Refugee-Led Organizations and the Obstacles They Face: A Comparative Study of Syria Bright Future and the Bhutanese Community Association of Pittsburgh

Priscila Elizabeth Cordoba Montoya

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REFUGEE-LED ORGANIZATIONS AND THE OBSTACLES THEY FACE: A COMPARATIVE STUDY OF SYRIA BRIGHT FUTURE AND THE BHUTANESE COMMUNITY ASSOCIATION OF PITTSBURGH

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In partial fulfillment of the requirements for
the degree of Masters of Arts

By
Priscila Córdoba Montoya

August 2017
REFUGEE-LED ORGANIZATIONS AND THE OBSTACLES THEY FACE: A COMPARATIVE STUDY OF SYRIA BRIGHT FUTURE AND THE BHUTANESE COMMUNITY ASSOCIATION OF PITTSBURGH.

By

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ABSTRACT

REFUGEE-LED ORGANIZATIONS AND THE OBSTACLES THEY FACE: A COMPARATIVE STUDY OF SYRIA BRIGHT FUTURE AND THE BHUTANESE COMMUNITY ASSOCIATION OF PITTSBURGH

By
Priscila Córdoba Montoya

August 2017

Thesis supervised by Dr. Jennie Schulze and Dr. Moni McIntyre

In the nexus of our collective history, human-induced political and social conflicts play a powerful role in displacing millions of people. The social insecurity produced by conflict persists long after they have ended, as refugees adjust to new circumstances, cope with loss, and attempt to regain a sense of normalcy. This study focuses on two distinct refugee-led organizations, namely a Syrian and a Bhutanese organization. These organizations operate in distinct stages of resettlement, in different parts of the world—one in a state of emergency, the other in resettlement in the United States. However, both organizations share a grassroots community organizing paradigm to address the stigma surrounding mental illness. The methods utilized in this study employed qualitative data sources that stem from interviews with refugee-led organization directors, volunteers, and community partners. Qualitative data, in conjunction with empirical evidence from the field, serve to provide a panoramic view of how refugee-led organizations operate. The findings of this study reveal that the success of refugee-led
organizations in their attempts to eliminate the stigma of mental illness, by using community programming and programming evaluations as their main tools, are intricately tied to the amount of human and social capital refugee-led organizations hold within their community and through its members. This paper concludes by emphasizing the complementary nature of community-based organizations and international humanitarian aid groups, suggesting that the combination of both offer a more comprehensive approach to addressing the mental health needs of refugee communities.
ACKNOWLEDGEMENTS

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vi</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>x</td>
</tr>
<tr>
<td>CHAPTER 1: Purpose and Significance of this Study</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of Research</td>
<td>1</td>
</tr>
<tr>
<td>Research Questions</td>
<td>2</td>
</tr>
<tr>
<td>The Value of Historical Context as Case Selection Justification</td>
<td>3</td>
</tr>
<tr>
<td>Syria: Causes of Refugee Flight</td>
<td>4</td>
</tr>
<tr>
<td>Bhutan: Causes of Refugee Flight</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER 2: Literature Review and Theory</td>
<td>7</td>
</tr>
<tr>
<td>The Stigma of Mental Illness</td>
<td>7</td>
</tr>
<tr>
<td>How Stigma Prevents Refugees From Accessing Mental Health Services</td>
<td>9</td>
</tr>
<tr>
<td>Psychological Distress Among Refugees</td>
<td>11</td>
</tr>
<tr>
<td>Effects of Exile on Mental Health</td>
<td>12</td>
</tr>
<tr>
<td>The Role of Western Medical Models in Treating Refugee Populations</td>
<td>13</td>
</tr>
<tr>
<td>Introduction to Refugee-Led Organizations</td>
<td>14</td>
</tr>
<tr>
<td>The Basics</td>
<td>14</td>
</tr>
<tr>
<td>The Case for Refugee-Led Organizations</td>
<td>15</td>
</tr>
<tr>
<td>Non-governmental Organizations</td>
<td>19</td>
</tr>
<tr>
<td>Application of the Public Good Theory: Weisbrod Theory</td>
<td>21</td>
</tr>
<tr>
<td>Literature Review Conclusion</td>
<td>23</td>
</tr>
</tbody>
</table>
CHAPTER 3: Methodology ........................................................................................................ 24
  Research Design and Methodology ........................................................................... 24
  Justification for Case Selections ............................................................................ 24
  Hypothesis ................................................................................................................. 26
  Qualitative Data Sources ........................................................................................ 26
  Interviews .................................................................................................................. 27
  Coding ......................................................................................................................... 28
  Limitations .................................................................................................................. 30

CHAPTER 4: Findings and Discussion .................................................................................. 31
  Introduction .................................................................................................................. 31

Section I: Syria Bright Future .......................................................................................... 31
  Background ................................................................................................................. 31

Syria Bright Future: Community Based Projects ....................................................... 33

Syria Bright Future Programming Evaluations ............................................................ 40

Syria Bright Future Summary ....................................................................................... 40

Section II: The Bhutanese Community Association of Pittsburgh .................................. 42
  Background ................................................................................................................. 42

The Bhutanese Community in Pittsburgh ................................................................. 43

The Structure of Community Based Projects in Bhutanese Refugee Camps .......... 44

BCAP Programming Strategies .................................................................................... 46

BCAP Programming Evaluations ............................................................................... 50

BCAP Summary .......................................................................................................... 52

Findings ....................................................................................................................... 53
Policy Recommendations……………………………………………………… 56
RLO and NGO Coalition………………………………………………………56
Recommendations for Further Research……………………………………… 59
References…………………………………………………………………………………… 61
Appendix A…………………………………………………………………………………… 67
Appendix B …………………………………………………………………………………… 68
Appendix C…………………………………………………………………………………… 73
Appendix D…………………………………………………………………………………… 74
Appendix E…………………………………………………………………………………… 75
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW</td>
<td>Community health worker</td>
</tr>
<tr>
<td>CVICT</td>
<td>Center for Victims of Torture</td>
</tr>
<tr>
<td>ECHO</td>
<td>European Commission for Humanitarian Aid and Civil Protection</td>
</tr>
<tr>
<td>MDM</td>
<td>Médecins du monde</td>
</tr>
<tr>
<td>MHFA</td>
<td>Mental Health First Aid</td>
</tr>
<tr>
<td>MHPSS</td>
<td>Mental health psycho-social services</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>ORR</td>
<td>Office of Refugee Resettlement</td>
</tr>
<tr>
<td>PFHRB</td>
<td>The People’s Forum for Human Rights, Bhutan</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>RLO</td>
<td>Refugee-Led Organization</td>
</tr>
<tr>
<td>SHHC</td>
<td>Squirrel Hill Health Center</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health worker</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugee</td>
</tr>
</tbody>
</table>
CHAPTER ONE: PURPOSE AND SIGNIFICANCE OF THIS STUDY

Purpose of Research

Mental illness carries a stigma in many refugee populations. This stigma is an obstacle for refugees who desire to seek help, but cannot, due to a fear of being ostracized by their community (K. E. Miller, 1999). As a result, this stigma of mental illness prevents refugees from accessing mental health services (Shannon, Wieling, Simmelink-McCleary, & Becher, 2015). The focus of this study is to analyze how refugee-led organizations (RLOs) organize at the grassroots level to address the stigma of mental illness prevalent within their communities. Through the exploration of two cases Syria Bright Future and the Bhutanese Community Association of Pittsburgh, this study investigates how these specific RLOs work to combat the stigma of mental illness.

This study supports the assumption that RLOs are specifically equipped to provide mental health care and address the stigma of mental illness in their communities, compared with NGOs, who are also present in refugee communities and addressing mental health needs. NGOs, who generally use Western methods in their approach to mental health services, tend to adopt a clinical approach to the treatment needs of refugees (Meyer, 2013, p. 21). As Miller & Rasco (2008) explain, Western mental health services are often underutilized by refugee populations because they are “culturally alien” (p. 2) to refugee populations, the majority of whom originate from non-Western societies.

RLOs provide services for the refugee communities they are embedded in, applying cultural advantages such as shared language. In many instances, refugees often lack adequate proficiency in the language of their host country. RLO service providers also share an intimate understanding of displacement related experiences, such as social stressors related to the multiple
losses and changes linked to the reality of displacement and the challenges of adapting to life in unfamiliar settings (K. Miller & Rasco, 2008). NGOs play a major role in mitigating distress among refugees who have access to and are willing to use the mental health services NGOs offer. Nonprofit organizations and international humanitarian aid groups play a vital role in the field of international assistance. They provide foreign aid to refugee populations suffering from the effects of war or natural disasters. NGOs also serve as the main implementers of governments’ foreign aid programs (Salamon, 2012, p. 330). This research suggests that RLOs should also serve a vital role in the humanitarian response, in conjunction with NGOs, to address the mental health needs of refugee communities.

It is important to note that this study only investigates the RLOs presented in this study. Therefore, this study presents an illustrative, rather than a comprehensive view of NGOs’ efforts in addressing the needs of refugee populations. However, this research suggests that RLOs are producing positive grassroots initiatives and change for their communities. Grassroots community organizing and mass migration have implications for public policy, as they are agents of social change. In sum, NGOs and RLOs likely possess different capacities and approaches to addressing the needs of refugee populations. This study demonstrates that RLOs are adept at providing culturally appropriate programming.

Research Questions

This study explores three central questions:

1. What programming do refugee-led organizations use to combat the stigma of mental illness within their communities?
2. How do RLOs evaluate program effectiveness?
3. How are these evaluations used to direct future programming?
These questions relate to RLO programming and strategies in how they address the stigma of mental illness prevalent in their communities. The second question investigating how RLOs evaluate program effectiveness is important because RLOs tend to have limited funding; to continue running programs that do not meet target goals would be a waste of valuable resources. Also, it is helpful to know how RLOs utilize the results of their program assessments to make decisions about staffing, space, and adjustments.

The evaluation of program strategy effectiveness is also useful for gaining perspective as to how RLOs operate, whether in the camps or resettlement. Conducting evaluations of community-based interventions in refugee communities is an enormous challenge. It is a difficult task to carry out systematic evaluations of mental health interventions in the chaotic environment of refugee camps, as renewed violence often leads to recurring displacements. Low literacy rates may complicate the use of questionnaires and the concept of systemic evaluation is itself often foreign. These components indicate the importance of developing evaluation methods that fit the multiple diverse settings in which refugee mental health interventions take place, either in refugee camps or in resettlement (K. Miller & Rasco, 2008, p. 52). In understanding the usefulness of community-based programming in RLOs overall, one may gain a perspective on the utility of evaluating programming strategies and how RLOs evolve in terms of programming strategies.

**The Value of Historical Context as Case Selection Justification**

In order to understand why refugee mental health is important, it is imperative that one consider the political and social contexts from which Bhutanese and Syrian groups originate. By understanding the experiences of these communities prior to the conflict and mass exodus from their homelands, one can understand the context of mental health services provided by RLOs.
Syria: Causes of Refugee Flight

The United Nations describes the Syrian conflict as one of the worst humanitarian crises of the modern era (United Nations High Commissioner for Refugees, 2015). Syria was once among the world’s largest hosts of refugees. After years of violent civil war, Syria is now the largest producer of refugees. As of September 2016, there are over 4 million refugees fleeing Syria (United Nations High Commissioner for Refugees, 2016). Meanwhile, as population displacement continues to increase, an entire generation of children has been exposed to war and violence. These children are increasingly deprived of essential services, education, and protection (ECHO, 2016). Refugees have fled to neighboring countries such as Lebanon, Iraq, Jordan, Turkey, Egypt, and parts of northern Africa (ECHO, 2013). Syria Bright Future (SBF) is currently located in Gaziantep, Turkey, a city located in the southeastern part of Turkey, an hour or so away from the Syrian border.

Inspired by the Arab Spring, following the collapse of overturned regimes in Tunisia, Libya, Yemen, and Egypt, Syrians took to the streets as part of a series of anti-government protests. Syrian demonstrations were peaceful; their demands focused on achieving political and economic reform to influence positive changes from the Assad regime towards justice, human rights, equal opportunities, and democracy for all citizens (Ajami, 2012). However, the nonviolent sit-ins and marches soon gave way to violence. Syrians began taking opposing sides, either for or against the Assad regime (Jabbar & Zaza, 2014).

Apart from anti-state grievances, the effects of climate change played a major role in destabilizing the Middle East by straining critical water and food resources through a mixture of extreme drought, natural resource mismanagement, and population dynamics. To understand the effects of climate change in this region, it important to note that from 2007-2010 Syria
experienced the worst drought in its history. This drought caused widespread crop failure and the mass migration of farming families to urban areas. Essentially, the conflict in Syria was a climate change induced civil war. Syria was without a drop of rain for almost five years. With no rain to grow their crops, farmers had no choice but to give up their lands and move to the cities. These same farmers that were affected by the drought protested the uneven distribution of aid. Unfortunately, Assad’s regime had no tolerance for civil resistance and jailed protestors (Kelley, Mohtadi, Cane, Seager, & Kushnnir, 2015).

