Mental Health Support and its Cultural Understanding –

A comparative study on the impacts of humanitarian aid in the context of IDP camps in Iraqi Kurdistan.

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Abstract

Mental health issues are a serious matter with great consequences on livelihoods. Iraqi Kurdistan is situated in one of the most unstable regions and experienced an influx of IDPs over time who are in need of mental health support. However, mental health support is shaped and understood differently according to the culture. The purpose of this research is therefore to investigate the consequences of the discrepancy between Western and local understanding and framing of mental health support (MHS) in IDP camps in Iraqi Kurdistan. To find answers to the research question, the methodology is based on the grounded theory by Charmaz. The data was mainly collected through semi-structured interviews with western psychologists working in the context of humanitarian aid in Iraqi Kurdistan and local mental health workers. The main findings revealed that a lack of understanding of what mental health support means and entails in the respective cultural contexts is based on differences. Differences in expectations, knowledge, the words used to describe the concepts, outlooks towards the future, how to approach the support, the way of sense-making, the suitability of solutions to certain problems, the expression of feelings, how society supports each other, and the communication of it all. This research concludes that mental health projects in IDP camps lack sustainability, practicality, and cultural appropriateness for humanitarian aid to fulfill its purpose. There needs to be a shift in how this work is realized, by decolonizing aid, which means localizing and including, by for example expanding the local education opportunities.

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Summary

The high rate of displacement has left the Kurdish Iraqi society with a large public mental health crisis (Sharma & Piachaud, 2011). Mental health is an essential element of health and the awareness of the interconnectedness of mental health is fairly new, to a degree where policies, procedures, and support mechanisms in humanitarian aid, have not been followed up (Tol et al., 2011a). One approach to dealing with disaster mental health is to offer mental health and psychosocial support with specially designed projects implemented by international NGOs and guided by psychologists (Miller & Pescaroli, 2018). Most disaster mental health methods apply Western psychological theories and implement psychological support by experts who are from outside of the affected community (Miller & Pescaroli, 2018). This is problematic because the approach reflects colonialist thinking in the sense of a so-called *'white gaze' (*Paige, 2021). Humanitarian aid programs can have a different impact on local development and change over time which makes them unpredictable in terms of the outcome and influence. Therefore, to provide citizens of a camp with the appropriate mental health and psychosocial support, it is essential to understand how their culture influences their perceptions and what consequences it has on aid (Natali, 2007). The goal of this thesis is to learn about what kind of consequences different understandings of mental health, based on different cultural backgrounds, can have on the support.

To find answers to the research questions, the methodology is based on the grounded theory by Charmaz (2006). The data was mainly collected through semi-structured interviews with western psychologists working in the context of humanitarian aid in Iraqi Kurdistan and local mental health workers as well as professionals being responsible for implementing the structures and processes in building a mental health system for Internally Displaced Persons (IDP) camps (Charmaz, 2014). The overall purpose was to ask the participants to share their experienced reality. Beyond that, to be able to also observe the participants and understand the local context, the data was collected in field research, where the researcher conducted the interviews mainly in person in Iraqi Kurdistan (Kawulich, 2005). The data collection had an inductive approach within a single in-depth case study design and was collected via interviews, observations, and documents such as field notes. For this research, grounded theory coding was used to analyze the data (Charmaz, 2006).

The entire research revolves around the understanding or framing of certain concepts and therefore are the findings structured after the main idea this project follows; '*the understanding of...'*. In this case, it is the personal and cultural dependent sense-making of mental health (incl. resilience and trauma) and support (incl. language, prevention, time, recovery, feelings, and relationships). The Kurdish understanding and framing of mental health are so new that it still lacks enough local knowledge to fully make sense of the concept, which increases the stigmatization and negative connotation of the term. Kurdish professionals acknowledge the importance of mental health support and emphasize awareness campaigns as a prevention strategy. The expectation from the recipients towards the support is a short-term medication to feel better. This does not meet the reality of the offered support which is often a long-term program without any medication. Due to the limited words that can be used to explain the concept of mental health, which is mainly shaped by the English language, the stigmatization of the support increases as well as the lack of understanding of how the Western world makes sense of it. The lack of expression of feelings, especially among men but also women, perpetuates the stigma around mental health and makes accepting Mental Health Support (MHS) seen as a weakness, whereas, in the West, there is a lot of attention towards feelings. The uncertain prospect of IDPs and the, therefore, lack of outlook on the future also makes long-term MHS seen as something not entirely essential. The Western perspective is more accustomed to the concept of mental health and its impact on livelihoods and had more time to research and explore the term, which makes it less stigmatized. The findings showed that not so much the different understanding of MHS is pivotal for the arising discrepancies, but more so the different experiences and contextual knowledge and thereby the communication of it.

To conclude, mental health projects in IDP camps lack sustainability, practicality, and cultural appropriateness. For humanitarian aid to fulfill its purpose, there needs to be a shift in how this work is realized, by decolonizing aid, which means localizing and including, by for example expanding the local education opportunities or offering women empowerment projects. Further, to offer support that is based on anonymity, that bears the necessary sensitivity when talking about mental health issues, and communicates that accordingly to the target group.

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List of Abbreviations

Abbreviation	*Definition*
CBT	Cognitive Behavioral Therapy
IDP	Internally Displaced Person
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organization
MHS	Mental Health Support
MHPSS	Mental Health and Psychosocial Support
NET	Narrative Exposure Therapy
NGO	Non-Governmental Organization
PTSD	Post-Traumatic Stress Disorder
UNDHR	United Nations Declaration of Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

1. Introduction

1.1 Background and Motivation

Iraq is the 9th most affected country in the world by internal displacement (IDMC, 2020). Despite the conflict against ISIS being officially over in 2017, Iraq remains deeply afflicted by insecurity, social unrest, and lack of livelihood opportunities, with, to this day, more than 1.6 million people being displaced for more than 3 years (IDMC, 2020). The high rate of displacement has left the Iraqi society with a large public mental health crisis (Sharma & Piachaud, 2011). This disaster has brought various humanitarian organizations and camp management to integrate support mechanisms regarding mental health in Iraqi Kurdistan's internally displaced person (IDP) camps, being a particular space between *"city and war"* which the citizens have to endure (Agier, 2002; Snider et al., 2013; Stevenson & Sutton, 2011). However, many of those initiatives dealing with disaster mental health, have been executed rather poorly (Isralowitz & Findley, 2016; Miller & Pescaroli, 2018; Miller & Wang, 2018). Most disaster mental health methods apply Western psychological theories, implementing psychological support by experts who are from outside of the affected community (Miller & Pescaroli, 2018).

1.2 Purpose and Research Question

The problem statement is that the Western understanding of mental health, being rather different from the people living in the IDP camps in Iraqi Kurdistan, impacts the project's effectiveness (Ibid). This is problematic because the approach reflects colonialist thinking in the sense of the so-called *'white gaze'- "the term for the process by which people and societies are viewed through the lens of White ethnocentrism, which assumes that Whiteness is the only reference of progress"* (Paige, 2021: 16 in Pailey, 2020). In general, there is limited research on how a different understanding of mental health issues has an impact on humanitarian aid and its ability to engage in those matters in a sustainable and culturally appropriate way (Ganasen et al., 2008; Ilcan & Rygiel, 2015; Neria et al., 2009; Stevenson & Sutton, 2011).

