deanery of Faculty of Medical Science/ School of Nursing

## Questionnaire

**Part one: Demographic Characteristics**

**1. Age** ☐ **years**

**2. Gender:**

Male ☐ Female ☐

**3. Marital status:**

Single ☐

Married ☐

Divorced ☐

Widows ☐

Separated ☐

**4. Number of children** ☐

**5. Did you lost member of your family .Yes** ☐ **No** ☐ **if yes your relationship with lost person** ☐

**6- Financial Statues**

Not sufficient ☐

Barley sufficient ☐

Sufficient ☐

**7- Educational level:**

Unable to read and write ☐

Able to read and write ☐

Primary school ☐

Secondary school ☐

Technical Institution ☐

College and higher education ☐

**8. Previous residential area (before immigration) :**

Urban ☐ Sub urban ☐ Rural ☐

**9. Occupation before migration :** ☐

**10. Current occupation or activities** ☐

**11. Do you Smoke cigarettes?**

**Yes** ☐ **No** ☐ **if yes how many cigarette per day** ☐

**12. Do you consume alcohol?**

**Yes** ☐ **No** ☐ **if yes how much per day** ☐

## Questionnaire

**13. How long have you been living current campus ?** ☐ **years** ☐ **months**

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

# Refugee Health Screener-15 (RHS-15)

## English Version

*Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.*

### DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.



Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

ID#

DATE

# REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

**INSTRUCTIONS:** Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

| SYMPTOMS | *NOT AT ALL* | *A LITTLE BIT* | *MODERATELY* | *QUITE A BIT* | *EXTREMELY* |
|---|---|---|---|---|---|
| 1. Muscle, bone, joint pains | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling down, sad, or blue most of the time | 0 | 1 | 2 | 3 | 4 |
| 3. Too much thinking or too many thoughts | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling helpless | 0 | 1 | 2 | 3 | 4 |
| 5. Suddenly scared for no reason | 0 | 1 | 2 | 3 | 4 |
| 6. Faintness, dizziness, or weakness | 0 | 1 | 2 | 3 | 4 |
| 7. Nervousness or shakiness inside | 0 | 1 | 2 | 3 | 4 |
| 8. Feeling restless, can't sit still | 0 | 1 | 2 | 3 | 4 |
| 9. Crying easily | 0 | 1 | 2 | 3 | 4 |

Developed by the Pathways to Wellness project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.



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ID#

DATE

# REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

| SYMPTOMS | *NOT AT ALL* | *A LITTLE BIT* | *MODERATELY* | *QUITE A BIT* | *EXTREMELY* |
|---|---|---|---|---|---|
| **10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?** | **0** | **1** | **2** | **3** | **4** |
| **11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?** | **0** | **1** | **2** | **3** | **4** |
| **12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?** | **0** | **1** | **2** | **3** | **4** |
| **13. Been jumpier, more easily startled (for example, when someone walks up behind you)?** | **0** | **1** | **2** | **3** | **4** |

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ID#

DATE

# REFUGEE HEALTH SCREENER-15 (RHS-15)

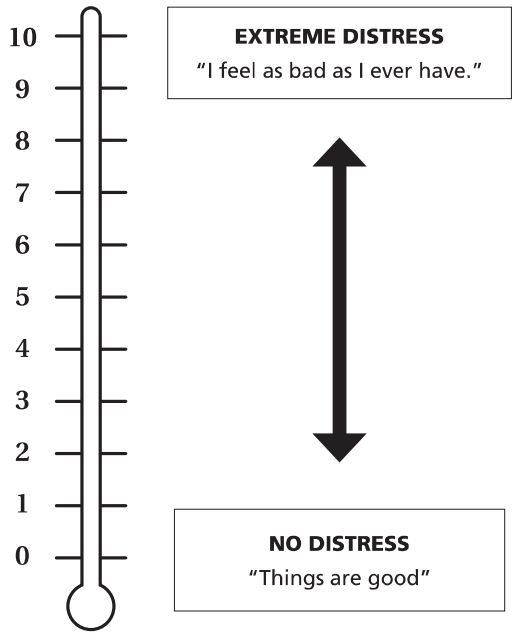
PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

