I was in Cairo, working at my desk in the refugee office. I hear this big commotion outside my door, and the staff can’t control it. I walk out, and here’s this man holding up his baby, straight out in front of him. He’s shaking his baby. He’s yelling and screaming that he can’t get food, but I can’t stop looking at this baby who is in total shock. I stay very calm. I ask the man if he would like to sit down and have a cup of tea, because tea is the answer to everything there. It’s part of the social fabric, it reminds people where they came from, it’s everything. I get him a cup of tea and the man starts to calm down. We talk it through. There’s no more food for me to give him because of the rations, but he’s drinking his tea. He’s calm and he eventually leaves. But I can’t stop thinking about that baby. I can’t get that baby out of my mind. What’s going to happen to him? His father has so much trauma. How is that baby going to survive it? The mental health needs are so great.

—Josh Lee, MSW candidate

The Need

The Syrian war has generated the largest displacement crisis of our time. Since 2011, opposing factions have committed violence and human rights violations on a massive scale. War crimes include massacres, murders, torture, sieges, shelling, hostage-taking and rape. Children have been used as human shields and recruited as soldiers. Basic infrastructures—for potable water, food, sanitation, education and health care—have been severely compromised, making it impossible for communities to function. In 2014, four out of every five Syrians were living in poverty so extreme that many were forced them to move, in search of stability and basic resources. Nearly half of the country’s population have now abandoned their homes; translated into actual numbers, that means 11 million people are now displaced, and more than half of them are children (UNHCR, 2015).

The trajectory of displacement is not a straight one. In more politically stable years, Syria served as a safehold for foreign refugees and asylum seekers who now join native Syrians to move within the country to safer locations. They often find themselves caught in another onslaught of violence as the war engulfs an ever-shifting frontier. They have been forced to move again, and then again.

If Syrians cross the border, their journey can quickly become treacherous. Human traffickers are taking as much money as they can, packing Syrians into trucks, then abandoning them on the sides of roads. Overloaded boats carry terrified people across the water, often in packed, airless rooms under the ship deck. As political and social pushback grow in hosting nations, fleeing Syrians can consider themselves lucky if they survive the journey, and even luckier if the destination country allows them across their borders. Syria’s closest, neighboring countries, which have taken in millions of Syrians, are reaching their limits; in a staggering example, one in every five people in Lebanon is now a Syrian refugee (UNHCR, 2015). Meanwhile, western countries are struggling with refugee resettlement policies, amid debate that pit economic interest against humanitarian responsibility. In the wake of recent terrorist attacks, these debates have reached a new pitch in fear and Islamophobia.

Syrian displacement is now in the spotlight, but it is only one crisis in the midst of a much larger global trend. In 2005, 38 million people were displaced by conflict and persecution. In 2015, that figure has swelled to 60 million. These numbers are so large that they remain difficult to digest even when broken down to the daily average of 42,500 (Guterres, 2015).

When migration is taken into account, the numbers swell still further. In 2014, there were approximately
11.3 million undocumented immigrants in the U.S. alone (Passel & Cohn, 2015). They, too, risk their lives to cross the border. They come hoping for jobs and shelter from drug-related violence, but then find it is a struggle to make their way without access to basic benefits and under the threat of deportation. It is frequently difficult for states to distinguish between those who should be granted asylum as refugees and those who should be considered immigrants (Crisp, 2007). The United Nations’ push to grant U.S. undocumented immigrant refugee status has fallen on deaf ears, but this population has experienced much of the same trauma, stigma, isolation and instability as refugees and asylum-seekers (Alberto & Weissenstein, 2014).

The global displacement crisis shows no signs of slowing. It is daunting in its historic scale, political upheaval, physical violence, cultural obliteration, economic depletion and psychological consequence. From our social work framework, multi-systemic analysis and action is required on every one of these fronts. Whether we work locally or globally, whether we approach displacement economically, politically or interpersonally, the well-being of this diverse population will be a concern for years to come.

In the face of the multi-faceted need—which spans shelter, employment, food, learning new languages, new cultures and new geographies—it is easy to view mental health as a luxury when it is not. Most people can adapt to extreme diversity; they need communities that work as opposed to mental health treatment. Accordingly, there is a great deal of evidence that mezzo interventions leveraging existing community resilience are powerful antidotes to trauma (Saul, 2013). But when mental health needs strike, they strike hard. The debilitating consequences of mental illness are so severe and globally rampant that the World Health Organization has projected depression will be the leading cause of worldwide disability by 2030 (2008). Depression will outpace cancer, heart disease and HIV. In economic terms, mental health disorders are expected to account for the loss of 16.1 trillion U.S. dollars over the next 20 years (Bloom et al, 2011).