The aim and starting point of this research project is to understand the cultural assumptions made in regard to mental health. First and foremost, by asking direct questions to local professionals in Iraqi Kurdistan as well as to Western experts working in the context. The goal is to learn about what kind of consequences different understandings of mental health, based

on their cultural backgrounds, can have. The project incorporates, after the data collection, lessons learned and recommendations which then can be applied by various stakeholders. Overall, this research attempts to make the audience familiar with the Kurdish context and give insights into their experienced reality to create learning that goes both ways.

To reach the research's goal, the main research question *"What are the consequences of the discrepancy between Western and local understanding and framing of Mental Health Support (MHS) in IDP camps in Iraqi Kurdistan?"* is unpacked into the following sub-questions:

1. What is the (cultural) understanding of MHS from the Western perspective?
2. What is the (cultural) understanding of MHS from the Kurdish perspective?
3. What potential lessons learned can be identified?

The thesis is structured as follows. The next and second chapter will describe the methodology while motivating the data collection and analysis. The third chapter will deal with the conceptual background of the term mental health and its forms of support. The fourth chapter will give insights into the context of Iraqi Kurdistan. The fifth and main chapter of the thesis will present the findings and discuss them accordingly. Finally, the sixth chapter will conclude the research and give recommendations.

2. Methodology

This chapter will define the work plan as well as the roadmap of the conducted research. It will describe the methods used, how they were used and why they were chosen. Firstly, the selected methodology will be outlined and motivated.

2.1 Methodology Description and Motivation

To find answers to the research questions, the methodology is based on the grounded theory by Charmaz (2006). The grounded theory provides the research with a guideline that structures the data collection (Ibid). Charmaz's (2006) version of the grounded theory was chosen because it correlates with the research project's assumptions that no data or theories are discovered during research, but rather that the researcher, as part of the world, constructs its theories due to the involvement of different perspectives and interaction with other people. It allows flexibility and data to be gathered at all times, because '*all is data'* (Ibid). Grounded theory is especially fitting in the context of mental health and has gained popularity within this field over the years since it follows a non-linear process (Tweed & Charmaz, 2012). It is well suited to explore a wide range of open-ended research questions that emphasize actions, patterns, and meaning within a specific context (Ibid). This demands the essential analysis of subjectivity of understanding and thereby leads the researcher to start from their research participants' perspective (Ibid).

Based on the grounded theory, this research adhered to the following process (Tweed & Charmaz, 2012). The point of departure was the research question. Accordingly, participants were sampled and recruited, followed by the data collection and subsequent coding. The coding process started with focused coding and categorizing. To create categories and to analyze, data were constantly compared with each other. After the categories reached their saturation, the conceptual background was built and the research project written. The strictly inductive focus of grounded theory changes because the theoretical sampling combines both inductive and deductive components (Ibid). The following paragraphs will describe and motivate in more detail how the data was collected, selected, and analyzed.

2.2 Data Collection Description and Motivation

The nature of the topic, being highly sensitive, suggests the method of data collection, which was conducted in a qualitative way (Charmaz, 2006). The goal is to explore the understanding of mental health from the practitioner's perspective in each cultural context. A combination of interviews, observation, and documentation was chosen.

The data was mainly collected with semi-structured interviews with western psychologists working in the context of humanitarian aid in Iraqi Kurdistan and local mental health workers as well as professionals being responsible for implementing the structures and processes in building a mental health system in IDP camps (Charmaz, 2014). To collect the data via the qualitative method of interviews, an interview protocol was designed beforehand. A semi-structured guideline was chosen as the best fitting approach since it is based on certain theoretical assumptions (which will be clarified in more detail later) but also leaves room for topics to occur during the interview and deepen the understanding of other thematic areas which might be relevant (Schmidt, 2004). The questions which were asked during the interviews were based on the previously conducted literature review and had three main areas of interest (see Appendix A-D). First, how MHS is being approached; second to unpack the cultural understanding; and third to consider the aspect of language (Lakeman, 2013; Msall, 2018; Patterson, 2014; Tummala-Narra, 2007). The specific goals of the questions were to understand what frameworks are being used, how cultural adaptation takes place, what tools were used to assess the mental health state, what are the barriers to the provided support and what is the cultural understanding of mental health and its support in the respective cultural context (Ganasen et al., 2008; Hwang et al., 2008; Kirmayer et al., 2010). The overall purpose was to ask the participants to share their experienced reality and to reflect upon the above-mentioned aspects (Charmaz, 2006). The interviews also served the purpose of analyzing the situation in the field and how mental health projects are understood, implemented, integrated, and followed up.

The research is, therefore, not limited to the understanding of mental health issues, but emphasizes the culturally based understanding of mental health support. Due to the different levels of knowledge and areas of expertise between groups of interviewees, two different sets of interview guidelines were created. One for humanitarian aid workers who have been involved in mental health projects, and another for researchers/professionals, such as psychologists. The latter served as key informants for the subject of mental health. The interviews with those who

worked in the field were prioritized since the answers then could be used as statements for the expert key informants (i.e., psychologists). Interviews were carried out iteratively to draw the most accurate picture of the experienced reality. The first interviews were used as pilots and participants were asked to give feedback on the questions as well as on the thematic areas. This way the interview guideline could evolve over the period of the data collection and be adapted to the needs of the research (Charmaz, 2006).

Beyond that, to be able to observe the participants and understand the local context, the data was collected in field research, where the researcher conducted the interviews mainly in person in Iraqi Kurdistan (Kawulich, 2005). The benefit of being present and directly involved in the interviews is that participant observations could be used, not as a data collection technique itself, but to facilitate the data collection process (Angrosino, 2007). Observations served the technique called verisimilitude, which aided in writing the results section, to draw the reader into the story that has been analyzed and to evoke a feeling of understanding (Ibid). The byproduct, next to the interviews, were therefore also field notes as written evidence of observational data created by fieldwork (Montgomery & Bailey, 2007).

To sum up, the data collection had an inductive approach within a single in-depth case study design (Charmaz, 2006). The data was collected via interviews, observations, and documents such as field notes (Ibid). This research project focuses on the area in northern Iraq, mainly including the cities of Erbil and Dahuk . The contextual background will be further elaborated in chapter four. Whereby the interviews' purpose was to gather raw data from professionals which can be analyzed and interpreted, the observations' purpose was to gain freely drafted reflections, to be able to tell a *'story',* for the reader to acquire a better understanding (Angrosino, 2007; Ibid). How the data sources were collected will describe and motivate the next section.