**14. Circle the one best response below. Do you feel that you are:**

| | |
|---|---|
| **Able to handle (cope with) anything** | **0** |
| **Able to handle (cope with) most things** | **1** |
| **Able to handle (cope with) some things, but not able to cope with other things** | **2** |
| **Unable to cope with most things** | **3** |
| **Unable to cope with anything** | **4** |

**Add Total Score of items 1–14** ☐

**15. Distress Thermometer**




Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

**SCORING** SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

**CHECK ONE:** ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

استبانة

**الجزء الاول:- خصائص ديموغرافية**

**1- العمر** ☐ **سنوات**

**2- الجنس**

ذكر ☐ انثى ☐

**3- الحالة الاجتماعية**

أعزب ☐

متزوج ☐

**4- عدد الاطفال** ☐

**5 - هل فقدت احد الافراد عائلة** نعم ☐ كلا ☐ ذا الجواب بـ(نعم) صلة قرابة ☐

**6- الوضع المالي**

غير كاف ☐

بالكاد يكفي ☐

كـاف ☐

**7- المستوى الدراسي**

لا استطيع القراءة و الكتابة ☐

أستطيع القراءة و الكتابة ☐

خريج ابتدائية ☐

خريج ثانوية ☐

خريج معهد تقني ☐

خريج كلية او أعلى ☐

**8- مكان الاقامة السابق (قبل الهجرة):**

مدينة ☐ الاقضية و النواحي ☐ الريف ☐

**9- المهنة قبل الهجرة:** ☐

**10- المهنة او العمل الحالي:** ☐

**11- هل تدخن السجائر؟**

نعم ☐ كلا ☐ إذا الجواب بـ(نعم) كم عدد السجائر في اليوم ☐

**12- هل تشرب الكحول؟**

نعم ☐ كلا ☐ إذا الجواب بـ (نعم) كم الكمية في اليوم ☐

**13- كم يبلغ مدة بقائك في المخيم الحالي؟** **سنوات** ☐ **أشهر** ☐

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

# Refugee Health Screener-15 (RHS-15)

## Arabic Version

*Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.*

### DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

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# الفرز الصحي للاجئين -15
REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

#ID / الرقم التعريفي:

DATE / التاريخ:

**تعليمات:** باستخدام المقياس الموجود بجانب كل عرض من الأعراض، يرجى الإشارة إلى درجة مضايقة كل عرض لك على مدى الشهر الماضي. ضع دائرة في العمود المناسب. إذا لم يكن العرض مضايقاً لك خلال الشهر الماضي، فضع دائرة في عمود «لا شيء على الإطلاق».

**INSTRUCTIONS:** Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

| الأعراض **SYMPTOMS** | لا شيء على الإطلاق *NOT AT ALL* | قليلاً *A LITTLE BIT* | معتدلا *MODERATELY* | كثيرا *QUITE A BIT* | إلى أقصى حد *EXTREMELY* |
|---|---|---|---|---|---|
| 1. آلام في العضلات والعظام والمفاصل<br>Muscle, bone, joint pains | 0 | 1 | 2 | 3 | 4 |
| 2. الشعور بالكآبة معظم الاوقات<br>Feeling down, sad, or blue most of the time | 0 | 1 | 2 | 3 | 4 |
| 3. كثرة التفكير<br>Too much thinking or too many thoughts | 0 | 1 | 2 | 3 | 4 |
| 4. الشعور بعدم القدرة على المساعدة (الشعور بالعجز)<br>Feeling helpless | 0 | 1 | 2 | 3 | 4 |
| 5. رعب مباغت بدون سبب<br>Suddenly scared for no reason | 0 | 1 | 2 | 3 | 4 |
| 6. إغماء أو دوخة أو ضعف<br>Faintness, dizziness, or weakness | 0 | 1 | 2 | 3 | 4 |
| 7. عصبية أو ارتجاف داخلي<br>Nervousness or shakiness inside | 0 | 1 | 2 | 3 | 4 |
| 8. عدم الشعور بالسكينة و عدم القدرة على الثبات<br>Feeling restless, can't sit still | 0 | 1 | 2 | 3 | 4 |
| 9. البكاء بسهولة<br>Crying easily | 0 | 1 | 2 | 3 | 4 |