It is a fact that in the displaced population, there are many traumatized parents and helpless children like the ones Josh Lee saw that day in Cairo. Most have not received a cup of tea, much less adequate mental health care. They will continue to be vulnerable to mental health issues, even after they have resettled. In Lindert’s systematic review on refugee mental health, found prevalence of depression stood at 44% and prevalence of anxiety stood at 40% (2009).

Mental disorders sap the energy and resilience that are necessary for a displaced person to start a new life in a new place. Numerous media portraits on displaced children emphasize the saving grace of their resilience and innocence. Nonetheless, the research shows that they are still at extreme risk (Thabet & Vostanis, 2000). Not only will children be affected by the violence of civil war in direct and indirect ways, they will also soak up their parents’ responses of despair, anger and fear, or of resilience, safety and hope (Feldman & Vengrober, 2011). Thus parental mental health directly effects the mental health of their
children. The consequences only become clear years later, but we know that instability and violence in the first, formative years can negatively impact IQ, behavior, relationships, brain development, the stress response and self schemas (Teicher, 2002). According to the landmark ACE Study, these children will also have an increased risk for substance abuse, depression, anxiety and chronic obstructive pulmonary disease.

The World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR) are looking for ways to change this situation. They are particularly interested in the potential of Interpersonal Psychotherapy, which has been gaining traction across the globe.

**Interpersonal Psychotherapy**

In the 1970s, New Haven social workers were delivering interventions that emphasized social relations and social roles. They thought that if they could heal relationships, they could heal suffering. Using these interventions as inspiration, Gerald Klerman, Myrna Weissman and Eugene Paykel developed and formalized Interpersonal Psychotherapy (IPT) at Yale (Frank et al, 2014). The short-term, psychodynamically-informed therapy highlights links between mood and interpersonal events. The framework proposes that mood disorders are alleviated when clients actively work on present problems in relationships. In the footsteps of the New Haven social workers, the therapist takes the stance that when you heal your relationships, you heal yourself.

Importantly for the displaced population, IPT is an effective treatment for depression (de Mello et al, 2005). It is also effective for post traumatic stress disorder, even when compared to exposure therapy (Jiang et al, 2011). IPT has been a particularly useful approach for co-occurring diagnoses because clients with depression often drop out of PTSD exposure therapy, but they will continue to attend IPT sessions (Markowitz et al, 2015). In addition to its proven effectiveness with these diagnoses, IPT is a good fit for the displaced population in ways that become clear with a closer look into the method itself.

IPT has a three-part theoretical base that incorporates attachment, communication and social theories (Stuart, 2006). According to attachment theory, we have an innate need to form and maintain close, reciprocal relationships with others. This need is not only a matter of emotional satisfaction, but a survival drive that starts at birth. As infants, we look to our caregiver(s) for safety and emotional regulation, particularly during moments of distress, and how our needs are met (or unmet) has far-reaching effects: physically, we suffer if we lack early attachments; psychologically, we establish relational patterns that underpin our adult interactions with partners, family, friends, colleagues and communities. Even those of us with healthy and highly secure attachment styles experience great distress when important relationships are disrupted. If we have insecure attachment styles, we are more prone to distress during conflicts, loss and role transitions.

While IPT uses attachment theory as a starting point, it does not seek to change underlying attachment styles. Instead, it treats the relational pattern as a given and emphasizes current interaction. IPT integrates communication theory by suggesting that, in the present moment, we attempt to fulfill attachment needs in ways that unintentionally elicit negative responses and deepens distress. IPT therapists support clients in getting what they need within relationships by asking clients to look closely at interpersonal fissures, building awareness around communication, and increasing relational choices. Social theory likewise highlights the role of interpersonal factors (such as social disruption, social scarcity and social loss) in response to major life events and in mood disorders. Using this framework, IPT animates relationships with protective and
alleviating powers that counteract depression and anxiety. The 16-week therapeutic agenda therefore focuses on learning and applying specific techniques to four relational problem areas: 1) Grieving and loss; 2) Interpersonal conflict; 3) Role transitions; 4) Isolation.