2.3 Data Collection Sources

As previously mentioned, the data collection should be as diverse as possible, therefore the '*maximum variation'* was chosen as the type of sampling (Creswell, 2013). The purpose was to have documentation about distinct variations of individuals or sites, based on specific characteristics (Ibid). To reach that diversity, the snowball system was used to identify cases of interest from participants who know other possible participants, which then expanded to an opportunistic/purposive sampling (Ibid). The source of data came from a semi-natural setting which involves asking individuals to report their attitudes, knowledge, values, and beliefs (Blaikie, 2010).

Each individual was chosen based on certain criteria. All participants had to be involved to some degree in mental health projects for IDPs in Iraqi Kurdistan or needed to be professionals in the context of mental health. Those criteria were put in place since the questions asked required previous knowledge about mental health (projects). The research targeted the providers of such support instead of the receivers out of accessibility as well as ethical reasons (Tarvydas, Levers & Teahen, 2017). Besides the general research ethics, the choice of topic holds specific ethical challenges, due to the sensitivity of the subject and target group (Siriwardhana et al., 2013). IDPs are especially vulnerable due to their unprotected status (Ibid). Further, interviewing individuals on their mental health issues is highly sensitive and would have required going through a research ethics approval which is not available to this research project, due to time and scope limitations.

The goal was that at least half of the total number of interviewees were Kurdish and the other half from the West, since the western perspective is wider spread among scholars than the Kurdish view on mental health support. The advantage was that all western participants have also been working or are working in the Kurdish context and therefore could underline the discrepancies between their understanding and what is practiced in the local context. As mentioned before, the target group was divided into two separate groups, one being humanitarian aid workers and one being researchers/professionals. This clear line became blurry since also all researchers/professionals have been working directly or indirectly with IDPs. The given freedom of the semi-structured interview guideline was used to adapt to the reality of the context.

The table below displays each interviewee, their country of birth, their broad profession, their sex as well as if the interview was held in person or online via Zoom, and how long it took. Additionally, whether a transcript was created or handwritten notes were taken. The interviews were in general transcribed literary since the level of English varied enormously among the interviewees (Kowal & O'Connell, 2014). Only for one interview, a translator was needed. The translation took place on the spot and was transcribed after what the translator said. For those where notes were taken, the interviewee did not want to be recorded. Further, no more details are being revealed since each interviewee was promised confidentiality and personal information were made anonymous (Charmaz, 2014).

Table 1: Interviewees

Interviewee	Country/Region of birth	Profession	Sex	Setting	Duration
1	Iraqi Kurdistan	Doctor	Male	In person - transcript	25min
2	Iraqi Kurdistan	Research Assistant	Male	In person - notes	20min
3	Iraqi Kurdistan	Mental Health Worker	Female	In person - transcript	60min
4	Iraqi Kurdistan	Project Manager	Male	Online - transcript	40min
5	Iraqi Kurdistan	Psychologist	Male	Online - transcript	60min
6	Iraqi Kurdistan	Founder of an NGO	Female	Online - transcript	45min
7	Iraqi Kurdistan	Psychologist	Male	In person - transcript (together with Interviewee eight)	30min
8	XXX	Founder of an NGO	Female	In person - transcript (together with Interviewee seven)	30min
9	Netherlands	Mental Health Clinic Coordinator	Female	Online - transcript	60min
10	North America	MHPSS Technical Advisor	Female	Online - transcript	40min
11	Netherlands	Psychologist	Female	Online - transcript	105min
12	Germany	Advisor on mental health projects	Female	In person - transcript	60min
13	Germany	Coordinator for a psychologist program	Male	Online - notes	25min

In total, 20 interviewees were contacted. Twelve interviews took place with 13 different participants. Seven of them have a Kurdish background, two have Kurdish parents but grew up in the West, and three are from the West. All of them, even with such different professions, have been involved in providing mental health projects in Iraqi Kurdistan for IDPs or offering support themselves. Of those 13 different participants, six were male and seven were female. The shortest interview lasted 20 minutes and the longest was one hour and 105 minutes (see Table 1).

While selecting the data source, four general ethical principles were paid attention to: (1) 'whether there is *harm to participants; (2)* whether there is a *lack of informed consent;* (3) whether there is an *invasion of privacy;* or *(4)* whether *deception* is involved' (Bryman, 2012: 135). It was kept in mind that direct or indirect participants did not have to sacrifice their working time to take part in the research (Siriwardhana et al., 2013). Further, non-maleficence practices were carried out to limit the potential harm to the participants and the findings were discussed in non-academic language (Ibid).

2.4 Data Analysis

For this research, grounded theory coding was used to analyze the data (Charmaz, 2006). The logic of initial coding was adopted, which means to remain open and explore whatever theoretical possibilities arise from the data. Thus, it was coded for sequence rather than for frequency to possibly find a form of causation between the codes. Hence, the overall approach was a combination of focused and theoretical coding (Ibid).

To learn from the data, it was first divided into the four research questions. While going through the transcripts, quotes that indicated an answer to one of the questions were put together. This step purely served the purpose of structuring the large amount of data and staying close to it. *'In Vivo* coding or *'verbatim'* coding was used, which is based on the participant's own words, to prevent interpretation errors, due to the different cultural contexts (Manning, 2017; Saldaña, 2021). The next step was to go through the data a second time, to then discover what codes arise, such as patterns or relationships, to explain why things happen - to move from focused to theoretical coding (Charmaz, 2006). This process ended as soon as categories were saturated, i.e., when new data did not reveal any new insights for the theoretical coding (Ibid).

Based on this method, the overall coding structure had one general theme, namely the understanding of two main concepts - the understanding of mental health and support (see Figure 1). Each concept revealed sub conceptions, hence sub-codes, which influenced the overall understanding of the main code and therefore formed one unit. For example, the understanding of mental health was linked to the understanding of resilience and trauma. The understanding of support was affected by the use of words, expression of feelings, societal relationships, attitude to the future, and understanding of prevention as well as recovery, in the context of Iraqi Kurdistan. These concepts were found during the literature review and were already mentioned in the questions asked during the interviews (see Appendix A – D). Therefore, the interview guideline, based on the literature review was the framework for analyzing the data and helped to define the above-mentioned categories. Within this framework, however, there was still space for whatever the data might newly suggest, which, in this case, was rather the correlation between the codes than the codes themselves.

All codes were divided between the Western and Kurdish perspectives and when a Western interviewee had an impression of the Kurdish understanding, it was marked accordingly, in order to be taken into consideration while analyzing. Both perspectives in each code were

compared with each other and keywords, similarities, as well as differences, were highlighted. Lastly, three more codes were created, namely challenges, consequences, and lessons learned, based on the comparison and quotes from the interviews, to be able to answer the main research question (see Figure 1). The criteria for each code were that the according quote had to describe the concept it was assigned to (see Appendix E). Tools used were NVivo to code and Excel to categorize and divide the data.