Environmental factors, combined with social discontent in neighboring political revolutions, played a role in the Syrian civil war. As Werrel and Femia (2015) state, recognizing the role of climate change does not minimize the social, political, or economic drivers of the unrest and conflict; rather, it provides an additional layer of explanation. What differentiates the Syrian conflict from others in the region is that this is a war being fought mostly in cities, towns, and villages (Jabbar & Zaza, 2014, p. 1-2). As a result, the majority of the damage occurs in the country’s infrastructure and economic sectors; most victims are civilians and children (ECHO, 2016).

*Bhutan: Causes of Refugee Flight*

Bhutan has long been touted as one of the happiest places earth. However, Bhutan is not without its dark past. The Lhotsampa, a Nepali-speaking southern Bhutanese people, were discriminated against by their government and were forced to flee their homeland due to ethnopolitical reasons. The Bhutanese government led an ethnic cleansing campaign against the Lhotsampa in the late 1980’s and early 1990’s in an attempt to preserve its Tibetan Buddhist culture and identity under the “One Nation, One People” policy (Pulla, 2015, pp. 25-26). The sole intention of this nationalistic policy was forcibly to homogenize the country and expel the
Lhotsampa minority in southern Bhutan. The government forcibly expelled one-sixth of its population. More than 100,000 Lhotsampa were deprived of their Bhutanese citizenship. According to Human Rights Watch, this ethnic cleaning campaign involved repressive tactics that included violence, harassment, arrests, torture, and the burning of all ethnic Nepali homes (Frelick, 2008).

The Lhotsampa are a people of Nepali origin who settled in Bhutan following the conflict in Nepal in the mid-1800s (Pulla, 2016). A historically agrarian population of farmers, the Lhotsampa set about clearing the densely-forested territory of southern Bhutan and converted this region into farmlands with great success. In fact, this area eventually became Bhutan’s primary source of food (Hutt, 2005). It was due to the simultaneous rise in the Lhotsampa social status and the launch of a grassroots pro-democracy movement that caused the Bhutanese government to feel uneasy, and this, led to the discriminatory “One Nation, One People” policy (Omeeren et al., 2001; Pulla, 2016).

The aim of the “One Nation, One People” policy was to unify the country under the majority Druk culture, religion, and language (Cultural Orientation Resource Center, 2007). The People’s Forum for Human Rights, Bhutan (PFHRB) was a campaign against the human rights violations faced by the Lhotsampa. As a result of the repressive “One Nation, One People” policy, any person who was part of the demonstrations was labeled as an anti-national (Rizal, 2004). Anyone who participated, or was suspected of participating, in these pro-human rights actions was forced to sign a voluntary migration form at gunpoint (Pulla, 2016). Peaceful protests quickly escalated into violence; reported attacks on police resulted in mass arrests as a form of retaliation (Bird, 2012). As a direct result of this violence, people began to flee the country due to a substantiated fear of government torture. Others were evicted from their homes,
labeled as terrorists, economic migrants, or illegal immigrants. To the bureaucratic establishment, the word “Lhotsampa” came to mean “anti-national” (Pulla, 2016, pp. 8-9).

Over 108,000 Bhutanese refugees relocated to refugee camps in Nepal for almost 15 to 20 years before several countries began to resettle them in 2008 (Bhutanese Community Association of Pittsburgh, 2016). During the 17 years of failed diplomatic bilateral talks, Nepali-speaking Bhutanese refugees were forced to relinquish their Bhutanese citizenship, forbidden to return to their homes in southern Bhutan, and officially barred from fully integrating into society in Nepal (Subedi et al., 2015). However, even if the Bhutanese government were to allow the Lhotsampa to be repatriated under international law, the continued discriminatory treatment of all ethnic Nepalese who continue to reside in southern Bhutan implies that refugees would not be allowed to return because their basic rights cannot be guaranteed (Frelick, 2008).

Western resettlement provided the opportunity for new beginnings. In a multilateral approach, the United States along with other countries helped to resettle tens of thousands of Bhutanese refugees. Some of the Bhutanese were resettled in Pittsburgh, Pennsylvania (Cultural Orientation Resource Center, 2007; Dhungana, 2010). BCAP as a nonprofit organization in Pennsylvania was formed in 2012. The intention of BCAP is to provide services and support to the various subsections of the Bhutanese community, such as youth, elders and family through community programming and mental health support to help in alleviating acculturation stressors (Bhutanese Community Association of Pittsburgh, 2015).
CHAPTER TWO: LITERATURE REVIEW AND THEORY

The Stigma of Mental Illness

This study defines mental illness from the sociological perspective of Stress Theory, which states that environmental and life stressors contribute to mental illness (Aneshensel, 1992). The sociology of mental illness tends to focus on behavior and action in a group environment (Busfield, 2000). Studies that support these findings include Holmes & Rahe (1967), who conducted research into life events by developing a questionnaire called the Social Readjustment Rating Scale to identify major common stressful life events, such as the death of a loved one or a personal illness. Their research revealed a positive correlation between life change scores and illness scores. The positive correlation between life events and the prevalence of disease means that the more life events (either positive or negative) individuals experienced in a given time, the more likely they were to suffer injury or become ill. Another study by Selye (1950) demonstrated that prolonged exposure to negative stress produces illness. Selye (1950) studied animals exposed to negative stimuli. He found three stages of response: fight or flight; resistance; and exhaustion. At the exhaustion state, the animal developed an illness. This study revealed that consistent negative exposure to stress from the environment could produce illness. These studies support the perspective of Stress Theory in environmental and life stressors contributing to mental illness. The definition of mental illness is defined in this study from a sociological viewpoint, applying Stress Theory, which states that environmental and life stressors contribute to mental illness. In sum, Stress Theory focuses on aspects of an individual’s current social situation and helps to explain why some groups are more vulnerable to mental illness than others, e.g. refugees in this case. While sociological theories do not explain the causes of all mental illness, they do, however, demonstrate that mental illness is not randomly
distributed, it occurs more often in disadvantaged groups (Busfield, 2000). The fewer resources to which one has access to, the more vulnerable the individual is to mental disorders (Aneshensel, 1992).

Mental illness also carries with it a stigma, or shame, in certain populations. One of the most commonly cited works on stigma is by renowned sociologist Erving Goffman (1963), who described stigma as an attribute that reduces a stigmatized individual “from a whole…person to a tainted, discounted one” (p.3). The stigma of mental illness is harmful because it plays a social role in preventing those suffering from mental disorders from properly accessing adequate care. This stigma also enforces the flawed notion that anyone seeking treatment for mental illness is socially undesirable (Goffman, 1963). More recent scholars argue that culture plays a significant role in legitimizing stigma. Culture can create, influence, and reinforce society’s stigmatizing beliefs and attitudes. These views reinforce the belief that any cultural deviation from what is understood and accepted as healthy behavior is considered unequal or deviant (Abdullah & Brown, 2011).

*How Stigma Prevents Refugees from Accessing Mental Health Services*

While research related to the stigma of mental illness in refugee populations tends to acknowledge that stigma exists, research into the reality of mental illness in refugee populations is limited. Shannon et al., (2015) explain that there is little refugee-specific research on help-seeking or how to utilize the services offered. Refugees in need of mental health services often fail to receive those services due to health system barriers, such as doctors and patients not initiating a conversation about trauma. The reasoning for this is linked to participants not relaying information about their trauma because they felt it was appropriate to discuss this topic only if the doctor initiated the discussion, or participants did not consider the impacts of war on
them as a health-related issue. In some cases, participants explained they did not want to raise negative memories (Shannon, O'Daugherty, & Mehta, 2012). The social repercussions of seeking mental health services is another reason why some refugees may not utilize services offered. A study by Saechao et al. (2012) revealed in a focus group of first-generation immigrants from Iraq, Iran, Cambodia, and Eastern Europe, that individuals who use mental health services in their communities fear they will be viewed as “crazy” (p. 103). This focus group also revealed that participants do not utilize health services for fear of being isolated from their communities and viewed as unstable. In a later study conducted by Shannon et al. (2015), a focus group of refugees from Burma, Bhutan, Somalia, and Ethiopia also agreed that a stigma of mental illness exists as a barrier to discussing mental illness.

In addition, a study administered by Shannon et al., (2015) reveals that mental health providers often cite the stigma of mental illness as a barrier to effective communication with refugee patients. From these case studies, we can conclude that the effects of stigma on mental illness are prevalent within refugee communities and that the stigma of mental illness plays an active role in preventing refugees from accessing mental health services. Based on these findings, Shannon et al., (2015) recommend community-based education programs aimed at destigmatizing the experience of mental illness for refugee communities. They also recommend offering community-based models of healing that can help address refugee fears of isolation due to mental illness. In addition, more research needs to be conducted with diverse refugee populations to understand culture-specific barriers to communication about trauma in primary care (Shannon et al., 2012).
Psychological Distress Among Refugees

The RLOs examined in this study, Syria Bright Future and the Bhutanese Community Association of Pittsburgh, aim to combat the stigma of mental illness as well as provide other necessary support services to their communities. It is important to examine the effects of exile on mental illness and the stressors that exacerbate mental health in order to understand the refugee experience within the context of mental illness and the work RLOs do to address the stigma of mental illness. As Porter and Haslam (2005) explain, the “refugee experience is characterized by multiple events, occurring in various contexts that persist over extended periods of time, sometimes decades” (p. 603). Refugees experience stressors that accumulate during different stages of their migration experience, including preflight, flight, exile, and resettlement/repatriation periods. Research has shown that different stressors link to common mental health disorders in populations that experience traumatic events (Baingana, Bannon, & Thomas, 2005).

In a meta-analysis of 80,000 refugees, Steel et al., (2009) report that post-traumatic stress disorder (PTSD) and depression were the most commonly cited mental disorders among refugees, affecting up to 30% of refugee trauma survivors. In some cases, despite suffering from debilitating symptoms of PTSD and depression, refugees were not likely to seek needed mental health services due to the stigma of mental illness or a lack of information regarding mental health and cultural norms or practices (Shannon et al., 2015, p. 283). Research surveys reveal that torture is prevalent in countries affected by widespread conflict. There is a high prevalence of PTSD and depression as well as a stigma of mental illness in the Bhutanese and Syrian populations examined in this study, which are populations that have been subject to conflict and violence in their countries of origin (Jabbar & Zaza, 2014; Steel et al., 2009).
Effects of Exile on Mental Health

Both stateless and displaced persons in refugee camps are unable to engage in productive activities that would provide them with a sense of purpose. In refugee camps, international NGOs and other humanitarian aid organizations tend to be overburdened. Because international NGOs tend to be overburdened regarding staffing, funding, or ensuring safety, there is little to stop refugees in refugee camps from entering poverty or dependence on foreign humanitarian assistance. Providing necessary resources to a population in flux is a difficult task, especially when the need is high (K. Miller & Rasco, 2008).

The literature on psychiatric needs in refugee populations demonstrates a clear link between conflict situations and disorder prevalence. Baingana et al. (2005) explain that following a conflict, issues surrounding mental illness are more likely to occur. Mental illness often leads to personal dysfunction, which in turn increases the risk of poverty, which leads to an increased sense of hopelessness and vulnerability (pp. 6-7).

In their analysis of pre- and post-displacement factors associated with refugee mental illness, Porter and Haslam (2005) explain that the aftereffects of displacement are not only the result of stressors on the individual, but they are also a continued result of the economic, social, and cultural conditions that refugees face when fleeing their homes. They concluded that “materially secure conditions, economic opportunities, and permanent private living spaces” (p. 610) are directly linked to positive mental health outcomes for refugees. This finding implies that mental health disorders among refugee populations are not an inevitable consequence of conflict; instead, they are the result of factors that can partly be resolved through the generous material support of humanitarian aid agencies.
The Role of Western Medical Models in Treating Refugee Populations

One theme that is prevalent throughout the literature on refugee mental illness is that much more needs to be done to enhance culturally appropriate mental health services for refugees. Murray, Davidson, & Schweitzer (2010) explain that mental health providers working with refugee populations “need to be assured that the therapeutic interventions they employ are appropriate for the populations with whom they work” (p. 576). For instance, following resettlement, refugees may struggle to overcome not only the long-term psychological impacts of threats to their personal safety and social and cultural displacement, but also linguistic, educational, and employment-related challenges that add to acculturation stressors (Murray et al., 2010).