These four problem areas have immediate relevance for displaced people. Without fail, this population has experienced profound loss as communities are decimated, parents separated from children, friends and family lose contact, and many people die. Grieving and loss are inescapable. Relationships are strained by stress, fear, despair and anger, all of which make interpersonal conflict more likely. Professional and community roles also transform as displaced people make new homes in new cultures, or in refugee camps. In the face of such loss, relational conflict, and role transition, displaced people are highly likely to experience social isolation. The social problems can easily continue after resettlement because cultural and linguistic barriers persist in even the most welcoming, resource-rich communities. By strengthening social ties in the four problem areas, IPT immediately addresses key psychosocial pivot points that are especially vulnerable for the displaced population. Finally, IPT envisions relationships as the ground for healing, which makes it well-suited to interdependent cultures, where the individual is deeply integrated within a social network.

**Interpersonal Psychotherapy on a Global Scale**

Helen Verdeli, PhD, is a researcher, clinical professor and founding director of the Global Mental Health Lab at Columbia University. Since 2002, she has played a key role in landmark studies on serving the mental health needs of low-resource communities. These studies have taken place in diverse settings (rural and urban), diverse countries (Uganda and India), and with varying age groups (adolescents and adults). The WHO and UNHCR have recommended group IPT largely because Verdeli’s research proves that the modality is effective for depression and PTSD across cultures (Chammay et al, 2013; Bunch, W. 2015). It is also crucially important that IPT can be delivered by non-licensed mental health professionals under supervision. The therapy thus becomes affordable and viable in non-western states with scant mental health resources. For all of these reasons, IPT is one of three therapies that the WHO recommends. Verdeli has played a large part in creating the WHO’s IPT manual for lay providers.

Training non-professionals to deliver global mental health care was accidental. Verdeli still laughs when she tells the story. She was working with World Vision for her IPT study in Uganda, and had been promised trained health workers to deliver the therapy. At the last minute, World Vision fell short on resources, and could not spare their trained health workers. They suggested replacing the World Vision staff with their brothers and sisters, who had minimal high school education. With few options, Verdeli and her team agreed. They adapted the training process to be more experiential and interactive, and they made the content simpler and more structured (Verdeli et al, 2013). Tragedy became triumph; it worked.
While it was unplanned, hiring lay-people to deliver care is not without precedent. It is a natural outgrowth of an existing trend to ‘task-shift’ primary care delivery to community members. Over the past few decades, organizations like BRAC and Partners in Health have found that patients will take important healthcare measures—like following their tuberculosis medication regimens and using birth control—if community lay people make care accessible. This has been a win-win discovery, now adopted by the WHO. Instead of using limited funds to ship in professionals, healthcare centers have provided jobs for community health workers who can leverage cultural literacy and existing status within the community. The task-shifting trend did not at first apply to mental healthcare because: 1) There is little or zero mental health services in developing countries; 2) Mental healthcare has been considered a luxury; and 3) There has been little funding for mental healthcare.

When the WHO embraced the principle that there is “no health without mental health,” the landscape changed. The WHO’s Action Plan for 2013-2020 serves as a guide for nation-level responses to the tremendous mental health needs across the globe. And, in September, 2015, the UN included mental health and wellbeing as a Sustainable Development Goal. In short, international attention and resources are now getting channeled towards mental health, and services are scaling up.

Over the summer, Verdeli and her long-time research partner, Kathleen Clougherty, LCSW, taught an intensive course covering group IPT at the Summer Institute in Global Mental Health and Psychosocial Support at Columbia University. Students included a small contingent of actual students—myself included—but most were professional researchers and mental health practitioners already in the field. There was the American Psychological Association representative to the United Nations, the national clinical director for the U.S. Border Patrol, two from the Arab American Family Support Center, three from Partners in Health, direct clinicians, a music anthropologist, and the varied list goes on. Many of us had seen global mental health needs first hand—from the doctors and nurses overwhelmed by their patients’ depression, to the mentally ill who are chained to posts, to the despondent, ghost-like women who have been abused.

IPT’s straightforward, interpersonal approach made so much sense to the class that many of us started practicing and strategizing. As of December 2015, there is still a monthly skype call to discuss our independent IPT-driven projects and research. Verdeli is continually interested in creative implementation. Over the next five to ten years, she would like to see a growing body of research in different training and delivery models that are “de-stigmatizing, feasible and accessible.” As for her current project, she is working on a systematic, national IPT training in Lebanon to provide therapy for Syrian refugees.

While the multi-national partnerships get bigger and the scale expands, Verdeli’s presence remains grounded and kitchen-table intimate. It is no surprise, then, that she emphasizes the importance of working within real partnerships on the ground. She continually returns to the people and felt experience. “You have to feel into the depression, into their world,” she told us in July. “You have to listen so that you can give them some relief. All they want is relief.”

Resources