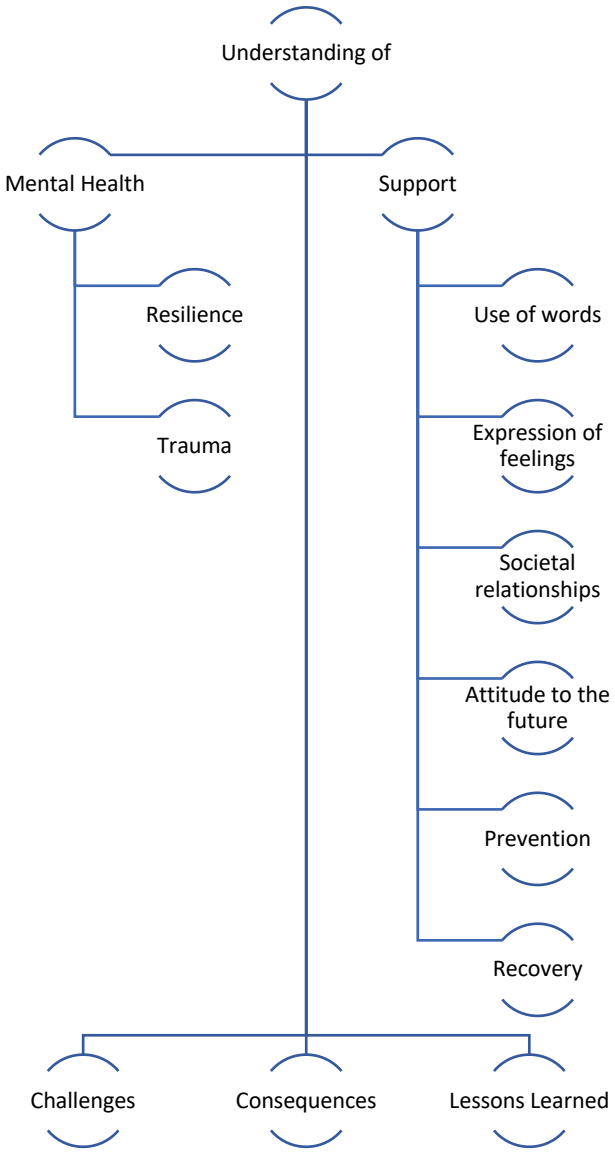

Figure 1: Coding structure

2.5 Limitations

Conceptual limitations regarding this research project are given by the nature of this topic and its context. It is intended to analyze the cultural understanding of highly sensitive concepts by someone who is not from that culture and has its own *"racialized and cultural system"* (Milner IV, 2007: 388). The data were analyzed as well as interpreted by someone different in power, status, sex, race, and age (Charmaz, 2006). Those dynamics limit, especially qualitative research, where interviews took place, by possibly unconsciously misinterpreting the data. Therefore, it is impossible to present the data in a value-free and unbiased way. Nonetheless, the chosen topic is based on the assumption that individual mental well-being is essential and has a strong impact on livelihoods.

The underlying research project's assumptions are that it does not matter what we truly believe in (Blaikie, 2010). For example, whether reality exists without the mind. What matters is that the consequences are real (Ibid). The research wants to make sense of each reality and find certain factors in which the felt reality does not match with each other.

It is essential to fathom that cultural knowledge constructions and practices are under no circumstances the only means by which the world is understood and experienced (Patterson, 2014). Therefore, the research is limited in the way that it does not aim to reflect the general understanding of MHS in Iraqi Kurdistan or from the Western perspective. Rather to give insights and a starting point of making this understanding common knowledge, due to its underrepresentation (Fryer et al., 2016). It is important to note that it is not the research goal to generalize, homogenize or speak for other people (Maxwell & Chmiel, 2014). It can rather be seen as a channel to reflect on other perspectives and compare them with those which are more established, to bring awareness to possible consequences. The data only mirrors the experienced reality of those who have been interviewed. This limits the validity and reliability of the explorative single case study design (Quintão, Andrade & Almeida, 2020). However, the collected data could inform other similar contexts from the perspective of the main research question. The findings are valid and might apply to other similar cases but this cannot be taken as given. This study can be seen as one case, one reality, and one way to make knowledge accessible (Blaikie, 2010). This could be replicated but this replication will create another reality (Ibid).

3. Conceptual background – Mental Health

This chapter will introduce conceptual clarification and aims to provide a clear scope for the research. It will review and discuss the literature establishing the concepts of mental health, including trauma, resilience, prevention, and recovery in the context of culture and its so far identified consequences on the provided MHS for IDPs. The latter mainly arose due to the scope of the research and are based on the understanding that each definition is shaped by the culture that defines it (Galderisi et al., 2015).

3.1 Disaster Mental Health

Mental ill-health is a wide term used for numerous conditions such as '*post-traumatic stress disorder (PTSD), depression, substance abuse, prolonged grief*, or even as a consequence of chronic and prolonged *physical illness*' (Neria, Galea & Norris, 2012: 594). *"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (WHO, 2022). Thus, mental health is an essential element of health. *"There is no health without mental health*" (Ibid).

The awareness of the interconnectedness of mental health is fairly new, to a degree where policies, procedures, and support mechanisms in humanitarian aid, have not been followed up (Tol et al., 2011a). Nonetheless, the importance of mental health as a non-communicable disease has been gradually recognized by various crucial actors in the humanitarian context, such as IFRC, WHO, UNICEF, or UNDHR (American Psychological Association, 2003; Inter-Agency Standing Committee; 2006; WHO, 2011). Mental ill-health is a complex factor of health in general, due to its '*invisibility*' compared to a physical disease and negative influence on other aspects like livelihoods (Demaio et al., 2013).

Disasters, such as earthquakes, floods, and wars can impact livelihoods and change one's environment (Ibid). This can be associated with loss of stability and ensuing traumatic experiences (Goldmann & Galea, 2014). Those burdensome incidents, due to their large impact on livelihoods, can negatively influence the mental health state of the victims (Ibid). A disaster follows certain phases over time and so does its victim's mental health state (Math et al., 2015). Immediately after a disaster strikes, survivors show altruistic behavior in the form of rescuing, sheltering, feeding, and supporting other victims (Ibid). Once relief organizations intervene, people who have remained can be relocated to a safer place such as relief camps, or are forced to find that safe place themselves (Ibid). For instance, one outcome, due to war, is (forced) migration or displacement (Adanu & Johnson, 2009). There are different forms of (forced) migration. Refugees for example are people who left their country and crossed an international

border, whereas IDPs also have been forced to leave their homes, but still reside in their own country (Castles, 2006). Those IDPs then come to live in relief camps built by either the local government or international humanitarian organizations, which ideally function as a temporary solution but often turn out to be a long-term way of living (Ilcan, & Rygiel, 2015). Those camps are far from an ideal living situation with crowded spaces, lack of electricity, or the fulfillment of basic needs such as food, water, or access to sanitary facilities (Kim, Torbay & Lawry, 2007). As soon as the involvement of external organizations is phased out, victims face post-disaster life, where the reality of rebuilding and rehabilitating appears to be far in the future, due to administration hurdles, discrimination, injustice, or corruption (Math et al., 2015). Those exceptional circumstances need to be withstood and endured for a prolonged time by the citizens (Stevenson & Sutton, 2011). This would either lead to mental health issues occurring or worsen existing ones (Math et al., 2015).