As Berger and Luckmann (1967) explain, a social construct is an idea that appears obvious to a person who accepts the social construct, although it is not a reality or apparent to others in another cultural context. The experience and expression of mental illness connect to a negative stigma and hurtful perceptions from community members that will personally affect the individual, often by transforming them into a social outcast. Cultural idioms of distress also influence the expression of mental illness through a combination of culturally grounded concepts (United Nations High Commissioner for Refugees, 2015). When applying Western standardized measures in treating non-Western populations, it is important for service providers to understand cultural idioms of distress tied to that particular population to better understand community needs.
Introduction to Refugee-Led Organizations

The Basics

The defining features of RLOs relate to the composition of their staff, their mission, and the fact that they are grassroots initiatives (Gleason, 2006, pp. 10-11). Refugee-led organizations are a vital component of refugee communities. They may be working in a camp setting, such as Syria Bright Future (SBF), or in resettlement as in the case of the Bhutanese Community Association of Pittsburgh. Despite differences in their context of operation these organizations tend to share commonalities. Refugees usually hold leadership roles, with executive directors and other senior leadership positions as well as the majority of the board of directors typically being refugees. They serve mainly refugee populations and focus on issues related to poverty, access to power, and lack of resources. The components that strengthen RLOs are the same that would support any other nonprofit organization, such as building leadership, external relationships, management functioning, and financial security (Crutchfield & Grant, 2008; Gleason, 2006).

Miller (1999) states that often outside professionals are scarce and difficult to access. “Outside professionals” refers to those service providers that work with refugee populations in the camps on the behalf of international NGOs or other humanitarian aid organizations. In addition, outside professionals are also unlikely to be familiar with local beliefs, values, and practices. To fill this need, RLOs harness the skills and knowledge available within their communities and thus bring relevant experience, cultural competency, peer learning, and leadership development to their work (Gleason, 2006, p. 16). Culturally appropriate services and competent service providers from within their communities help refugees to feel empowered and comfortable accessing services, in a way that international aid organizations cannot.
Gleason (2006) also points out that RLOs provide opportunities for capacity building, similar to the way NGOs do. Capacity building is a broad term that encompasses actions that improve nonprofit or community organization effectiveness program quality or growth. Training a community group on how to provide basic first aid is an example of capacity building. Roles such staff or board member offer significant opportunities for refugees to build collective skills and power. Many RLOs are small, emerging, under-resourced, and address multiple pressing and distressing, community needs. RLOs are often in flux due to changing environmental and social circumstances. The multitude of stressors on RLO organizers can present many challenges for capacity builders, although this is not unique to community organizations. Capacity building is a core component of grassroots refugee organizations, and one of the ways in which RLOs re-establish local healing and support networks (K. Miller & Rasco, 2008).

*The Case for Refugee-Led Organizations*

RLOs encounter many obstacles in their pursuit of community engagement. These include an inconsistent access to resources as well as lack of funding, personnel, skills, and safety, in addition to refugee service providers’ personal trauma while delivering services for other refugees (K. Miller & Rasco, 2008, p. 398). RLOs are able to address refugee community needs because they do so through what Miller (1999) describes as an “ecological model” (p. 284). This community design focuses on identifying local resources within a community to aid in the development of coping and adaptation strategies. These resources use culturally appropriate means in order to help communities respond successfully to stressful circumstances. The ecological model aims to involve communities in the process of addressing and solving their problems without relying on scarce outside professionals (Rappaport, 1977).
RLOs draw upon prioritized self-identified needs. Due to these characteristics, RLOs are better equipped to develop treatment-focused interventions that are contextually grounded and culturally-appropriate because RLO staffs share a common language, culture, and similar conflict experiences with the population they serve (K. Miller & Rasco, 2008). Since RLO service providers are refugees themselves, this creates an intimate understanding of the refugee experience, allowing RLOs to provide services that are culturally appropriate (Gleason, 2006).

From their work in contributing to rebuilding refugee communities, Miller and Rasco (2008) note that the integration of RLOs in refugee communities is an act of intervention as RLOs become a unified part of refugee camp communities. RLOs are vital in promoting the reestablishment of local healing and psychosocial support networks. The term “psychosocial disorder” here refers to the interrelationship between psychological and social problems. Baingana et al., (2005) defines psychosocial in this way, the psychological component of psychosocial includes those aspects that affect thoughts, memory, and learning ability. The social dimensions of this term refer to aspects in one’s life that include culture, values, family and community. The psychosocial dimension also incorporates the economic realm and its effects on status and social networks. The interrelationship between social factors and an individual’s thoughts and behaviors is important because it incorporates the social component of an individual’s experience, rather than solely mental health components. If the focus is solely on mental health, then this ignores the aspects of social context that are also vital to one’s wellbeing. RLOs adopt a psychosocial approach to their community organizing by designing programs and activities implemented in meeting places that provide safe, supportive, and predictable environments, i.e., spaces where refugees know what to expect at these locations.
Refugees experience consistent loss, hurt, and uncertainty. RLOs stand as a testament to the resilience of refugees. Grassroots organizations in refugee populations rebuild social bonds and community structures lost in the pre- and post-migration experience, as social contracts dissolve. It is ultimately the fruits of grassroots organizations that belong to and stand as a point of pride and comfort to refugee communities.

By training local staff as paraprofessionals, building leadership from the ground up, and not relying heavily on outside experts, RLOs provide culturally appropriate assistance and ongoing, dependable psychosocial care to their communities (K. Miller & Rasco, 2008). Although international aid organizations provide necessary care and resources for the populations they serve, international aid groups ultimately lack the fundamental aspect of culturally-appropriate interventions. RLOs frequently have the advantage of trust within their communities because RLO staff and volunteers share similar language and dialects, culture, and post-migration experiences that allow them to design culturally-appropriate interventions. Often, international NGOs and other aid groups do not provide culturally or contextually grounded approaches to help refugee populations become empowered, such as addressing barriers to economic or social independence. Miller and Rasco (2008) note that NGOs choose to rely on scarce outside professionals instead of relying on local resources.

A 2013 report by The United Nations High Commissioner for Refugees (UNHCR) details their approach to mental health and psychosocial support (MHPSS) within various refugee communities. The report specifically details how the UNHCR Syrian program response consists of MHPSS case management, which involves the identification of individuals with severe mental disorders or other specific vulnerabilities. The program response also includes community-based psychosocial outreach and a psychosocial center along with capacity-building programs resulting
in the development of curriculum and training materials based on international standards that are appropriate to the Syrian context (Meyer, 2013, p. 44). RLOs also provide capacity-building services, case management inventory and community-based approaches to MHPSS. The advantage for RLOs is that they are already internally integrated into the refugee communities they are designed to serve. RLOs hold certain social advantages because they share and understand the refugee experience. They share a common dialect, culture, and understanding of the difficulties in adapting to life in a refugee context. Consequently, this helps to build trust between RLOs and the refugee community. This trust factor is part of what makes RLOs more accessible to refugees than NGOs.

The 2013 UNHCR report also explained that providing clinical mental health services in a context where these services are limited or of low-quality would be an ideal way to draw on capacities within host countries’ national health systems to fund mental health services for refugees (Meyer, 2013). While this is a vital service for refugee populations in need of mental health services, health system barriers, especially in the case of outside service providers, are at play. For example, the Syrian refugee population in Turkey faces increased social tensions within their host community. This is due to a massive influx of refugees from the region that have flowed into cities creating economic challenges in housing, business, and education (O'Toole, 2016).

Social tensions within host communities limit refugee integration into local communities and access to basic services (United Nations High Commissioner for Refugees, 2015, p. 13). In this instance, there are several health system barriers in place for refugees in this context. Due to social tensions within the host community, refugees are less likely to go out of their way to use mental health services from the host community. In addition, communication can be another
formidable obstacle that further limits refugees’ access to mental health services, as refugees often lack mastery in the language of their host country (K. Miller & Rasco, 2008). In addition, mental health clinics for refugees typically have a small staff and operate on a tight budget. As a result, they can receive only a small number of individuals in need of mental health assistance (K. E. Miller, 1999).

While NGO efforts in addressing the MHPSS needs of refugee populations are indeed valuable, the context of the refugee experience creates barriers to NGO efforts. These obstacles could be at least partly removed through the strengthening of community-based locally integrated organizations, like RLOs. Banatvala and Zwi (2000) explain that humanitarian interventions are increasingly complex as well as expensive. The authors note that research to determine effective and efficient approaches to the delivery of aid requires additional investment. Banatvala and Zwi (2000) also explain that generating knowledge to promote evidence-based policy in NGO decision-making would be a helpful strategy and would call for collaborative initiatives between implementing agencies, academics, and donors. This is another task that would be just as challenging and costly.

*Non-governmental Organizations*

Much of the research on refugee mental health focuses on the NGO level, where outside aid agencies intervene in camp settings (K. Miller & Rasco, 2008). The services that international NGOs provide are important to the success of their programming strategy and outreach as well as to the well-being of the populations they aid. For all the good NGOs do, they can also be problematic. This is explained in what Cooley and Ron (2002) describe as “The NGO Scramble.” This phenomenon refers to the growing number of international aid agencies and NGOs within a global sector or region. As more international aid agencies descend onto a
specific zone, there is an increase in uncertainty, competition, and insecurity for all international organizations. These nonprofit organizations respond to contractual incentives and organizational pressures similar to the way for-profit groups do when they seek control of the same project (Anheier, 2005). The more humanitarian aid organizations descend on a camp, the more discord occurs among aid groups as they compete for contracts and resources to stay. Cooley and Ron (2002) note that this is evidence that the humanitarian aid environment has become marketed. Cooley and Ron’s (2002) study indicates that international aid organizations aimed at providing necessary resources for populations in need feel constant pressure to demonstrate their ability to gain influence and win contracts—even if that comes at the cost of disconnecting from their broader project outcomes (p. 22). Almoshmosh (2015) supports the findings of Cooley and Ron (2002), who argues that when humanitarian agencies arrive in a region, they focus on meeting basic needs. However, as more humanitarian organizations enter the region, less coordination takes place among them. Almoshmosh (2015) also states that valuable efforts are impeded when each humanitarian aid agency has a different focus regarding approaches to mental health, as well as different terms and conditions for receiving contracts to stay in those regions. Efforts are wasted or duplicated due to the lack of coordination and often non-existent information sharing among the competing humanitarian aid agencies on the ground. Salamon (2002) also explains that due to a heavily marketed system of humanitarian aid, NGOs are less effective in addressing challenges for refugee populations.

Although RLOs may lack the financial backing they need, RLOs can make up for it in cultural competency, shared language, and community integration. While NGOs are battling it out amongst one another for temporary contracts in an inefficient institutionalized system, RLOs are the grassroots initiative created and supported by the refugee community. RLOs are set up
with a prioritized list of needs and goals that aim to address the real needs within their communities in a camp setting.

Application of Public Good Theory: The Weisbrod Theory

The Weisbrod theory is applied in this study to understand the interrelationships between RLOs and NGOs in a market-based economy. The Weisbrod theory highlights principles of public good within the non-profit sector (Weisbrod, 1972). The Weisbrod theory focuses on the concept of “market failure,” when the for-profit sector is unable to or does not provide necessary goods or services to the population. Weisbrod explains that when the market and government fail to provide services or resources to the public, this leads to non-profit activity. The Weisbrod theory primarily describes donative nonprofit organizations, in which the funding of nonprofits occurs through the donations of citizens who want to increase the output of public goods. These goods may include healthcare or education, for instance (Kingma, 1997).

Figure 1: Weisbrod Model Adaptation to Refugee-Led Organizations
From the perspective of Weisbrod theory, Kingma (1997) explains how nonprofits function as part of the public sector that operates as a safety net for society’s most vulnerable individuals. Nonprofits do this by providing provisions and services previously unfilled by the government. The public good theory requires that an organization produce public goods in response to the demands of their donors. Since the stated goal of nonprofits is not to seek profit-maximizing goals, this, in turn, increases trust from consumers and donors, because they know that this organization serves their interests. The Weisbrod theory provides a rationale for the creation of nonprofit organizations to provide public goods.

The model above applies the Weisbrod theory to RLOs. The dotted oval around RLOs represents the entity being researched in this study. This model demonstrates how RLOs combine public service components of both government and NGO efforts in providing goods and services. As previously mentioned, this study demonstrates that RLOs possess unique attributes that equip them to address the stigma of mental illness in their communities. This study only explores the RLO side of the figure above, and neither the government nor international NGOs. While NGOs also provide public service components of government, they are not explored in this study.

In the Ben-Ner and Gui (2003) theories of nonprofit enterprise, the heterogeneity hypothesis supports the Weisbrod theory. The heterogeneity hypothesis states that in diverse, heterogeneous communities, citizens have a need for “public goods that are different from that of the average voter” (p. 58). Therefore, there will be more nonprofit organizations providing public goods to fill that need. This theory can apply to this study’s analysis of RLOs and NGOs in the field, because in the same way that non-governmental organizations provide public goods undersupplied by the government, RLOs likely supply public goods in a more accessible manner.
As Salamon (2012) notes, the nonprofit sector has become marketed. The marketization of the nonprofit sector undermines a nonprofit organization's commitment to their core values. As a result, NGOs choose between doing what is right and what is popular or financially advantageous. Increased competition with for-profit and other non-profit organizations, the slow growth of public giving, and decreased government funding are factors that make it likely that non-profits will respond to market pressures in ways that are financially and commercially advantageous to them. Salamon (2012) further explains that market engagement has its advantages, including more access to private resources and talents, which non-profits need to provide the public goods they were designed to deliver. This theory can apply to this study's analysis of RLOs and NGOs in the field. This study suggests that in the same way that non-governmental organizations provide public goods undersupplied by the government, RLOs possess unique traits that allow them to provide public goods, such as culturally-appropriate mental health services, in much the same way as NGOs.