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PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

# الفرز الصحي للاجئين -15
REFUGEE HEALTH SCREENER-15 (RHS-15)

#ID / الرقم التعريفي:

DATE / التاريخ:

**التجارب التالية يمكن ان تكون تجارب مؤلمة متعلقة بالحرب او الهجرة, كم مرة شعرت بالاعراض تالية خلال شهر الماضي:**
The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

| الأعراض **SYMPTOMS** | لا شيء على الإطلاق *NOT AT ALL* | قليلاً *A LITTLE BIT* | معتدلا *MODERATELY* | كثيرا *QUITE A BIT* | إلى أقصى حد *EXTREMELY* |
|---|---|---|---|---|---|
| **10. هل عانيت من استعادة تذكرك لهذه الصدمة بخيالك أو تمثيلها أو الشعور كأنها تحدث مرة أخرى؟**<br>Had the experience of reliving the trauma; acting or feeling as if it were happening again? | 0 | 1 | 2 | 3 | 4 |
| **11. هل عانيت من ردود فعل بدنية (على سبيل المثال، كثرة تصبب العرق، سرعة دقات القلب) عندما تمّ تذكيرك بالصدمة؟**<br>Been having physical reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? | 0 | 1 | 2 | 3 | 4 |
| **12. هل شعرت بانعدام المشاعر (على سبيل المثال، تشعر بالحزن ولكنك لا تستطيع البكاء، أو غير قادر على الإحساس بمشاعر الحب)؟**<br>Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)? | 0 | 1 | 2 | 3 | 4 |
| **13. الآختلاج و سرعة الآجفال ( مثال على ذلك، تشعر أن هناك شخص يمشي ورائك)**<br>Been jumpier, more easily startled (for example, when someone walks up behind you)? | 0 | 1 | 2 | 3 | 4 |

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# الفرز الصحي للاجئين -15
REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

#ID / الرقم التعريفي:

DATE / التاريخ:

**14. ضع دائرة حول أفضل رد أدناه. هل تحس أنك:**
Circle the one best response below. Do you feel that you are:

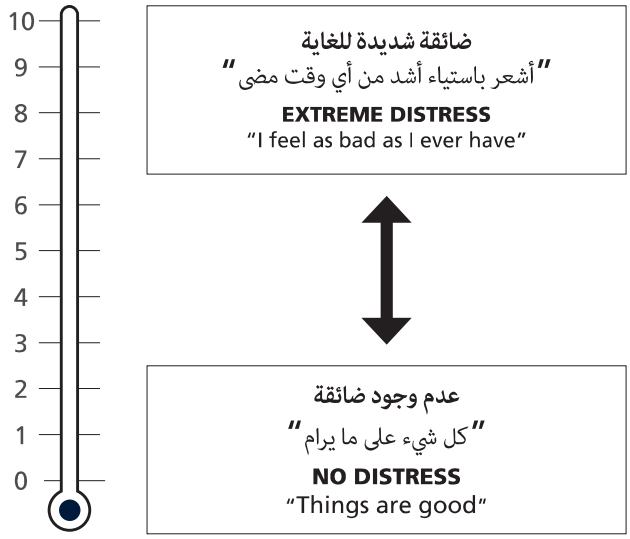
| | |
|---|---|
| **0** | **قادر على التعامل مع (مواجهة) أي شئ**<br>Able to handle (cope with) anything |
| **1** | **قادر على التعامل مع (مواجهة) معظم الأشياء**<br>Able to handle (cope with) most things |
| **2** | **إنك قادر على مواجهة بعض الأمور وغير قادر على مواجهة الأمور الأخرى**<br>Able to handle (cope with) some things, but not able to cope with other things |
| **3** | **أنك غير قادر على مواجهة معظم الآمور**<br>Unable to cope with most things |
| **4** | **إنك غير قادر على مواجهة كل الأمور**<br>Unable to cope with anything |

**Add Total Score of items 1–14** ____

**مقياس حدة الضائقة**
15. Distress Thermometer

**الرقم (من صفر إلى ١٠) الذي يصف مقدار حدة الضائقة التي عانيتها في الأسبوع الماضي بما فيه هذا اليوم.**

Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.