3.2 Mental Health and Psychosocial Support – Conceptual delimitation

Mental health and psychosocial support[1] (MHPSS) indicates any form of support that is directed toward the protection or promotion of psychosocial well-being and thereby trying to prevent or manage mental disorders (UNHCR, 2022). The overall goal of MHPSS is to assist people during their recovery phase to prevent relapses by offering coping strategies for the recipient to be able to adapt to new living conditions (Ibid). In short, to enhance the individual's resilience (Davydov et al., 2010).

To be able to enhance one's resilience, especially as an external person, it is essential to explore the term resilience and its meaning in this context (Ibid). Preventing, coping, recovering, and adaptation are all theoretically embedded in the term resilience (Becker, 2014). Resilience is an exceptionally complex concept and contains numerous aspects of art, law, science as well as engineering, but can be useful when describing individuals' states of mind or behaviors (Alexander, 2013). However, the lack of agreement and controversial opinions about what it means and entails creates confusion among scholars as well as practitioners in the field of how to reach the overall goal of MHS (Southwick et al., 2014). The definition of resilience is dependent on which discipline it is applied to, but even within one field, opinions widely differ (Ibid). The American Psychological Association (2014) defines resilience as *"the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress",* which does not reflect the complex nature of resilience according to various scholars

[1] The research intentionally focused on the mental health aspect and therefore is also referred to as mental health support (MHS).

(Ibid:2). Overall, resilience can be described as the '*ability to adapt*', which presumes to not only bounce back to a prior function and to recover, but more so to move forward (Becker, 2014; Pendall, Foster & Cowell, 2010; Southwick et al., 2014). For most individuals, recovering is considered a synonym for a cure, implying that the person will find their way back to the conditions that existed before the onset of mental illness (Davidson, & Roe, 2007). However, it is possible to go a little further and not only recover **from** but **in** mental illness, which involves the process of living one's life and pursuing one's hopes while facing the presence of an illness. This process entails identifying one's strengths, minimizing the destructive impact on the individuals to make their own decisions, following their dreams and pursuing the activities they enjoy (Ibid). Thus, adaptation means to not only bounce back to the mental state that was there before a traumatic experience, but to move forward and adapt to constant change. Therefore, adaptation incorporates pro- and reactive functions of preventing, coping, and recovering (Becker, 2014).

While trying to find a definition for resilience it is important to determine whether resilience is understood as capacity, process, resource, or outcome (Southwick et al., 2014). This understanding is dependent on the culture and environment it is applied to (Ibid). Culture can be seen as an "*idea to think with"* and as *"patterns in a way of life characteristic"* where the patterns reflect the *"successful adaptation to relatively stable environmental (economic, social, and political) conditions*" (Eisenhart, 2001 in Carlone & Johnson 2012:151,153,154). Therefore, culture influences interactional behavior (assumptions, values, and beliefs), knowledge activation, and the communication of it (Patterson, 2014). How prevention, coping mechanisms, and recovery can take place and how they should take place is dependent on the cultural context (Southwick et al., 2014).

For example, in certain cultures, prevention or preparedness can be seen as something that is not necessary, useful, or even valuable (Ibid). Preventive strategies aim to reduce the risk or likelihood of mental ill-health occurring and therefore need to be carried out before the onset of the illness to have the largest effect (Coppola, 2006; WHO, 2002). Nevertheless, it is also a possibility to reduce risk consequences, by reducing the severity, course, and duration of the illness (Ibid). A way to do this is by promoting mental health to enable people to take control and improve their health and, ultimately, to appeal to the general public or individual's capacity to adapt (WHO, 1986). The strategy is to promote mental health with a positive connotation instead of portraying the negative consequences of mental ill health (WHO, 2002). Yet again, the successful framing of mental health promotion is dependent on the context and culture it is practiced in (Ibid). Another example of how culture influences behavior is that psychological

or emotional distress can be expressed differently (Fischer, Jome & Atkinson, 1998). Particular coping mechanisms can be differently powerful, as in the cases of religion and belief systems (Georg et al., 2000). Further, in some cultures, it is generally not accepted to seek help and where to go for culturally appropriate support varies (Hwang et al., 2008). Additionally, how trauma is experienced differs from context to context (Kirmayer et al., 2010). The term trauma was originally used to describe a physical injury. However, since the late 1800s, trauma also came to refer to a spectrum of psychological impacts resulting from violence, injury or loss, and traumatic events (Leys, 2000). Culture determines the experience, perception, and interpretation of such events and their sense-making of them (Ibid).

Those cultural implications need to be taken into consideration during practical responses and the lack of attention to such undermines the effectiveness of well-intentioned humanitarian support (Kirmayer et al., 2010). Therefore, to provide citizens of a camp with the appropriate MHPSS, it is essential to understand how their culture influences their perceptions and what consequences it has on aid. With the slowly growing recognition of the importance of mental health among IDPs, various international humanitarian organizations have designed projects and guidelines to ensure an appropriate support system (American Psychological Association, 2003; Inter-Agency Standing Committee; 2006; WHO, 2011). The following section will explain why this system may neither be sustainable, culturally appropriate, or practical within the context of IDPs. The ineffectiveness, cultural inappropriateness, and impracticality are the conceptual conditions that contribute to the overall problematization this study deals with. The following section will establish the background to the complex question this research poses.

3.3 Mental Health and Psychosocial Support – Conceptual conditions

Support can be approached differently and there are various forms of it. One approach to deal with disaster mental health is to offer MHPSS with specially designed projects implemented by international NGOs and guided by psychologists (Miller & Pescaroli, 2018). Those projects incorporate for example narrative exposure therapy (NET), meditations, mindfulness exercises, or cognitive behavioral therapy (CBT) (Robjant & Fazel, 2010; Singh et al., 2008).

They are directed by various guidelines which, in some cases, could contribute to the challenges and pitfalls MHPSS encounters in the context of the displaced population (Ventevogel, 2018). Those guidelines were created by different international organizations or standards such as the '*Sphere Handbook'* or the *'ISAC Guidelines'* shaped by WHO, UNICEF, and UNHCR (Ibid). The reason why those guidelines were designed is due to the lack of suitable information, needs assessment, inadequate coordination, or the tendency of implementing organizations to

emphasize their success while minimizing and downplaying critical issues (Eloul et al., 2013; Ventevogel, 2018). The purpose of those guidelines is to standardize common procedures (Ibid) and to meet the problem of complex humanitarian emergencies and badly coordinated services (Fritsche, 2001; Ventevogel, 2018). The main issue with most of these guidelines is that the framework used views mental health disorders as the endpoint rather than the beginning of an imbalance in social aspects being an expression of problems occurring on an individual level (Silove, Ventevogel & Rees, 2017). The discourse is embedded in the Western context and makes this specific cultural and moral groundwork problematic for contexts that are culturally and contextually different from such (Kienzler, 2008). In addition, there is a lack of collaboration between international actors and local government as well as local NGOs (Dickson & Bangpan 2018), even though research found that such collaboration can benefit the development of mental health projects (Budosan & Bruno, 2011). These benefits include, for instance, trust building by making the support community based on a participatory approach (Ibid). Trust building is fundamental because of how projects can be designed and implemented (Paige, 2021). It mirrors colonialist structures within humanitarian aid. It is the perfect example of how today's unequally distributed power structures are interconnected with what is seen as knowledge or whose expertise is valued (Ibid). This is problematic when one perspective is always seen as '*superior'* (American Psychological Association, 2003). Psychologists, like everyone else, are influenced and shaped by their cultural heritage, which is recognized by almost all guidelines, but not truly addressed (Ibid).