**Literature Review Conclusion**

The research on refugee mental health reveals that the stigma of mental illness in refugee communities is a factor that prevents refugees from accessing service providers’ help in treating mental disorders. This literature also demonstrates that NGOs are less effective in treating mental illness for refugee populations due to language barriers, a lack of cultural competency among service providers, as well as a lack of coordination among service providers. Although NGOs provide necessary goods and services, access to those resources is often limited because NGOs are overburdened. This results in few follow-ups from NGO service providers.

As competing non-governmental organizations and other international humanitarian aid groups enter refugee camps, they often create a dependency on foreign aid, never fully
empowering refugees with the capacity to address their needs. As demonstrated in the literature, the non-profit sector tends to behave in the same manner as the for-profit sector. Many NGOs spend much of their time bidding for contracts and funding from their donors to stay in the region, which can detract from NGO core values. NGOs often duplicate the efforts of other NGOs and for-profit groups with whom they are in competition. RLOs share a common language, culture, and migration experience with the populations they serve. RLOS organize from the ground up and do not share the same market tendencies as NGOs. These characteristics demonstrate how RLOs operating at the grassroots level can be an efficient and advantageous method of community organizing to address community issues and needs, compared with NGOs.

CHAPTER THREE: METHODOLOGY

Research Design and Methodology

Justification for Case Selections

This study examines how the stigma of mental illness operates as a barrier to RLOs that provide mental health programming. Furthermore, this study examines RLO programming strategies and subsequent programming evaluations. This study used a focused comparison of two RLOs in different parts of the world. Syria Bright Future (SBF) is a grassroots community-driven organization, founded and operated by Syrian refugees in Gaziantep, Jordan. The other organization, the Bhutanese Community Association of Pittsburgh (BCAP), operating out of Pittsburgh, Pennsylvania, United States, is also founded and staffed by Bhutanese refugees.

SBF and BCAP make an interesting case for comparison because they are both well beyond their start-up phase, have gained the recognition and trust within their communities, and deal with mental disorders within their communities. However, one of their main distinctions is
that they operate in different stages of resettlement. SBF operates in a crisis situation for refugees in the camps as well as those internally displaced in Syria, while BCAP operates in the context of Western resettlement.

Multiple variables affect program effectiveness, such as a lack of consistent access to funding, staffing, resources, and space. Reliable access to these variables would significantly improve program effectiveness for RLOs. The variables that affect program evaluation and efficacy depend on the human and social capital within refugee communities from which RLOs draw their volunteers and staff. Human capital refers to the collective knowledge or skills that contribute to the economic value of an individual, organization, or community. Education, for example, is an investment in human capital because it most often contributes to higher income in the long run (Becker, 1994). Social capital is defined as the value of social networks which organizations use to bond to similar organizations and groups for the betterment of their organizations (Adler & Kwon, 2002).

From a thorough analysis of the literature, the researcher of this study understands that refugee resettlement programs in the United States employ a two-party process for integration (Penninx, 2003). For example, the host country and refugee community work together throughout the integration process to create social and community bonds. In this study, the resettlement context applies only to BCAP. Ultimately, given that these RLOs operate at different points of the refugee experience, the distinct stages of development between SBF and BCAP allowed the researcher to observe the evolution of RLO programming strategies through a multi-level perspective, from refugee camps to resettlement. These two RLOs demonstrate how strategies and evaluation methods are likely to evolve in different contexts.
**Hypothesis**

This study examines the assumption that RLOs possess particular cultural components in their organization that make them accessible and equipped to provide mental health services for refugee populations. It is important to reiterate that this study only examines RLOs, not NGOs, who also provide similar services for refugee populations.

The first research hypothesis states that RLOs utilize approaches to mental health interventions that are culturally appropriate because the RLOs share a common culture, dialect, and experiences as the population they are serving. The second research hypothesis states that of the two RLOs analyzed in this study, BCAP should produce better evaluation strategies because it operates in a resettlement context in the West and has greater access to resources. Because SBF is currently based in the midst of an on-going crisis in the Middle East, access to necessary material resources needed to continue operating are likely scarce or difficult to access.

**Qualitative Data Sources**

This study analyzed interview transcripts, RLO websites, social media, and journal publications published by RLOs about their organization and the work they are doing. Analysis of interviews occurred through inductive content analysis to develop theory and identify themes. Content analysis was applied as a research technique because it allowed for making replicable and valid inferences from texts and other meaningful material (Krippendorf, 2004).

During interviews, a snowball sampling approach was employed in conjunction with semi-focused interviews. This design allowed subjects to deviate from questions or topics in order to address related issues, or mention other individuals that may be pertinent to the research. These methods provided an informed view of how Syria Bright Future (SBF) and the Bhutanese Community Association of Pittsburgh (BCAP) set programming strategies to combat the stigma
of mental illness. All secondary qualitative data, such as RLO websites, RLO social media, and journal publications published by RLOs about their work and the work they are doing was based on previous research conducted on Syrian and Bhutanese refugee populations by other academics in the field or in Western resettlement to the United States.

**Interviews**

Semi-structured interviews guided conversations with study participants to gather information about previously described dimensions of the stigma of mental illness, RLO programming, and community support. This study utilized a snowball sampling approach in conjunction with semi-focused interviews to allow respondents to deviate from questions to address related issues or mention other individuals that may be pertinent to this study (See Appendix A: General Interview Questions). The snowball sampling method was appropriate because it allowed the researcher to obtain information on difficult-to-observe phenomena, especially in areas that involve sensitive cultural and personal issues (Faugier & Sargeant, 1997).

The snowball sampling method is a convenient method for building contacts when gathering data. When respondents would mention an individual or organization relevant to this study, the researcher would then contact that person. Having the reference of a colleague or revered community partner lent credibility in making contacts. Interviews were conducted in-person, on the phone, or over Skype. Athreon: Transcription Services Company was the professional service used in this thesis to transcribe voice recordings.

Five in-depth semi-structured interviews involving distinct relationships to the RLOs in question were analyzed in this study; each participant possessed a distinct background and insight into the inner-workings of these RLOs. This study includes two respondents from SBF and four from BCAP. In order to gain IRB approval in working with refugee populations, this
study cannot reveal respondents’ identities. Although the refugee communities are large, the organizations themselves are small. Leadership is concentrated within a handful of people that are the main decision makers in these organizations.

The first people contacted in this study were volunteers and journalists who had reported on RLOs. These individuals were essentially gatekeepers. Lavrakas (2008) describes gatekeepers as individuals who present access to a social role or structure that the researcher alone cannot access without prior approval from the gatekeeper. These gatekeepers are individuals who maintain close relationships with the RLOs in question, possess an intimate understanding of RLO operations, and are also invested in their success and development. These gatekeepers included RLO directors, board members, community partners, journalists, and community volunteers. Meeting with RLO gatekeepers lent credibility to the researcher and the opportunity to build rapport with community members. This opened access to RLO founders, directors, and community partners. RLOs are grassroots initiatives with leadership focused within a small group of individuals. Based on the hierarchy and structure of RLOs, interviewing individuals outside of RLO leadership netted less information, because these individuals were not as deeply involved in the day-to-day operations, for instance, in creating program evaluations. Interviewees were generous with their time. The length of each interview and meetings ranged from one to two hours. All interviews, including two follow-up interviews, were conducted in English.

Coding

Thematic coding was used in this research by linking keywords that were consistently identified in interview transcripts. These keywords were separated into distinct major categories to establish a framework of thematic ideas. The Coding Manual for Qualitative Researchers by Johnny Saldaña was a guiding source throughout the coding process. The meaning of codes was
derived from thematic content analysis of transcripts of personal interviews, participant observation field notes, literature, photographs, and websites. These codes were processed to support the main argument of this paper, which states that RLOs are equipped to fill mental health needs in refugee communities because they do so in a culturally appropriate manner.

All coding was manually completed using copies of interview transcripts and note cards. Due to the small quantity of data employed in this study, manually coding interviews was the easiest method to use. Pre-coding was completed by highlighting specific words or ideas that were repeated throughout the interview. All codes are summarized and condensed from raw data. Categorizing codes into lower and higher order categories to generate major themes was based on the relationship between codes. The first cycle of coding consisted of repeated phrases that were organized into low-order categories. In the second cycle of coding, these low-order categories were then matched into higher-order categories depending on their relationship to the specific words or ideas presented in the raw data (Johnston, 1995). The coding table demonstrating how codes were constructed from raw data, organized into lower order and higher order categories a framing map, and definitions of high order categories are included in Appendix B through D. The table below outlines the major themes and their associated concepts found in this study.

Table 1: Themes and their Associated Concepts

<table>
<thead>
<tr>
<th>Themes</th>
<th>Associated Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural Approaches to Mental Illness</td>
<td>Emergency situation, mental illness, social repercussions, a stigma of mental illness, community programming, grassroots efforts</td>
</tr>
<tr>
<td>MHPSS (Mental Health Psychosocial Services)</td>
<td>Emergency situation, feel human again, community support, address issue of mental illness at the root, self help, empowerment</td>
</tr>
<tr>
<td>RLO Independence</td>
<td>Lack of funding, ownership, empowerment, collective effort, apolitical, trust, pride</td>
</tr>
</tbody>
</table>
Limitations

Studying refugee populations presents unique challenges. As Porter and Haslam (2005) explain, refugee populations are often physically, linguistically, and culturally inaccessible to researchers. In a crisis, humanitarian aid organizations hold a higher priority for intervening than formal scientific investigation. The post-migration stressors that refugees face include marginalization, socioeconomic disadvantages, acculturation difficulties, loss of social support systems, and grieving for the loss of their homes. These are post-migration factors that must be recognized and addressed. For these reasons, access to humanitarian aid holds a higher priority in crisis situations than formal scientific investigation (p. 603). There were many persistent barriers faced in accessing the Syrian refugee population abroad. During the data collection stage of this research, conflict erupted in southern Turkey where SBF is currently based. Travel to this area was heavily restricted, which created difficulties in gathering empirical data. Also, the United States government implemented a travel ban as of January 2017. This created problems for accessing Syrian refugees who may have been familiar with SBF or who later planned to travel to the region. As stated above, one of the main difficulties in studying refugee populations is accessing them; in this case, physically accessing the members of this organization was an unobtainable goal. As a result, on-site observations are not available for this portion of the study. All information on programming and community support from the refugee camps in which SBF operates are based on second-hand information gathered from individuals who work there, have recently visited the organization, or maintain close ties with the SBF.

Another limitation of this study is that it cannot demonstrate how strategies that aim to remove the stigma of mental illness programming may evolve over time. As these RLOs grow in funding, personnel, or change locations over time, new strategies are likely to be adopted to
address the stigma of mental illness. The strategies presented in this study reflect contemporary approaches.

CHAPTER FOUR: FINDINGS AND DISCUSSION

Introduction

This chapter explores the origins of Syria Bright Future (SBF) and the Bhutanese Community Association of Pittsburgh (BCAP) and describes the various community programs SBF and BCAP offer to combat the stigma surrounding mental illness, as well as the obstacles they face along the way.

Section I: Syria Bright Future

Background

Syria Bright Future (SBF) is an apolitical, humanitarian, refugee-led Syrian organization. This RLO strives to provide psychosocial care in an integrated manner, using a multi-disciplinary approach. SBF is a mental health and psychosocial support system for fellow refugees (Abo-Hilal & Hoogstad, 2012, p. 91). From the Zaatari refugee camp in Jordan, SBF relocated to new headquarters in southern Turkey in summer 2016.

SBF was established in Syria in 2008 with the cooperation of many other mental health psychosocial support networks during the years preceding the Arab Spring, which began in 2011 (Ajami, 2012). Syrian mental health professionals recognized a burgeoning need within their communities to address mental health issues. They understood the necessity of implementing mental health care for the Syrian population (Abo-Hilal & Yousef, 2014).

Under the regime of Bashar al-Assad and the Ba’ath party, all formal mental health and psychosocial support (MHPSS) activities fell under the surveillance of the state. It became
impossible to establish an independent mental health organization or network under such oppressive state regulations. Despite state restrictions and state surveillance, mental health professionals managed to create an informal network to address MHPSS needs (Abo-Hilal & Hoogstad, 2012).