**SCORING** SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

**CHECK ONE:** ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

# Refugee Health Screener-15 (RHS-15)

## Burmese Version

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### DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

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PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

# Refugee Health Screener-15 (RHS-15)

## Sorani Kurdish Version

### Produced in partnership with Mercy Corps- Iraq

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**DEMOGRAPHIC INFORMATION**

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

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#ID

/DATE

# راپرسی پشکنینی تەندروستی پەنابەر #ID (RHS-15) 15
# REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

ڕێنماییەکان: بە بە کارهێنانی پێوانەی تەنیشت هەر نیشانەیەک، تکایە ئەو پلەیە دیاری بکە کە نیشانەکان بێزارکەر بوونە بۆ تۆ لە مانگی ڕابردوودا. هێمایەک لە ستوونی گونجاودا دابنێ. ئەگەر نیشانەکە بێزارکەر نەبووە بۆ تۆ لە ماوەی مانگی ڕابردوودا، چەماوە بکێشە بە دەوری "بەهیچ شێوەیەک".

**INSTRUCTIONS**: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."

| گەلێک زۆر EXTREMELY | تۆزێک زۆر QUITE A BIT | بە شێوەیەکی مامناوەندی MODERATELY | کەمێک A LITTLE BIT | بەهیچ شێوەیەک NOT AT ALL | نیشانەکان SYMPTOMS |
|---|---|---|---|---|---|
| 4 | 3 | 2 | 1 | 0 | 1. ماسولکە و جومگە ئێش وژان دە کە ن<br>Muscle, bone, joint pains |
| 4 | 3 | 2 | 1 | 0 | 2. هەست بە بێتاقەتی و خەمباری دەکەی بە بەردەوامی<br>Feeling down, sad, or blue most of the time |
| 4 | 3 | 2 | 1 | 0 | 3. ئایا تۆ زۆربەی کات لە بیرکردنەوەدایت<br>Too much thinking or too many thoughts |
| 4 | 3 | 2 | 1 | 0 | 4. هەستکردن بە بێ توانای<br>Feeling helpless |
| 4 | 3 | 2 | 1 | 0 | 5. ترسان لە ناکاو وبێ هۆ<br>Suddenly scared for no reason |
| 4 | 3 | 2 | 1 | 0 | 6. هەستکردن بە لاوازی و سەرئێشە و بێ تاقەتی<br>Faintness, dizziness, or weakness |
| 4 | 3 | 2 | 1 | 0 | 7. ئایا هەست بە نیگەرانی یان لەرزین لە ناخەوە دەکەیت<br>Nervousness or shakiness inside |
| 4 | 3 | 2 | 1 | 0 | 8. هەستکردن بە بێ تاقەتی، هێشتا ناتوانیت دابنیشێت<br>Feeling restless, can't sit still |
| 4 | 3 | 2 | 1 | 0 | 9. گریان بەئاسانی<br>Crying easily |

**SCORING** SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

**CHECK ONE:** ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

#ID

/DATE

# #ID (RHS-15) 15 راپرسی پشکنینی تەندروستی پەنابەر
# REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

لەرانەیە ئەم نیشانانە پەیوەست بن بە ئەزموونی ترۆمایی لە ماوەی جەنگ و کۆچکردن. ئایا لە مانگی ڕابردوودا چەندە ئەمانەت هەبووە:

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

| نیشانەکان SYMPTOMS | بەهیچ شێوەیەک NOT AT ALL | کەمێک A LITTLE BIT | بە شێوەیەکی مامناوەندی MODERATELY | تۆزێک زۆر QUITE A BIT | گەلێک زۆر EXTREMELY |
|---|---|---|---|---|---|
| 10. ئەزموونی ڕزگار بوون لە ترۆما؛ هەڵسوکەوت کردن یان هەستکردن بەوەی وەک ئەوەی دووبارە ڕوو بداتەوە<br>Had the experience of reliving the trauma; acting or feeling as if it were happening again? | 0 | 1 | 2 | 3 | 4 |
| 11. بوونی کاردانەوەی جەستەیی (بۆ نموونە کەوتنە نێو ئارەقە، خێرا لێدانی دڵ)<br>کاتێک ترۆمایەکت بیر هات بێتەوە؟<br>Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma? | 0 | 1 | 2 | 3 | 4 |
| 12. هەستکردن بە ئەبوونی هەست (بۆ نموونە، هەستکرن بە خەم بەڵام ناتوانیت بگریت، ناتوانیت هەستی خۆشەویستیت هەبێت)؟<br>Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)? | 0 | 1 | 2 | 3 | 4 |
| 13. داچڵەکین بە ئاسایی (بۆ نموونە، کاتێک کەسێک لە دواتەوە دەروات)<br>Been jumpier, more easily startled (for example, when someone walks up behind you)? | 0 | 1 | 2 | 3 | 4 |

**SCORING** SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

**CHECK ONE:** ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

#ID

/DATE

# راپرسی پشکنینی تەندروستی پەنابەر #ID (RHS-15) 15
# REFUGEE HEALTH SCREENER-15 (RHS-15)

PATHWAYS TO WELLNESS
Integrating Refugee Health and Well-Being

**14. چەماوە بەدەوری باشترین وەڵامدا بکێشە. ئایا هەست دەکەیت تۆ:**
Circle the one best response below. Do you feel that you are:

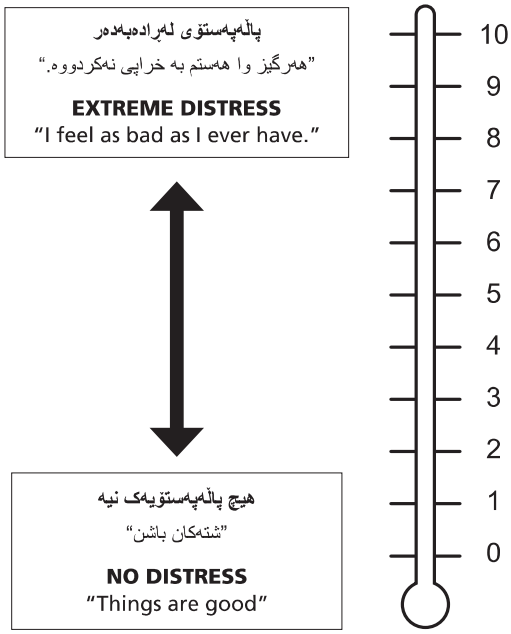
| | |
|---|---|
| 0 | **دەتوانیت خۆت لەگەڵ هە موو شتێک بگونجێنیت**<br>Able to handle (cope with) anything |
| 1 | **دەتوانیت خۆت لەگەڵ شتەکان بگونجێنیت، بەڵام هە موویان نا**<br>Able to handle (cope with) most things |
| 2 | **دەتوانیت خۆت لەگەڵ شتەکان بگونجێنیت، بەڵام ناتوانیت لەگەڵ شتەکانی تر بگونجێیت**<br>Able to handle (cope with) some things, but not able to cope with other things |
| 3 | **ناتوانیت خۆت لەگەڵ زۆرینەی شتەکان بگونجێنیت**<br>Unable to cope with most things |
| 4 | **ناتوانیت خۆت لەگەڵ هیچ شتێک بگونجێنیت**<br>Unable to cope with anything |

**Add Total Score of items 1–14**

**15. پێوەری پاڵەپەستۆ**
Distress Thermometer

تکایە چەماوە بەدەوری (0-10)دا بکێشە کە باشترین وەسفی چەندیەتی پاڵەپەستۆت دەکات کە دووچاری بوویت لە هەفتەی ڕابردوودا، بەڵەخۆگرتنی نەمڕۆش.

Please circle the number (0 –10) that best describes how much distress you have been experiencing in the past week, including today.