For example, language is part of a culture (Nilsen, 2016). Our used language determines what is seen as '*true*', *'better',* or what is even seen as '*reality'* and with that, what is considered '*knowledge*' (Ibid; Klintman, 2021). As Hearn (2012) concludes in his article, the idea of power is explored mainly by Western cultures and understood, described, and grasped through the English language. With the power of language, mental health is mostly outlined by a Western-focused approach (Lakeman, 2013). Most literature about MHPSS has the underlying assumption of a Western understanding of it (Ibid). This is also reflected by Tol et al. (2011b), concluding that most research questions highlight the integration of perspectives from affected people and the need to strengthen local research, thereby confirming their dominance.

Furthermore, issues of funding and finance cannot be ignored, where MHPSS projects are funded by one donor who already decides beforehand the objectives and expected results with almost no wiggle room to adapt to the local context (Paige, 2021). Most donors are Western-based or from the northern hemisphere and will ultimately design a project with, consciously or unconsciously, Western-based assumptions, values, and beliefs (Ibid). This is also confirmed by another study from Tol et al. (2011a), summarizing that most MHPSS is applied and funded outside of the local or national context, if it is funded at all (Ventevogel, 2018).

The way MHPSS is designed and imposed within humanitarian aid is problematic in many ways and mostly stems from the cultural discrepancies as outlined before. Conceptually MHPSS has been narrowed down. How this support is contextually influenced by the environment of IDP camps in Iraqi Kurdistan will be showcased in the next chapter.

4. Contextual analysis - Iraqi Kurdistan

Various contextual aspects impact the feasibility and cultural appropriateness of internationally offered MHS in IDP camps and further complicate their work (Ommeren, 2015). Therefore, this chapter aims to shortly present and analyze Iraqi Kurdistan geographically, historically, politically, and in societal aspects. Iraqi Kurdistan has an extensive and complex past and therefore only factors helping to understand the specific context of MHS for IDPs will be defined. This serves as the contextual groundwork for the research findings which will be described in the following chapter.

4.1 Iraqi Kurdistan – 'Safe haven'

Iraqi Kurdistan is an area that experiences constant change, geographically as well as in terms of social and economic aspects (Stansfield, 2003). Geographically, Kurdistan has no official borders and expands into Turkey, Iran, Syria as well as Iraq (Ibid; see Figure 2).

Figure 2: Map of Iraqi Kurdistan adapted from Stansfield (2003: 28), identified by population distribution

Kurdistan is not a recognized state since neighboring countries deny the existence of *"a contiguous Kurdish geographical entity"* (Ibid: 27). It is mostly referred to as the *"land or region inhabited by the Kurds"*(Ibid). However, defining Iraqi Kurdistan became academically relevant after a Kurdish–controlled region in Northern Iraq was involved in the aftermath of the Gulf War in 1991 (Ibid). Post-Gulf war changes in Iraq had different regional development paces as a consequence (Natali, 2007). The central, as well as southern areas, had to deal with severe political and economic instability whereas the Kurdish north benefitted from growth and stability and became internationally legitimized (Ibid).

The area has experienced exceptional support from international humanitarian organizations and therefore became a humanitarian *"Safe Haven"* by 1995 (Leezenberg, 2000:31). After enduring the Iran-Iraq war and Saddam's totalitarian regime including human rights abuses, such as torture and ethnic cleansing, Iraqi Kurdistan was, and still is, an appreciated refuge for IDPs (Amowitz et al., 2004; Leezenberg, 2005; Romano, 2005). Iraqi Kurdistan is nowadays past the reconstruction phase and its infrastructural facilities education and medical systems are meeting regional standards (Leezenberg, 2005). Humanitarian aid has played an important role in building such systems (Leezenberg, 2000). Up to today at least 109 international NGOs and 85 NGOs are present in Iraqi Kurdistan *(Last updated 17 October 2021)* (NCCI, 2022). Therefore, international humanitarian aid organizations also were and are involved in shaping the mental health system in Iraqi Kurdistan (Sharma & Piachaud, 2011). However, not all efforts on behalf of international NGOs were praised and some scholars see their intervention as rather problematic with paradoxical consequences and missed local solutions (Leezenberg, 2000). The nature of aid can favor some over others and therefore on one hand negatively affect conflict and on the other hand enhance local development as well as establish international relationships (Natali, 2007). Humanitarian aid programs can have a different impact on local development and change over time which makes them unpredictable in terms of the outcome and influence, especially when the context is quite diverse (Ibid).

4.2 Iraqi Kurdistan – 'A complex cultural melting pot'

Iraqi Kurdistan is situated in an extremely diverse context (Ibid). Even though Iraqi Kurdistan seems comparably stable, it is situated in one of the most unstable areas in a particularly volatile region with a complex political and population geography (Stansfield, 2003). Through the influx of Iraqi IDPs over time, ethnic groups consist of Kurds, Assyrians, Arabs, Yezidis, Shabaks, and Mandeans with three main religions, namely Muslim, Christian, and Yezidi (GOV.KRD, 2022; Shanks, 2019). Languages spoken are mainly Arabic or Kurdish, including the Sorani and Badhinani dialects, which are distinctly different from each other (Stansfield, 2003). This leaves the population with a communication issue that bears various sensitive political implications (Khedir, 2021). For example, Arabs do not see the necessity to learn Kurdish or vice versa (Ibid). The fact that Kurdistan is not an independent state with various ethnicities claiming demographic dominance makes the language one speaks a political statement (Shanks, 2019).

Not only do those different languages and dialects pose an obstacle within society and for INGOs in the region, but also for the different ethnicities and religions, which come to live side by side, due to (forced) migration (Stansfield, 2003). For example, one of the Kurdish religious minorities is the Yezidis (Msall, 2018). Yezidis, identify themselves as Kurdish but have different religious views and cultural norms, which makes them unique within the IDP population in Iraqi Kurdistan (Ibid; Stansfield, 2003). They are often referred to as "*devil worshipers"* and were persecuted which led to an influx of Yezidi IDPs after the invasion of ISIS (Msall, 2018: 1). That resulted in a rapid change among the whole population in Iraq and made IDPs the opposite of a homogenous group (Ibid). This is also reflected in the latest report from IOM about '*Urban Displacement in the Kurdistan Region of Iraq'*, rating the main cities (Dahuk, Erbil, Sulaymaniyah, and Zakho), between fairly homogenous and heterogeneous (DTM, 2022).