Following violent conflicts in Syria in 2011, many mental health activities in the country came to a halt. This affected the lives of members of the informal Syrian psychology network as many attempted to avoid the escalating conflict, while others joined the uprising against the regime. As the fighting intensified, many fled Syria to save themselves and their loved ones. During this period of unrest, many male members of the Syrian psychology network were arrested and suffered (Abo-Hilal & Yousef, 2014, pp. 334-335). By the end of 2011, several remaining members of the Syrian psychology network fled to Jordan, where they provided MHPSS services for other Syrian refugees in the country. Providing MHPSS services to a migrating population in chaos was not easy, especially given that there were no specific international funds allocated to provide mental health services for Syrian refugees at that time (Abo-Hilal & Hoogstad, 2012, p. 90).

At the height of the Syrian conflict, Syrians were forced to relocate to neighboring countries, such as Jordan and Turkey. (See Appendix E for a map of the locations of Syrian refugee camps and internally displaced sites.) For the past six decades, Jordan has received an influx of refugees from neighboring countries due to conflicts in the region. This mass migration has resulted in a wave of resource scarcity and resentment towards new incoming refugees (O’Toole, 2016). For this reason, Syrian refugees are susceptible to discrimination from within their host communities (Interviewee 2, 2016a). The legal status of refugees in Jordan grants them neither permission to work nor the right to obtain a driver’s license. These adverse factors
created obstacles for SBF being recognized as a legitimate organization in Jordan because of the refugee status of its founders and staff (Abo-Hilal & Hoogstad, 2012; Interviewee 1, 2016; Interviewee 2, 2016b).

**SBF: Community Based Projects**

The Syrian mental health network promoted the treatment of mental health beyond the professional community through capacity building and community engagement. Mental health requires an interdisciplinary approach that recognizes the need for attention to cultural aspects of the Syrian refugee experience (United Nations High Commissioner for Refugees, 2015). To address the need for culturally appropriate services, SBF employs refugees within the camps as community volunteers to help with programming implementation. It is not a requirement for volunteers to possess a formal education in MHPSS work; they are recruited based on personality, motivation, and commitment. For instance, at one point, community volunteers have been physicians, (including a specialized surgeon), engineers, kindergarten teachers, and students (Abo-Hilal & Hoogstad, 2012).

What is unique about the SBF refugee camp is that Syria Bright Future has Syrian volunteers. It is Syrians helping one another. Interviewee 2 (2016b) explained that some of the volunteers who work in SBF actually live in the camp as refugees themselves. The community volunteers are embedded in the community in which they serve. Interviewee 2 (2016b) explained that running an RLO requires different specialties and trust in order to be able to address peoples’ needs. In SBF, community volunteers are trained to provide basic support (Interviewee 2, 2016a). Before becoming a community volunteer, candidates receive training from SBF mental health providers on how to identify signs and symptoms of mental disorders, communication skills, and how to provide basic psychological first aid (Interviewee 1, 2016;
Interviewee 2, 2016a). Many of the psychological problems SBF addresses, share a close connection to the Syrian conflict, which can include the social and emotional barriers of adjusting to camp life. These social and emotional barriers include dealing with the stressors of the newly acquired life as a refugee, such as insecurity about the future, desperation, and consistent feelings of sadness, anger, fear, or frustration, which can culminate in family problems (Abo-Hilal & Hoogstad, 2012, p. 91). In addition, SBF meets with people suffering depression, post-traumatic stress disorder (PTSD), or schizophrenia (Interviewee 2, 2016a).

SBF is well-connected to the Syrian refugee community, allowing them to reach individuals and families easily. The oppression and widespread corruption in all aspects of Syrian life was pervasive, including the involvement of the secret police. As a result, Syrian families do not easily trust formal organizations or institutions because they fear it is possible that members of the regime could have infiltrated these organizations. The advantage SBF holds is that because they are operated by Syrian refugees, SBF workers are often from the same areas or cities as the families they assist. This contributes to fewer obstacles to building trust. As a result, families tell SBF that they feel both safe and understood in working with SBF (Abo-Hilal & Yousef, 2014, p. 91).

As previously stated, it is not a requirement for volunteers to have a formal education in psychology or MHPSS. RLO embeddedness is either an advantage or disadvantage. On the one hand, dealing with personal trauma experienced by others could be a drawback if it acts as an emotional trigger. On the other hand, RLO embeddedness could also be an advantage. There is a benefit in Syrians helping Syrians in something as personal and stigmatizing as a mental illness because it contributes to building trust and communicating with others who can empathize and
understand. A respondent in this study explained the value of recruiting refugees from within the community to provide services:

The intent was Syrians helping Syrians. People like Syrian refugees are suspicious of somebody who is not Syrian trying to help them because they want somebody who understands what they are going through. Most of the Syrians who were helping those Syrian refugees come from the exact same villages … they know the family names. They know where you come from (Interviewee 2, 2016b).

The tradeoffs in terms of advantages and disadvantages would require further research.

As a grassroots initiative operating within refugee camps, SBF holds close ties to the community they are serving. Knowing and understanding the roots of one’s home helps in building and reinforcing trust for refugees in connection to RLOs. While the Syrian community holds a stigma against mental illness, it is not enforced or applied with negative social repercussions from the Syrian community. SBF operates in an emergency crisis, so it is understood within the community that people would display symptoms of mental illness related to the stressors of prolonged conflict in their country of origin. It understood that everyone had lost someone or something of value to them; adjusting to life in refugee camps is not an easy task.

SBF provides a wide swath of programming for various subsections of their population, including women, children, the elderly, and the disabled. Children make up a majority of the population in the refugee camps (Jabbar & Zaza, 2014). To address the needs of children in the refugee camps, SBF provides programming to train teachers in host community schools including how to deal psychologically with adolescents; provide activities for women’s
psychological support; vocational training; awareness sessions about early marriage; and gender-based violence (Interviewee 1, 2016).

As of 2017, some of the programs SBF is currently running include:

1) Social Visits Project/Home Visits

This program involves a small group of two or three community volunteers and experienced staff who visit families they know or that have been referred by other people or colleagues. During the first visit to a family, they meet with the client and family members for approximately two hours (Abo-Hilal & Hoogstad, 2012). These visits are an opportunity to introduce SBF to families who may be unaware of the potential sources of support in the camps either from SBF or from international service providers (Interviewee 2, 2016a). These visits are also a way to talk with families and offer play and recreational activities for the children to help build trust and support. This first meeting is typically used to assess basic needs and problems within the family, such as medical needs, housing difficulties, or psychosocial needs (Abo-Hilal & Hoogstad, 2012).

2) Psychiatric Clinic

SBF employs a lead psychiatrist who runs the clinic, as well as several other psychologists who treat Syrians for psychiatric disorders such as PTSD or depression caused by extreme violence in Syria. In the extreme case, where a patient is unable to visit the clinic, the SBF team is available to make home visits and provide required psychological care (Abo-Hilal & Yousef, 2014; Interviewee 1, 2016).

3) Teaching Recovery Techniques

This program is designed for children suffering from PTSD. The program applies proven techniques developed by the Children and War Organization, which has partnered with SBF to
implement community-based programs. In this program, children learn strategies to control abnormal or intrusive PTSD-related reactions and to engage in community activities. Activities include one-on-one therapy, in which children describe terrifying memories, and group sessions that try to help children cope with nightmares and flashbacks. Children learn to visualize a safe space, use relaxation techniques and confront bad memories by drawing them (Kamaliddin, Hol, Leotaud, & McKinney, 2015).

4) Psychological Screening of the Wounded

The SBF team offers psychological support to those bedridden in hospitals, homes, and in the refugee camps. Each patient receives a preliminary psychological screening, after which they receive help through psychotherapy and counseling sessions (Abo-Hilal & Yousef, 2014; Interviewee 1, 2016).

5) Irqa Compensatory Readings

The Irqa Compensatory Readings provides tutoring for students, ages 7 to 15. A family’s refugee status prevents children from attending school regularly, which creates huge gaps in children’s intellectual development. As Interviewee 2 (2016) explains, Syrian refugee children in Jordanian schools, for example, are bullied by their peers for fleeing their countries, asking Syrian children why they left their country, why they were cowards, why they do not support their country’s regime, and other painful questions. As bullying intensifies, some children face beatings and assaults from their peers. It is likely children repeat the political rhetoric they hear from adults, scapegoating refugees for their countries’ migration and economic problems. This creates an intimidating environment that is not suitable for learning or healing from past traumas. Often children drop out of school. This leaves them vulnerable to being recruited by gangs who
commit violence. SBF steps in to help children catch up with the curriculum and fill in gaps in their education (Abo-Hilal & Yousef, 2014; Interviewee 2, 2016b).

The literature on refugee children demonstrates that educational activities during a crisis provide children with a safe space to begin the trauma-healing process and to learn the skills and values they need. While there is consensus in the literature that child protection efforts and education interventions work to support and promote the well-being of children in emergencies, these measures often fail to be implemented in practice (Jabbar & Zaza, 2014, p. 17). To address the issue of education and protection, SBF provides educational activities to fill in the educational gaps for Syrian children and provide them with spaces that are predictable and safe.

6) Parental Counseling

This program is designed to provide psychological support to Syrian mothers in the Zaatari camp in Jordan by providing trauma counseling and childcare training, especially that which focuses on behavior common in children who are dealing with traumatic experiences (Abo-Hilal & Yousef, 2014; Interviewee 1, 2016; Interviewee 2, 2016b).

7) Helping Children with Special Needs

SBF also specializes in aiding children with autism, quadriplegia, learning disabilities, speech difficulties, and hearing impairments. An SBF psychologist first makes a diagnosis and then follows up with families to locate special needs centers for their children. SBF also offers counseling on how to raise a child or children with special needs (Interviewee 1, 2016).

8) Zaatari Camp Project

SBF works in collaboration with Medcins du Monde (MDM) and the World Health Organization (WHO) to implement a comprehensive psychosocial support system for refugees in
the Zaatari camp, which is home to more than 100,000 refugees (Jabbar & Zaza, 2014). This project provides:

a) home visits to families in tents and caravans;
b) awareness campaigns on early marriage and gender-based violence;
c) lectures on mental health care and personal well-being;
d) safe spaces for younger children to play

(Kamaliddin et al., 2015).

9) Protection Program

As of 2016, SBF has been able to provide peer social services and protections for refugees and internally displaced individuals still residing in Syria. This protection program targets various community groups, including women, children, the disabled, and the elderly, to ensure self-dependence and enhance the MHPSS protection perspective. This initiative is carried out in community-based centers, schools, refugee camps, and other community institutions. This program was designed to help participants find a balance between physical and MHPSS well-being and healthy socialization with others (Interviewee 1, 2016; World Health Organization, 2010).

10) Research and Studies

The SBF team pursues both quantitative and qualitative research studies to improve their work and promote information regarding refugee mental health to the wider community. The value of an RLO such as SBF in providing community support is that they provide more than medical help. SBF, an RLO staffed by Syrians to aid Syrians, helps in providing what Interviewee 2 (2016a) describes as, “…a sense of security, a sense of family, a sense of community that you can relive your old life again.” Addressing mental health in populations
affected by trauma is important because the implications of involving psychosocial support can help individuals “feel human again” (Interviewee 2, 2016b).

**SBF Programming Evaluations**

Community program assessments stem from systems of evaluation based on scientific methods. These methods of community programming evaluations incorporate approaches that focus on individual participation, community feedback, attendance, or program surveys in order to evaluate program success. SBF uses statistical analysis to measure program development and improvement. SBF achieves this by disseminating program questionnaires to participants to measure when and how specific programs meet target goals. SBF has created two sliding scale evaluations to measure target acquisition for PTSD and depression. The evaluations are analyzed at the end of every cycle, which is every 1.5 months. Each program in a repeated cycle begins with a pre-test and ends with a post-test. The programs are repeated in cycles with the same groups of participants until target acquisition is achieved. In sum, community programming evaluations adjust according to findings as they measure the effectiveness of reaching programming target goals. SBF publishes their research and findings in academic journals of peace and conflict, psychology, and mental health.

**SBF Summary**

SBF is a refugee-led organization operating amidst a crisis. Despite the difficult circumstances in which they operate, SBF provides guidance and information regarding mental health resources and provides culturally appropriate mental health services that are relevant to the Syrian refugee community (Abo-Hilal & Hoogstad, 2012). While SBF offers many services other than those to alleviate mental illness—such as protection and education services—MHPSS services are the cornerstone of SBF initiatives. Within the Syrian refugee community, SBF saw a
need to address the prevalence of mental illness following the onslaught of the Syrian conflict, and took the initiative to provide MHPSS services. An RLO providing mental health services in a crisis is not without difficulties, however. SBF faces challenges in funding and allocating spaces for offices and programming, for instance.