**SCORING** SCREENING IS POSITIVE IF: ❶ ITEMS 1–14 IS ≥12 OR ❷ DISTRESS THERMOMETER IS ≥5

**CHECK ONE:** ☐ **POSITIVE** ☐ **NEGATIVE** ☐ SELF-ADMINISTERED ☐ NOT SELF-ADMINISTERED

PATHWAYS TO WELLNESS

Integrating Refugee Health and Well-Being

# Refugee Health Screener-15 (RHS-15)

## Tigrinya Version

*Bilingual versions of the RHS-15 have been translated by an iterative process involving experts in the field, professional translators, and members of the refugee community so that each question is asked correctly according to language and culture. The English text is provided for reference only; using the English alone negates the sensitivity of this instrument.*

### DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Gender: _____ Date of Arrival: _____ Health ID: _____

Administered by: _____ Date of Screen: _____

Developed by the *Pathways to Wellness* project and generously funded by Robert Wood Johnson Foundation, Bill and Melinda Gates Foundation, United Way of King County, Medina Foundation, The Seattle Foundation, Boeing Employees Community Fund and M.J. Murdock Charitable Trust.



Pathways to Wellness: Integrating Refugee Health and Well-Being is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Michael Hollifield, M.D. of Pacific Institute for Research & Evaluation. For more information, please contact The *Pathways* Project at 206-816-3253 or pathways@lcsnw.org.

## List of Expert's names

| Expert name | Scientific Degree | Work place |
|---|---|---|
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| Dr. Salwa Shakir Alkurwi | professor | School of nursing /Sulaimani University |
| Dr. Radhwan Hussein | professor | College of Nursing \ University of Mosul |
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## الخلاصة

**الهدف:** لتتقيم المشاكل النفسيه لدى اللاجئين السوريين في مخيم قشتبه الواقع جنوب مدينة أربيل.

**المنهجية :** دراسة وصفية أجريت بين الخامس عشر من تشرين الثاني، (2015) الى الخامس عشر من تشرين الاول (2016) .مجتمع اللاجئين السوريين خلال السابع عشر من نيسان 2016 ضم (6410) لاجئ سوري مسجل في ذلك المخيم. عشوائيا تم اختيار (300) شخص عينة الدراسة . ماسح الصحة اللأجئين 15 الذي صممه مؤسسة المسارات الى الرفاهيه وأستخدمة كأداة في الدراسة الحالية. دراسه اولية أجريت للفتره من الخامس و العشرين من أيار لغاية العاشرمن حزيران (2016) .ثبات الأداة تم خلال أستخدام طريقة الأختبار و اعادة الأختبار بفارق زمني كان أسبوعان. معامل الأرتباط (بيرسون) تم أحتسابه و كانت نتيجة الثبات هي ( 0.91) .

**النتائج :** توصلت الدراسة الى أنه ( 60.7% ) من اللاجئين لديهم أعراض معتدلة للقلق و( 38 % )منهم لديهم مستوى متوسط (62.7 %) من اللاجئين لديهم اعراض متوسطه للكأبة و(36.3% ) لديهم مستوى معتدل. كذلك اشارت النتائج ان ( 53% ) من عينة الدراسه يعانون من أعراض الأضطرابات الصدمه التاليه للكرب (45.3% ) لديهم مستوى متوسط(69.7% ) يعانون من الكرب العاطفي.

**الاستنتاجات و التوصيات :** أستنتجت الدراسة بأن الأغلبية من اللاجئين لديهم أعراض القلق والكأبة وأضطرابات التالية للكرب.تقريباً جميع اللاجئين السوريين لديهم الكرب العاطفي.وأخيراً أوصت الدراسه بتحسين الحاله المعيشيه للاجئين وخاصة في مخيم قشتبه .المخاوف من المهددات البيئة والحاجة الى تحسين المستوى المعيشي كانت الأكثر اعترافاً من قبل اللاجئين السوريين في ذلك المخيم معظم الذين تم مقابلتهم في المخيم والذين يعيشون في الخيم عبرو عن حاجتيهم لأمتلاك كرفان.