In addition, those IDPs who are living in a camp, face a return issue (Ibid). From today's 664,237 IDPs living in Iraqi Kurdistan *(August 2021)* no one has returned yet *(September 2021)* (KRSO, 2022). Even though a return seems possible, the good security situation in Iraqi Kurdistan leads people to stay displaced (DTM, 2022; Khedir, 2021). Especially, ethnic minorities, such as the Yezidis, tend to choose to remain permanently (Khedir, 2021). However, their livelihoods can hardly compare to the pre-crisis level, with basic needs barely met (DTM, 2022).

Especially female-headed households are less likely to return, mostly because they are more vulnerable (DTM, 2022). More vulnerable because of the male dominant society in which the women's role has been often overlooked (Bagheri, 2021). Women's participation in civil society is certainly limited because of national laws which are discriminatory and more so societal attitudes (Kaya, 2017). The Iraqi Kurdish society is a patriarchal one, to the extent where Kurdish women are banned from high-political positions and essential decision-making processes (Bagheri, 2021). In the eyes of society, women are *"morally pure, good, mothers and virtuous wives"* who ideally hope for early marriage and remain sexually abstinent, until then, to not shame their families (Ibid:15). Gender-based violence, honor crimes, and female genital mutilations are still common practices (Shabila, 2021), which are an apparent violation of women's and girls' rights and a severe kind of discrimination (Bagheri, 2021; Ibid). However, it is important to note that Iraqi Kurdish women are comparably empowered and did play a role in shaping the political system (Bagheri, 2021). Further, the Iraqi Kurdish society shows collectivist and hierarchical characteristics, where social support is seen as a family matter and decisions are made by the more powerful, men (Al-Ali & Pratt, 2011).

Primary needs for IDPs are medical care, food, repaying debts, support of extended family, paying for a new shelter, education, and clothing. Noted advantages of living in their current location, albeit being displaced, are the good security situation, freedom of movement, and functioning healthcare systems and schools. Interestingly enough, psychosocial care, in all main cities, was noted as the worst aspect of living in the current location (Ibid). A reason for the perceived insufficient care could be that MHS has been neglected by the government over the years (Sharma, & Piachaud, 2011). Therefore, it is no surprise that the consequently attached stigma to mental illness is imposing another challenge on society and its support system (Ibid). As those camps barely manage to meet basic needs, MHPSS is only considered in certain guidelines of how a camp ideally should be built and designed (Karsu, Kara & Selvi, 2019). However, that is far from reality and even though IDPs are in an extraordinary situation they do not lose their human right to exactly this kind of support (Lee, 1996).

4.3 Iraqi Kurdistan - Interim conclusion

Iraqi Kurdistan is a '*Safe Haven'* for IDPs which makes return a long-lasting process. It is past the emergency state and slowly transitioning towards a development phase, where now an essential part is to recognize the longing of individuals to take an active part in daily life and the importance of the community's well-being (REACH, 2021; Stevenson, & Sutton, 2011). This indicates that MHS is more than ever a crucial aspect to improve the livelihoods of IDPs living in Iraqi Kurdistan. IDPs still have pressing needs, with MHPSS being one of them (DTM, 2022).

The **(a)** complex history, **(b)** the continuous fight for independence, **(c)** the great positive as well as negative influence of international humanitarian organizations, **(d)** the diversity of the population, **(e)** the highly sensitive political situation, **(f)** the fact that IDP's face a return issue and are mostly not well taken care of, **(g)** the negligence of MHS and the **(h)** patriarchal, collectivistic and hierarchical structures are all impacting not only the feasibility and cultural appropriateness of internationally offered MHS but also the understanding and framing of such.

The next chapter, with the lens of such contextual factors, will present the findings of the two sub-research-questions and thereby answer the main research question:

1. What is the (cultural) understanding of MHS from the Western perspective?
2. What is the (cultural) understanding of MHS from the Kurdish perspective?

The following chapter will outline the cultural understanding and framing of MHS from the Western as well as Kurdish perspectives to then conclude with the consequences of the discrepancy between the two. Finally, lessons learned and recommendations will be presented.

5. Results and Discussion

Throughout this chapter, it will be shown what consequences the relationship towards mental health has on the MHS provided by international humanitarian aid organizations. Raw data in the form of quotes will back up the statements made. Quotes were chosen based on their significance and how well they reflect the general point of view among the interviewees.

The conceptual background already highlighted the understanding of MHS from the Western angle since the literature is mainly shaped by the Western perspective. Therefore, the results and discussion will focus on the Kurdish context because knowledge about their point of view is still lacking. The goal is to provide a first insight into the case-specific contextual knowledge about mental health.

The entire research revolves around the understanding or framing of certain concepts and therefore the findings are structured after the main idea this project follows; '*the understanding of...'*. In this case, it is the personal and cultural dependent sense-making of mental health (incl. resilience and trauma) and support (incl. language, prevention, time, recovery, feelings, and relationships). The classification of the results is already a finding in themselves since during the analysis, based on the approach of coding, it became evident which aspects influence which concept. Therefore, it emerged that the understanding of mental health is influenced by how resilience and trauma are framed and *vice versa*. It is important to note that those are, of course, not the only factors influencing the understanding of mental health, but are the main ones found during the analysis. The understanding of MHS is mainly shaped by the language spoken, whether feelings can be openly expressed, attitudes to the future, what form of relationships are usually formed within society, whether prevention is practiced and how recovery takes place.

The following sub-sections will present each finding on its own to then be able to view the bigger picture and answer the main research question. To interpret the Kurdish framing of MHS, the understanding of mental health needs to be analyzed before. This will be discussed in the next subsection. Throughout, the Kurdish perspective will be compared with the Western point of view to emphasize the understanding from both sides as well as in relation to each other.

5.1 Understanding of Mental Health

Keywords used to describe mental health from the Kurdish perspective were *multidisciplinary; being active; to develop; having relationships (with yourself and others); agency; lack of knowledge/understanding; crazy; a sin; affects body and mind; it's a weakness* (see Appendix E).

Keywords from the Western perspective were to *realize own ability; balance; daily; in connection to resilience and capacity; to be able to cope; feel positive; to function; to take care of oneself* (see Appendix E).

The main difference between both is that mental health is still very much stigmatized in Iraqi Kurdistan, as already mentioned during the contextual analysis. Therefore, mental health has rather a negative connotation. It is mainly described as a sickness rather than a tool to improve one's life. It is important to note that that was not the professionals' own opinion, but what they hear from their patients and other society members they talk to.