There is also a stigma of mental illness within the Syrian community. A 2015 report commissioned by the UNHCR, titled “Culture, Context, and the Mental Health and Psychosocial Wellbeing of Syrians” explores the stigma around psychological distress and mental illness. As the report explains, in Syrian culture, emotional distress is recognized as a part of life; it is the labeling of emotional affliction as being psychologically linked that creates shame, embarrassment, and fear of scandal. Being labeled as psychologically unstable or “crazy” (p. 35) creates shame for the individual(s) who has mental illness and their families. The stigma of mental illness affects a person's decision to seek professional help or to follow treatment options.

This UNHCR report (2015), interviews with SBF gatekeepers (Interviewee 2, 2016b), and journal articles published by SBF leaders (Abo-Hilal & Hoogstad, 2012) explain how Syrians have held a skeptical view of psychology, psychiatry, or the use of mental health services in general. This trepidation is tied to the negative perception of mental illness, in addition to the fear of stigma and scandal. However, as demonstrated in the findings of this study, many Syrian refugees are willing to seek help from MHPSS services. The UNHCR report (United Nations High Commissioner for Refugees, 2015) also reveals that, in needs assessments, Syrian refugees often rank services for mental health and psychosocial support as crucial.

While there is a general stigma of mental illness within Syrian culture, from the perspective of this study, it appears that Syrian refugees are open to learning about mental health and addressing the stigma of mental illness. From interviews with SBF, this study notes that
there seems to be less stigma when SBF discusses mental health and psychosocial support. An SBF leader explained it this way: “It is not a big problem to invite people to come to activities. Before the revolution, we used to do classes and workshops to talk about mental health. Within 5-10 minutes people realize there’s something useful called psychology” (Interviewee 1, 2016). There is an understanding within the Syrian community that everyone has experienced loss or grief, so there is no shame engaging in help-seeking behaviors.

Section II: The Bhutanese Community Association of Pittsburgh

Background

The Bhutanese Community Association of Pittsburgh (BCAP) is a community nonprofit organization established in 2010 in Pittsburgh, Pennsylvania, USA. Their mission is to "ensure a high quality of life for all members of the Bhutanese community by supporting their integration into American society through culturally-informed services and activities" (Bhutanese Community Association of Pittsburgh, 2016). At the end of 2007, the United States along with other countries launched a refugee resettlement program to serve tens of thousands of Bhutanese refugees residing in Nepalese camps because they were unable to return to Bhutan or resettle permanently in Nepal (Cultural Orientation Resource Center, 2007; Dhungana, 2010).

In Pittsburgh, the Bhutanese community faces a high suicide rate. This is due, in part, to the prevalence of mental disorders, which are heavily stigmatized among the community. As one respondent explained, mental disorders are brought on by constant frustration and stress in acculturation to a new life in the West: “...[t]here are so many things that people can feel, it can start with an addiction. It can just start with the stress of their jobs... lack of access to resources, or just a general feeling of constant frustration” (Interviewee 3, 2016). As interviews revealed, this feeling of constant frustration tends to be brought on by managing various social roles or
constantly comparing oneself to peers in the community. These factors are attributed to anxieties and stressors that can eventually manifest into a mental illness or acting “crazy” (Interviewee 3, 2016). In addition, Bhutanese refugees face difficulties navigating the American welfare system and institutions due to language barriers and acculturation struggles. Mental illness arising from PTSD, depression, or trauma is prevalent in the Bhutanese community, and the cultural stigma of mental illness plays a role as a significant stressor contributing to the high Bhutanese suicide rate (Omeeren, 1998; Steel et al., 2009).

Mental illness is heavily stigmatized in the Bhutanese community, and the social repercussions of having a mental illness are reinforced. As a BCAP community leader explained, “We do have some stigmas because people don’t take mental illness as part of their physical illness. People do not share their mental illness with their family members, or they don’t seek mental help” (Interviewee 3, 2016). In general, there is a lack of understanding about mental illness in the Bhutanese community, but BCAP, as an RLO, is making efforts to address mental illness within their community through programming that addresses acculturation stressors.

The Bhutanese Community in Pittsburgh

Each year more than 500 Bhutanese refugees are resettled in Pittsburgh, Pennsylvania (Jones, 2016). The Pennsylvania Office of Refugee Resettlement works in collaboration with the Squirrel Hill Health Center (SHHC) to complete the initial health screening for the majority of newly arrived refugees. Health and social workers say that many new refugees arrive with a host of mental disorders, including post-traumatic stress, and are exhausting the human resources and funding available to help refugees heal (Jones, 2016).

The thousands of Bhutanese refugees resettled in Pittsburgh were urgently concerned with finding work when they first arrived. As a result, the stressors of acculturation and
navigating American institutions brought to a boiling point mental disorders that were simmering beneath the surface. Language proficiency is another stressor in the Bhutanese community (Interviewee 3, 2016; Interviewee 5, 2016). Many older Bhutanese are illiterate in their primary language, so this makes learning English an additional hurdle. While the youth may find work and attend school, the elders have nothing to do (Jones, 2016). In Bhutanese culture, elders support their families. Resettlement in the United States has taken away elders' ability to fulfill their social and cultural expectations as family leaders, due to their inability to navigate American institutions and transportation on their own. This can be distressing and results in a feeling of lack of purpose (Interviewee 3, 2016).

**The Structure of Community-Based Projects in Bhutanese Refugee Camps**

Bhutanese refugees lived in Nepali refugee camps for close to two decades. The refugee camps in Nepal operated with various democratic and representative forums introduced by international NGOs that provided support to Bhutanese refugees over the years. These organizations included the United Nations High Commissioner for Refugees (UNHCR), Camp Management Committee (CMC), World Food Program (WFP), and other international aid groups that operated within the camps (Pulla, 2015). The European Commission for Humanitarian Aid and Civil Protection (ECHO), which coordinates with the World Food Program (WFP) to provide food rations to the camps, stated that the coordination between UNHCR, WFP, and other NGOs was “complementary,” and “overall a well-managed refugee intervention” (Shrestha, 2014, p. 3).

*The Role of Center for Victims of Torture Nepal (CVICT) in Refugee Camps*

The Center for Victims of Torture Nepal (CVICT) was established to provide medical services to native Nepalese who had faced torture before or during the conflict between Nepali-
speaking Bhutanese and the Nepalese government. CVICT is a registered nonprofit NGO in Nepal that focuses on the rehabilitation of torture victims and the prevention of torture in Nepal. In 1991, when a large number of Bhutanese refugees entered Nepal, CVICT was there to provide services: the program consisted of one doctor, two counseling supervisors, and a health assistant for each of the six refugee camps, and about 30 community health workers. Except for the physician and counselors, all CVICT staff were Bhutanese refugees (Omeeren, Sharma, Prasain, & Poudyal, 1998, p. 266). Between 1994 and 1997, CVICT ran a community-based rehabilitation program that provided medical and psychosocial care for tortured Bhutanese refugees (Omeeren, Sharma, Prasain, & Poudyal, 1998, p. 259). CVICT is also an implementing partner that operates in conjunction with UNHCR-coordinated aid structure to provide community-based rehabilitation programs for torture survivors in the Bhutanese refugee camps (Center for Victims of Torture, 2017).

![Map of Nepal with locations of the Centre for Victims of Torture (CVICT) clinics and the Bhutanese refugee camps.](image)

*Figure 2: Map of Nepal with locations of the Centre for Victims of Torture (CVICT) clinics and the Bhutanese refugee camps.*
CVICT is an NGO based in Nepal that hired Bhutanese refugees to help provide mental health and first aid services for the Bhutanese refugee community. Specifically, community volunteers from the refugee community were to support female torture survivors from the Bhutanese refugee population. Initially, volunteers were offered training and support by counseling supervisors, social workers, and medical personnel from CVICT. The volunteers’ main task was to serve as a direct link between existing facilities that provide psychosocial services and individuals in need of those services.

Another program utilized in the Bhutanese camps was an integrated community-based program that hired and trained “community health workers” (CHWs) in basic listening and problem-solving skills, relaxation exercises, and yoga. There was also a monthly medical clinic available to refugees, which included a female doctor for female torture survivors. This program, however, posed significant drawbacks in that it only served two people at a time due to staff shortages, and high overhead costs (Omeeren et al., 2001, pp. 265-266). One noted advantage of these approaches used in the camp programming was that the Bhutanese volunteers shared similar backgrounds with the population they were serving and could better relate to clients (Omeeren et al., 1998, p. 265).

**BCAP Programming Strategies**

BCAP offers a variety of community-based programs for various groups within the Bhutanese community to help members successfully integrate into American society. They also address mental illness and the stigma surrounding the issue. BCAP has many community partners in Pittsburgh who help to coordinate, plan, and implement community-based programs, such as the Carnegie Library, Life Span, and the Jefferson Regional Foundation of Pittsburgh (Interviewee 3, 2016; Interviewee 4, 2016).
1) **Seniors**

Senior programming is for seniors above the age of 55. Many Bhutanese seniors did not grow up in urban areas, so to help reconnect to those aspects of agrarian life they are most familiar with, annual Senior tours are planned to the Phipps Conservatory and Marburger Farm in Evans City, which lies a half hour north of Pittsburgh, Pennsylvania (Interviewee 3, 2016).

2) **Women’s Day: Teej**

Teej is a traditional Hindu festival where Nepali women celebrate marriage. It is a day of fasting and wishing their husbands a long life. This festival involves dancing and acts of worship in which women perform various rituals while praying. By incorporating the Teej festival, BCAP aims to empower Bhutanese women by having them arrange this festival. They create ideas for events, design flyers, arrange food, entertainment, hosting, renting sound systems, and organizing registration for over 500 guests. Hosting this event helps Bhutanese women develop confidence in themselves, their leadership roles, and connect to resources in the Pittsburgh area.

3) **English Language & Civic Education (ECLE) Classes**

After fleeing their home country, refugees may languish in a country of refuge for years or even decades. These individuals have limited rights and often no legal status while they are waiting to return to their country of origin or secure permanent resettlement. Some host countries restrict movement and access to legal employment and educational opportunities for refugees living in camps. Host countries impose these restrictions to limit local integration or for security concerns. As a result, in situations where refugees are granted limited rights or access to employment or educational opportunities, there exists a correlation between refugee camp experience and low literacy rates (Capps et al., 2015).
To combat illiteracy and secure American citizenship, BCAP offers English language courses that double as civic education courses in preparation for the United States Citizenship examination. These classes are culturally and linguistically appropriate and provide dual language instruction. The ECLE program was run by BCAP for four years before receiving a grant from the Office of Refugee Resettlement (ORR) in 2014 (Giammarise, 2017; Interviewee 3, 2016).

4) Parent-Child Cultural Club (PCCC)

Refugees who arrive as children have more opportunities than adults to develop English language skills (Capps et al., 2015), which fosters a linguistic and cultural gap between generations. The Parent-Child Cultural Club is a program run on-site at the BCAP office. The aim of this program is to narrow the linguistic and cultural gap among children, parents, and grandparents by teaching children to speak Bhutanese. Learning to speak Nepali is beneficial for Bhutanese children growing up in the United States because as they become bilingual, the community preserves the Nepali language, and this creates activities for children and their parents to do together. The PCCC program is open to children three years of age and older. Children also listen to stories and participate in peer activities that demonstrate the importance of being a dual language speaker (Bhutanese Community Association of Pittsburgh, 2015).

5) Yoga

The yoga classes last for about 2-3 hours and take place every weekend. The classes are neighborhood-based in communities with a large Bhutanese community to make it easier for members of the Bhutanese community to attend. They are also accessible by public transportation. The goal of these yoga courses is to mitigate physical ailments and loneliness as people come together in music, dance, and meditation (Interviewee 3, 2016).
6) *Funeral Fund*

The Funeral Fund is one of the first community projects established in the Bhutanese refugee camps in Nepal that was applied in United States resettlement. The Funeral Fund is for community members to contribute to the funeral costs of families who have lost a family member to suicide. Due to the high prevalence of suicide in the Bhutanese community in the acculturation process, the sudden death of an immediate family member places a heavy financial burden on the poorest in the community. The Funeral Fund began as a door-to-door fund solicitation in 2013 with the formation of BCAP. There are about 300 members that pay into the Funeral Fund on a monthly basis. The purpose of this fund is "to act as a lifeline in the storm" (Interviewee 3, 2016) and to help relieve the stress and anxiety amidst the chaos of a loved one’s untimely death. BCAP will write a check to the funeral home to ease the economic burden of families are who are struggling financially. Community members will provide financial assistance or meal preparation as they are able (Interviewee 5, 2016). BCAP hopes one day to establish a funeral home to be utilized by their community members (Bhutanese Community Association of Pittsburgh, 2015; Interviewee 5, 2016).