حكومة إقليم كردستان

وزارة التعليم العالي و البحث العلمي

جامعة سليمانية

كلية التمريض

# تقييم المشاكل النفسية للاجئين السوريين في مخيم قشتبه-محافظة أربيل

رسالة مقدمة الى مجلس كلية التمريض / جامعة سليمانية كجزء من متطلبات نيل شهادة الماجستير في تمريض الصحة النفسية و العقلية

من قبل

**مريوان قادر حمه رش زنگنه**

بكالوريوس علوم تمريض (2011)

بأشراف

المدرس

**د.هيوا ستار صالح صوفي**

بكالوريوس علوم تمريض-ماجستير تمريض صحة مجتمع –دكتوراه تمريض صحة مجتمع

| | | |
|---|---|---|
| 2016 ميلادي | 1438هجري | 2716 كردي |
| كانون الاول | ربيع الاول | ره شه مي |

# پـــوخـــتـــه

**ئامانج**: بۆ پشتیوانی کردن لە کێشە دەروونییەکان لە نێوان پەنابەرە سوورییەکان لە کەمپی قوشتەپە، کە دەکەوێتە باکووری شاری هەولێر.

**شێـــواز**: لێکۆڵینەوەیەکی وەسفی کرا لە نێوان 15 تشرینی دووەمی 2015 تاکو پازدەی تشرینی یەکەمی (2016). وەکو ئەوەی کە لە ئاماری ئەنجومەنی پەنابەرە سوورییەکان هاتووە لە 17 نیسانی 2016دا، ڕێژەی پەنابەرە سوورییەکان دەگاتە (6410). بێ ڕیزبەندی (300) نموونە هەڵبژێردرا وەکو سامپل بۆ لێکۆڵینەوەکە. پشکێنەرێ تەندروستی پەنابەر 15 (RHS-15) نەخشەی دانرا لە لایەن (Pathways to Wellness agency) بەکارهێنرا وەکو ئامێرێك بۆ ئەم لێکۆڵینەوەیە. ڕێڕەوی لێکۆڵینەوەکە هاتە ئەنجامدان لەنێوان 25 ئایار بۆ 10 حوزەیران 2016. ووردی ئامێرەکە پێوانەکرا لە ڕێگای بەکارهێنانی شێوازی تاقیکردنەوەو دووبارە تاقیکردنەوە، وە ماوەکەی تەنها دوو هەفتە بوو. هاوکۆڵکەی هاوپەیوەندی کەس (r) ژمێردرا. ئەنجامی ڕاستەقینەکە (0.91) بوو.

**ئەنجام**: لە لێکۆڵینەوەکە دەرکەوت کەوا (60.7%) لە پەنابەران نیشانەی کەمیان هەیە لە نیگەرانی، وە (38%) ئاستێکی مامناوەندیان هەیە، وە (62.7%) لە پەنابەران نیشانەی مامناوەندیان هەیە لە پەستان، وە (36.3%) ئاستێکی کەمیان هەیە، وە (53%) لە پەنابەران نیشانەیەکی کەمیان هەیە لە PTSD، وە (45.3%) ئاستێکی مامناوەندیان هەیە، وە (96.3%) لەوان دەنالێنن لە تەنگانەی بەسۆزی.

**دەرکەوتن و ڕاسپاردن**: لە لێکۆڵینەوەکە دەرکەوت کەوا زۆربەی پەنابەران نیشانەیەکی کەمیان هەیە لە نیگەرانی، پەستان وە PTSD. نزیکەی، هەموو پەنابەرە سوورییەکان تەنگانەی بەسۆزیان هەیە. لە کۆتاییدا، لێکۆڵینەوەکە رایسپارد کەوا پەرەپێدانی باری ژیانی پەنابەرە سوورییەکان بە تایبەتی لە کەمپی قوشتەپە. ترس لە هەڕەشەی ژینگەو پێویستی بۆ باشکردنی باری ژیانیان بە زۆر زەرور دانیان پێداناوە لە لایەن زۆربەی پەنابەرانی کەمپەکە.