7) *Capacity Training: Mental Health First Aid Training (MHFA)*

BCAP offers many programming strategies to address mental health needs, and one of the impactful community strategies that focuses exclusively on mental health is the Mental Health First Aid training (MHFA). MHFA is a popular initiative to train people within immigrant and refugee communities to recognize symptoms of anxiety, trauma, or depression (Jones, 2016). The MHFA is widely used to train human service workers in the United States. This training is offered to a variety of audiences including hospital staff, business leaders, faith communities, and law enforcement (Subedi et al., 2015, p. 2). The program is primarily intended
to increase mental health literacy, decrease stigmatizing attitudes, and help prepare community members to recognize and assist individuals who are in crisis (Kitchener & Jorm, 2006). BCAP incorporated this training into its community programming to educate the Bhutanese community on symptoms of mental illness as a way to reduce stigma (Interviewee 3, 2016; Interviewee 4, 2016). However, the results published by Subedi et al., (2015) on MHFA state that the training does not result in a “change of personal or perceived stigma following training” (p. 4).

MHFA training in the Bhutanese community has been shown to be effective in educating the community in recognizing the symptoms of depression and in changing beliefs about treatment. The training incorporates fully bilingual training materials and pairs MHFA instructors with respected community leaders. These measures help to make MHFA training effective in reducing negative attitudes toward those suffering from mental disorders (Subedi et al., 2015). In their research, Subedi et al., (2015) discovered that Bhutanese participants identified social and economic factors (not mental health disorders) as the dominant risk factors for suicide. These factors include language barriers, family disputes, and the generation gap as sources of emotional stress and potential causes of suicide. MHFA training prepares community members to support their peers as they face mental illness as a result of social and economic challenges.

**BCAP Programming Evaluations**

Interviews with RLO leaders and community partners indicate that BCAP does not use programming evaluations. The lack of programming evaluations is due in part to the low level of human capital within BCAP as an organization. BCAP staff do not possess the working knowledge and skills to create program assessments that measure program growth or whether a program has met its target goals. First, in addressing the levels of educational attainment, a report
from the Migration Policy Institute explains, that in refugee populations that spend many years in refugee camps, host countries impose restrictions on movement, access to legal employment, and educational opportunities for refugees as a method of limiting refugee integration into the local community or to quell security concerns. Almost all Bhutanese refugees that have resettled in the United States lived in one of Nepal’s seven refugee camps prior to their arrival. As previously cited, there is a slight correlation between refugee camp experience and low literacy rates (Capps et al., 2015, p. 354). This is due to the restrictions imposed on refugees by their host country while they are living in refugee camps. The Migration Policy Institute also explains how refugees’ educational attainment varies by country of origin. Bhutanese refugees were among the least educated refugees: 42 percent of men and 56 percent of women from Bhutan had not completed high school (Capps et al., 2015, p. 357). Through no fault of their own, BCAP does not possess the human capital within their community to create, measure, and implement evaluation methods for community programming strategies (Interviewee 2, 2016; Interviewee 3, 2016; Interviewee 4, 2016).

While BCAP lacks the human capital necessary for program evaluation methods, they have access to social capital within the Pittsburgh community that helps to grow and maintain the organization. For substantive and ideological reasons, there is no consensus in the academic field as to a clear and undisputed meaning of social capital (Foley & Edwards, 1997). For this study, however, social capital is defined as the value of social networks, in which the bonding of similar people and bridging between diverse people is a key component for the betterment of an organization (Adler & Kwon, 2002).

In the Bhutanese camps in Nepal, international organizations, such as the UNHCR and other NGOs present in the camps, were helpful in providing a base to create stabilizing strategies
that would offer community programming. In resettlement, BCAP used those same strategies employed in the refugee camps. Refugee resettlement programs in the United States utilize a two-party process for integration. This is understood by BCAP as a process in which the host society is very much involved alongside the refugees in creating a successfully integrated community (Interviewee 5, 2016). In resettling to the United States, BCAP has built relationships with many supportive community partners in Pittsburgh who are willing to provide assistance in acquiring grants, ready to serve on the board of trustees, and willing to provide general guidance as needed (Interviewee 4, 2016). These community partnerships provide BCAP with the social capital to be independent and self-sufficient. Because BCAPs’ primary mission is to provide acculturation services, as opposed to solely mental health and psychosocial services, BCAP does not see a need to measure program strategy effectiveness. As one respondent explained, the mainstream behavioral mental health approaches are Western—these populations are not interested in evaluations. It is not culturally appropriate to measure because Western methods are interested in diagnosis and treatment. Being diagnosed with a mental illness or taking medication to treat a mental illness is heavily stigmatized in the Bhutanese community with social repercussions and not a label or perspective from the community that one can easily change (Interviewee 3, 2016). The sentiment is that as long as BCAP, as an organization, can keep their doors open, that is sufficient. They believe that it is not considered culturally appropriate to measure the effectiveness of community programming because other priorities remain at the forefront.

**BCAP Summary**

In the context of Western resettlement, BCAP has found a home in Pittsburgh where the Bhutanese community can gather and begin anew. The mission of BCAP is to help facilitate
successful integration for all members of the Bhutanese community in Pittsburgh through culturally-appropriate services and activities that address suicide prevention within the Bhutanese community. As one BCAP community partner explained, “[BCAP] is doing more to address mental health than most other community groups. They are the best staffed and organized” (Interviewee 4, 2016).

The presence and positive influence of international organizations and NGOs in the Bhutanese refugee camps, such as the UNHCR and CVICT, working closely with the Bhutanese population, helped to establish the framework for community organizing that was transferred in resettlement to the United States. Refugees stated that they felt the community programs they started in the camps, such as the education program (BREP), were successful due to high community engagement. This was thanks to the collaboration of international organizations and NGOs that helped them manage and maintain the camp programs. Ultimately, community involvement in the refugee camps positively affected resettlement staging in the United States.

In summary, BCAP translated the programming strategies used in the refugee camps of Nepal into the context of Western resettlement and managed to succeed with the help of community partners in Pittsburgh. Community partners have played a significant role in stabilizing BCAP as a refugee-led organization in Pittsburgh, helping BCAP to access vital funding through community grants, for instance. BCAP does not use program evaluations to measure the effectiveness of their community programming. This is attributed to a lack of human capital within the organization and community. Other priorities remain at the fore, such as keeping the doors of BCAP open.
Findings

Interviews with principal informants provide insight as to how RLOs operate within their communities to decrease or eliminate the social stigma of mental illness. The first research hypothesis states that RLOs employ strategies to mental health interventions that are culturally appropriate because the staff of RLOs share similar post-migration experiences and cultural characteristics as the refugee populations they serve. The second research hypothesis states that BCAP should produce better evaluation strategies because BCAP operates in a resettlement context in the West with greater access to resources. Because SBF is currently operating in the midst of an on-going crisis in the Middle East, resources needed to continue operating are likely scarce or difficult to access. An examination of the literature on the stigma of mental illness, social factors, and the difficulties refugees face in post-migration provide the theoretical and methodological rationale of this study.

This study applies the Weisbrod Theory of NGO operating structure in a market-based economy to address how RLOs are capable of providing culturally appropriate services. This study finds that both RLOs analyzed in this study utilize community programming strategies to combat mental health stigma, but only one employs scientific methods to evaluate the effectiveness of program strategy. Qualitative interviews with members of Syria Bright Future and the Bhutanese Community Association of Pittsburgh reveal that these RLOs operate with a combination of human and social capital that directly affects their ability to evaluate program strategy effectiveness.
The complementary roles of human and social capital affect a RLO’s ability to evaluate programming strategies and measure their success. The efficient manner in which SBF employs program strategies and program evaluations is attributed to the human capital possessed by RLO staff and volunteers, but most importantly, because of the SBF leaders who come from a medical background. This is a vital component because it provides SBF with the knowledge and experience to be able to organize data, understand the implications of data gathered, and disseminate research findings. However, one of SBF’s challenges is a persistent lack of funding. SBF operates in a crisis environment, alongside highly-funded backed NGOs and a population that is constantly shifting. Therefore, proven ability to measure and collect data for mental health programming is a remarkable feat. SBF requires more social capital considering the amount of funding their labor-intensive research requires, in addition to paying their staff, keeping up with office and building costs, and expanding program services into protection and education.
Policy Recommendations

RLO and NGO Coalition

There is a case to be made for the positive influence of RLOs. These are grassroots organizations that implement a community-focused approach that demonstrate the benefits of culturally appropriate interventions. This study presents a perspective on the role of RLOs in recognizing community-focused approaches to refugee needs, specifically in the context of mental illness. This study also illustrates how RLOs are active in treating and combatting the stigma of mental illness because RLOs are already integrated into the refugee community and hold many common experiences, such as shared post-migration experiences and language.

As Porter and Haslam (2005) stated in their study, materially secure conditions, economic opportunities, and shelter were directly associated with greater mental health outcomes for refugees. This finding demonstrates that generous material support on behalf of humanitarian aid agencies can help partly to resolve mental health disorders among refugee populations. This study builds upon these findings and adds that, although material support is a vital component of refugee well-being, the added component of cultural competency aids in addressing mental disorders and empowering refugee communities. This point is illustrated in the figure below:
Figure 4 demonstrates how refugees sit at the nexus of NGO and RLO efforts. Refugees receive various necessary resources and services from both entities. Together RLOs and NGOs provide a somewhat holistic approach to care in dealing with mental illness. With regards to the Weisbrod Theory, the model above demonstrates how NGOs and RLOs provide different sets of social services. On the one hand, the public goods that NGOs provide include material goods, such as clean water, shelter, food, and other needed resources. On the other hand, the public goods that RLOs provide are based in social relations, such as providing culturally appropriate services. This can include an ease of access due to shared language, opportunities to share post-migration experiences with others who have undergone similar experiences, or other opportunities to rebuild community. This study only examined refugee-led organizations. NGOs possess other capabilities not explored in this study, so this study cannot say for sure that NGOs
are only suited to provide material aid to which RLOs may not have ready access. That is one example of NGO capacities derived from the literature and reports from the UNHCR.

RLOs are humanitarian grassroots initiatives that begin within the community, often with very little funding. Both SBF and BCAP began with community members contributing what money they had to begin this organization. The majority of the RLO staff is based on volunteers that have been recruited from the community. Volunteers contribute their time and receive very little or no pay because they believe in the mission of the grassroots initiative to address issues they see present in their community. Together, RLOs and NGOs provide a holistic approach to care in dealing with mental illness that neither organization would be able to provide alone. In a way, each possesses what the other needs.

This study suggests that RLOs are providing necessary services to their community in a culturally appropriate manner; however, this study does not examine NGO efforts. The international response that NGOs manage during crises is vital. The point this study makes is to reveal the program capabilities of RLOs in combatting the stigma of mental illness and analyzing the counterintuitive findings of this study which reveal that of the two RLOs examined in this study, SBF implements better programming evaluations. Originally this study hypothesized that BCAP, an RLO in resettlement the West with more access to resources, would be better at program analysis. However, it was revealed that SBF performs better objectively programming evaluation. The explanation for this is due to varying levels of human and social capital that each of these organizations possesses, which impacts program evaluation capabilities.

The primary policy recommendation this study makes is for NGOs and RLOs to collaborate in providing services for refugee populations. Having RLOs and NGO work together to provide complimentary services would not only empower refugees through capacity building,
but would also train a new organized entity to fill the void once the international NGOs leave the camps. Although some refugee camps have become a permanent settlement in some cases (e.g., the Palestinian camps in Jordan), NGOs will eventually have to leave pre-existing refugee populations to serve other refugees elsewhere. When that happens, it is important to maintain a willing and enabled population that will be self-sufficient. This means not just providing refugee populations with necessary resources such as food and clean water—that will always be important. However, it is equally important to include grassroots efforts developed by refugee groups to grow and thrive.

It is better to empower leaders from within the community than to leave the well-being of a refugee population in the hands of a local government, who may not be as involved or invested in the wellbeing of this population. Refugees hold no political power, whether as internally displaced persons in their country of origin, in camps, or in resettlement areas across the world. RLOs function as apolitical grassroots organizations that establish themselves in refugee communities and focus their efforts on serving community needs. Interviews throughout this study revealed that refugees feel a sense of pride in having created an organization designed to aid their communities. Refugee-led organizations have the ability to contribute to part of a lifelong healing process and become a beacon of light amidst new beginnings, fears, and the hopes many refugees hold.

**Recommendations for Further Research**

This study argues that RLOs are adept at providing services for refugees because they are embedded within the communities they serve. This is because RLO staff and volunteers share important commonalities with the population they serve. As a grassroots initiative started by the community, this makes RLOs accessible and able to build rapport and trust within the
community. However, this argument is based solely on communication and empirical research conducted on RLOs, not NGOs. It is probable NGOs are implementing community programming strategies in more efficient or innovative way than RLOs are currently capable of achieving. This study only examines refugee-led organizations. It is imperative that in further research on refugee-led organizations, or refugee services in general, that the NGO component of this argument also is examined.

Moreover, in further research, it would be relevant to examine if RLO embeddedness in the communities is always an advantageous position. This thesis presents RLO embeddedness in the refugee communities they serve as an advantage. It is possible that for refugees in the process of working through personal trauma and grief, working in a service provider capacity for other refugees could have long-term detrimental impacts concerning their personal trauma, or be emotionally triggering. This research would be useful in contributing to NGO work on refugee mental health because outside NGO service providers do not carry the same personal trauma or grief as RLO service providers.

It would be effective if all follow-up interviews were administered within the same time frame (e.g., all follow-up interviews occur two weeks after the initial interview). Due to conflicting schedules and time zones, follow-up interviews took place at different intervals throughout the study. Another of the challenges presented throughout this study was to gain the trust of RLO "gatekeepers." While some participants were willing to share information on RLO operations, others were protective of the information they shared regarding RLO operations. The sense of protectiveness can be due to the fear of presenting RLOs in a negative light. These changes would improve the precision of qualitative findings.
Further research should involve cross generational studies of RLO influence on mental health among Syrian and Bhutanese refugees in comparison to those displaced during WWII. Such cross-case comparisons would provide a number of interesting opportunities for teasing out RLO and NGO influence. Additionally, it would also be interesting to conduct a follow-up with SBF in resettlement. Given the rise of terrorism in the Middle East in recent decades, Syrian refugees undergo a far more stringent resettlement process than other refugee groups. Given the negative political rhetoric and actions towards Syrian refugees in the past few years, a study observing resettlement models of Syrian refugee-led organizations in Western resettlement are received by their host community. Would a Syrian refugee-led organization, like SBF, receive the same enthusiasm and access from host community organizations in the same manner BCAP did? Moreover, it would be interesting to study whether cultural differences regarding the stigma of mental illness influence the assessment strategies and programming of other refugee groups.
Bibliography


63


Appendix A: General Interview Questions

1) In your opinion, what are the major barriers to providing programming for general mental health for (BCAP/SBF)?

2) How is mental illness viewed from within the (Bhutanese/Syrian) community?

3) What types of challenges does mental illness present to the (Bhutanese/Syrian) community?

4) What strategies has this organization used to combat the stigma of mental illness?

5) How has paraprofessional training/capacity building helped in programming around mental illness? (The purpose is to discuss capacity building to specific programs.)

6) What has been the community reaction to mental health programming by SBF/BCAP?

7) In your opinion, how successful have these strategies been?

8) What has been the most successful strategy/program?

9) How do you measure the success or growth of community programming?

10) How have you seen community programming that addresses mental illness make a difference in this community?

11) What obstacles have you faced in implementing community programming? Or in gaining access to the necessary resources to implement this project?
Appendix B: Coding Tables

For the purposes of deriving/identifying major categories identified throughout the course of interviews, quotes from interviews have been matched to their codes in the table below. The interviewee number in the first column is the number designated to each interviewee.

<table>
<thead>
<tr>
<th>Interviewee No.</th>
<th>Raw Data</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>“[BCAP] uses programs based on what worked in camps.”</td>
<td>Programming</td>
</tr>
<tr>
<td>5</td>
<td>“These populations are not interested in evaluation, because it is not culturally appropriate to measure.”</td>
<td>Culture Evaluation</td>
</tr>
<tr>
<td>5</td>
<td>“Mainstream behavioral mental health approaches are Western. Western methods have a rigid protocol, not enough flexibility. Refugees aren’t likely to use these resources.”</td>
<td>Western MH Approaches</td>
</tr>
<tr>
<td>5</td>
<td>“Mental health likes evidence based programming, but RLOs aren’t exactly there.”</td>
<td>Programming</td>
</tr>
<tr>
<td>5</td>
<td>“They do training within the community, using FirstAid Response training.”</td>
<td>Community training</td>
</tr>
<tr>
<td>4</td>
<td>“BCAP is doing more to address MH in their community than other community groups.”</td>
<td>Bhutanese helping</td>
</tr>
<tr>
<td></td>
<td>“There is not a great deal of capacity as an organization, so they use community resources.”</td>
<td>Bhutanese</td>
</tr>
<tr>
<td>3</td>
<td>“We do have some stigmas because people don’t take mental illness as part of their physical illness. It’s a private thing.”</td>
<td>Social Capital</td>
</tr>
<tr>
<td>3</td>
<td>“We have some dedicated volunteers in the community... who go out and examine the conditions of that family/individual. Kind of a discrete job.”</td>
<td>Stigma of mental illness</td>
</tr>
<tr>
<td>3</td>
<td>“When volunteers visit...they make them feel comfortable, saying we don’t talk about stigmas. We tell them it is a normal type of disease, saying that a mental illness is not to be stigmatized...like a physical ailment.”</td>
<td>Stigma of mental illness</td>
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<tr>
<td>Interviewee No.</td>
<td>Raw Data</td>
<td>Code</td>
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<td>“Mainstream behavioral mental health approaches are Western. Western methods have a rigid protocol, not enough flexibility. Refugees aren’t likely to use these resources.”</td>
<td>Western MH Approaches</td>
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<td>“Mental health likes evidence based programming, but RLOs aren’t exactly there.”</td>
<td>Programming</td>
</tr>
<tr>
<td>5</td>
<td>“They do training within the community, using First Aid Response training.”</td>
<td>Community training</td>
</tr>
<tr>
<td>4</td>
<td>“BCAP is doing more to address MH in their community than other community groups.”</td>
<td>Bhutanese helping Bhutanese</td>
</tr>
<tr>
<td>4</td>
<td>“There is not a great deal of capacity as an organization, so they use community resources.”</td>
<td>Social Capital</td>
</tr>
<tr>
<td>3</td>
<td>“We do have some stigmas because people don’t take mental illness as part of their physical illness. It’s a private thing.”</td>
<td>Stigma of mental Illness</td>
</tr>
<tr>
<td>3</td>
<td>“We have some dedicated volunteers in the community... who go out and examine the conditions of that family/individual. Kind of a discrete job.”</td>
<td>volunteers</td>
</tr>
<tr>
<td>3</td>
<td>“When volunteers visit...they make them feel comfortable, saying we don’t talk about stigmas. We tell them it is a normal type of disease, saying that a mental illness is not to be stigmatized...like a physical ailment.”</td>
<td>Stigma of mental illness</td>
</tr>
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</tr>
<tr>
<td>2</td>
<td>“The volunteers themselves are from there, and they’re really proud of being part of that organization because it’s run by Syrians.”</td>
<td>Pride</td>
</tr>
<tr>
<td>2</td>
<td>“They need a sense of ownership to their own support, and to have people from their own community doing it is just amazing.”</td>
<td>Pride</td>
</tr>
<tr>
<td>2</td>
<td>“It’s not like you can just pluck an individual out, treat them, and then send them back into that same environment they came from… and I think it’s important for people who are doing mental health there to keep that in mind.”</td>
<td>Humanitarian Aid</td>
</tr>
<tr>
<td>2</td>
<td>“The sense of loss… you are changing your identity completely from being that farmer with your whole community support… you’re in a camp, … very limited resources… and I think for people to completely process that, they need to see qualified Syrians, not somebody from the outside.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“Their goal is to reach more people, but they can’t because of the funding and resources.”</td>
<td>Funding</td>
</tr>
<tr>
<td>2</td>
<td>“A lot of Syrians said, ‘if I’m stuck here, I’m not going to sit around and mope. I have to do something.’”</td>
<td>Volunteers</td>
</tr>
<tr>
<td>2</td>
<td>“He calls it ‘untapped potential’; you have so many refugees who are going through a lot and if you don’t give them something to do, they’re going to just lock themselves up and be depressed.”</td>
<td>human capital</td>
</tr>
<tr>
<td>2</td>
<td>“Context is important because that stigma is an issue. Kids are going to school and they’re dealing with stigma. When you have politics, it’s painful.”</td>
<td>Stigma of mental illness</td>
</tr>
<tr>
<td>2</td>
<td>“There are international NGOs… but you’re talking about the mental health focus. It’s important, but it’s not enough. The biggest challenges are kind of neglected. They think about girls and women… but they don’t focus on boys at all.”</td>
<td>NGO neglect</td>
</tr>
<tr>
<td>Interviewee No.</td>
<td>Raw Data</td>
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<tr>
<td>2</td>
<td>“You have adults getting support. You have kids getting support. We just focus it more on children because they are a vulnerable group.”</td>
<td>Mental health support</td>
</tr>
<tr>
<td>2</td>
<td>“He’s a Syrian psychiatrist refugee. He’s not even in legal status. His own challenges have affected him delivering the service, but he’s fought to do it regardless. The fact that you have a refugee himself trying to fight all those”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“A lot of Syrians work to help other Syrians…and it’s creating community.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“It’s different having a Syrian help out…You have a sense of community…you have no home, you have no family, you have…it’s just you and the refugee camp. That actually goes a long way.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“International NGOs tend to brush it off just because they do one project then they move on and such, but in this case, it’s very serious. If we lose SBF, there isn’t much — I don’t see another initiative by Syrians.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“This is not an NGO for anything that’s common in emergency situations. Mental health is neglected.”</td>
<td>NGO neglect</td>
</tr>
<tr>
<td>2</td>
<td>“What makes it unique is that it’s Syrian refugees supporting Syrian refugees. What makes it a regular NGO is that you would be anybody supporting these refugees, right?”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“In SBF, that organization exists for mental health. Nobody else focuses on mental health solely.”</td>
<td>mental illness</td>
</tr>
<tr>
<td>1</td>
<td>“It is not a big problem to invite people to come to activities. Before the revolution, we used to do classes and workshops to talk about mental health. Within 5-10 minutes people realize there is something useful called psychology.”</td>
<td>Stigma of mental illness</td>
</tr>
<tr>
<td>2</td>
<td>“We are an apolitical, non-religious organization. We believe in our vision for helping people. We are not doing things because we have an agenda. We believe in this and in promoting comprehensive multi-disciplinary approach.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>Interviewee No.</td>
<td>Raw Data</td>
<td>Code</td>
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</tr>
<tr>
<td>2</td>
<td>“You cannot just throw a lot of money, a lot of experts at the beginning and then disappear...Capacity building is a favorite word for a lot of NGOs. But that means nothing if you don’t leave them with enough support that when you go the structure doesn’t fall apart because you’ve passed it on to a local government that doesn’t really care.”</td>
<td>NGO neglect</td>
</tr>
<tr>
<td>2</td>
<td>“The intent was Syrians helping Syrians. Syrians are suspicious, especially of somebody who is not Syrian coming to try to help them because they want somebody who understands what they’re going through.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“It took awhile for people to build trust even with Syrians. So having a Jordanian come is not helpful, especially when there is stigma between the host communities and the refugee community.”</td>
<td>Trust</td>
</tr>
<tr>
<td>2</td>
<td>“There are international NGOs...in the camps that are offering mental health support, but SBF has Syrians. It’s just Syrians helping each other. Some of the volunteers who work in the organization live in the camp, they’re refugees from the camp.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“Volunteers were recruited from the camps. They have their tents there. They have their cell phones on them. They are from that community.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“My understanding is that emergency funding has different areas to go to, and mental health is a temporary one.”</td>
<td>NGO neglect</td>
</tr>
<tr>
<td>2</td>
<td>“Providing tents and food and all of that is great, but for mental health, like SBF, I would give them money just to keep them sustained within the refugee camp because they’re employing people from there.”</td>
<td>Syrians helping Syrians</td>
</tr>
<tr>
<td>2</td>
<td>“They’re training [volunteers] to provide basic support. Those people in sessions for awareness, sometimes they just need to talk. When you go around and talk to people, a lot of them just want to talk.”</td>
<td>volunteers</td>
</tr>
<tr>
<td>2</td>
<td>&quot;Mental health funding is important because psychosocial support will get you feeling like a human again, and if you don’t have that, you’re kind of vulnerable for anything.”</td>
<td>Funding</td>
</tr>
</tbody>
</table>
Appendix C: Framing Map
# Appendix D: Higher Order Category Meanings

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RLO Resilience</td>
<td>NGO neglect leads to RLOs addressing the needs NGOs leave unfilled; RLOs provide cultural competency, not just material provisions.</td>
</tr>
<tr>
<td>Cultural Understanding</td>
<td>How RLOs employ cultural approaches and understanding in programming and evaluations.</td>
</tr>
<tr>
<td>Stigmatizing Perceptions of Mental Illness</td>
<td>Community perceptions on stigma of mental illness influence how individuals are treated by the group.</td>
</tr>
<tr>
<td>Grassroots Efforts</td>
<td>The positive outcomes that result from RLOs coordinating in the community.</td>
</tr>
<tr>
<td>Barriers to Organizing</td>
<td>Obstacles RLOs face as they organize within community.</td>
</tr>
</tbody>
</table>
Appendix E

Retrieved from the United States Department of State Humanitarian Information Unit, this map depicts the locations of Syrian refugee camps in the region as of March 2017.