"It's a disease, it's useless"
(Interviewee 1, Kurdish Doctor)

Further, it became evident that there is a general lack of understanding of mental health in the Iraqi Kurdish society and what it means to be mentally ill since the field of psychology and the occupation of therapists are rather new (Interviewee 4). Education programs have not followed the *'trend'* of recognizing the importance of mental health with just one master's program in place. The issue with only one master's program in place is that a master's degree is often needed to be hired by an NGO or INGO. The interest is there, with yearly more applicants for the master's program than they take, but the lack of opportunities to start a career led to an enormous lack of local staff (Interviewee 13). Being a therapist is not a secure occupation in Iraqi Kurdistan. Many strive for government employment since it also covers their pension (Interviewee 10). This contributes to the overall issue of society not being able to learn about mental health issues from their perspective due to the lack of local education leading to either a lack of interest or lack of professional opportunities.

The newness of mental health as a concept in Iraqi Kurdistan suggests that if there is someone who takes care of their mental health state, is different from the rest of the society, which increases the stigmatization of it and forms the actual barriers to seeking help (Interviewee 5). Different in the sense of taking care of oneself or taking care of the personal mental health state. One Kurdish Interviewee mentioned, for example, meditation as one method, and as a professional, he understands that it will help him. However, since most of society does not do this, the ones who do take care of themselves, mentally, will be seen as *"abnormal"*(Interviewee 5). This creates a barrier to looking after yourself by seeking help since it would mean being different in the community, which is certainly challenging to be in a collectivistic society.

From the Western perspective, mental health is something that is increasingly part of daily life. In that sense, the Western and Kurdish professionals have a similar understanding that there is not enough awareness and understanding about mental health in the Kurdish society, but that is important to take care of oneself. One Western Interviewee said that especially the idea of self-care is a *"big buzzword in the humanitarian work right now"* and that comes with knowing how to get support and knowing how to *"keep yourself filled up when you are depleted"* (Interviewee 11, Dutch/Kurdish psychologist), which is not common knowledge in Iraqi Kurdistan. To be able to take care of oneself, both agree that the environment plays a crucial role. Also, both acknowledge that there is a tendency for dichotomous thinking in the Kurdish society, which would explain the negative connotations when describing mental health or mental ill-health (Interviewees 3 & 12). This highlights the severity that is attributed to mental ill-health from the Kurdish perspective, whereas in most Western societies it is normalized in the sense that even if someone is mentally-ill it can be dealt with and it is not shameful or a weakness per se.

"So, I think it has, just until now, it's only been perceived as that there's everybody's normal. And if you're not normal, you're sick."

(Interviewee 12, German mental health project advisor)

5.1.1 Understanding of Resilience

The environment was also a factor mentioned from both perspectives that, positively, influences resilience. For example, the environment was described as supportive, accepting, stable, and safe (Interviewee 6). Other similarities were that being educated in the sense of knowing yourself (e.g., emotions and reactions) play a crucial role in whether someone is resilient or not. Common keywords mentioned were *to have control; to accept; to be strong, confident, empowered,* and *to cope* (see Appendix E).

Both describe resilience as a resource, which is interesting looking back to the conceptual background, mentioning that it is certainly culturally dependent on whether resilience is understood as a capacity, process, resource, or outcome (Southwick et al., 2014). In this case, both agree on resilience being a resource. However, from the Kurdish perspective that is not necessarily something positive. One Kurdish interviewee did not view resilience as an improvement (which is normally attributed to the term from the Western perspective), but rather recognize it as something *'you have to do'* (Interviewee 5). This brings the aspect of voluntariness of resilience into the conversation. The main difference between both perspectives is that negative events make you stronger versus you having to be strong to endure negative events. While for the Kurdish interviewee's resilience is a way to adapt and move on (Interviewee 5), from the Western perspective it is mainly a coping mechanism to bounce back, whereas in the Kurdish context there is no stable status quo to go back to in an environment that is seldom stable or safe (Interviewee 10).

Interestingly enough, Kurdish interviewees used many metaphors and real-life examples to explain resilience, unlike Western interviewees who had a more distant description and use of technical/academic terms. This result can be attributed to the use of words and previous experiences in life, which will be discussed later. For example, descriptions like this *"I turn to see the place of the bombing I saw the children's doing like, like this, like dancing with the rhythm of the bombing"* (Interviewee 5, Kurdish psychologist), indicates the brutal reality that comes with the term of resilience in the Kurdish context, causing children to get used to hearing the sound of bombs, hence downgrading the asperity of the experience. Another example of an explanation of resilience from the Western point of view is *"So, resilience is like an internal capacity, to accept life as it comes"* (Interviewee 11, Dutch/Kurdish psychologist). This difference in defining resilience nicely emphasizes the gap in understanding what resilience means and its contextual lived experience.

5.1.2 Understanding of Trauma

Experiences also play a role in withstanding trauma. Kurdish interviewees answered that trauma is more or less normalized in society, unlike mental ill-health. Normalized in the sense that "*if you are not traumatized, you are not normal, you should be traumatized"*, as mentioned by a Kurdish interviewee (5).

Both agree that trauma is something certainly individual and can be shown in various ways and is dependent on the accumulated experiences one has made. However, it can be argued that the severity of trauma and the thereby experienced life stories are '*more extreme'* than what most Western therapists have experienced. One Kurdish humanitarian worker, for example, mentioned that if he sees an explosion he will not be shocked anymore (Interviewee 4). Another sign of the normalization of trauma in the region. Another Kurdish mental health worker thinks that their life, culture, and circumstances are so different, that trauma has to be different as well (Interviewee 3). Those circumstances, especially for IDPs, look like living in a camp, that lacks electricity, adequate washing facilities with no privacy in place, and with numerous ethnicities, holding various conflict potentials (Interviewee 8).

Kurdistan has the special case that the therapists working in this context have had similar experiences as their patients and therefore naturally can relate on a different level. However, this also has certain implications: if everyone is traumatized in society that means that therapists are traumatized as well and if mental health is stigmatized in the region then therapists also grew up with that stigmatization (Interviewee 5). Those implications will be further discussed in the conclusion.

All those experiences made, stand in close correlation with personal resilience. Resilience is a way to deal with experienced trauma and could lead to a healthy mental health state. The relationship between mental health, resilience and trauma in this context is that trauma can have a negative impact on one's mental health state and resilience is the resource on which victims can fall back on. The conceptual background already stated that resilience is the '*ability to adapt'* (Becker, 2014). The different contextual and cultural experiences determine how this is then lived through, positively or negatively. However, it can be stated that those lived experiences can make an enormous difference in the understanding of all of those concepts.

To conclude, the Kurdish understanding and framing of mental health are so new that it still lacks enough local knowledge to fully make sense of the concept, which increases the stigmatization and negative connotation of the term. This makes it more difficult for people to deal with their mental health state and seek help since it would mean being an outsider within society. Mental health as well as resilience have a rather negative connotation which can be related to the severity of trauma experienced.

The Western perspective is more accustomed to the concept of mental health and its impact on livelihoods (Interviewee 11). Mental health as well as resilience have more of a positive connotation and are seen as a tool to improve one's life (Interviewee 12). It became evident that the description of such terms was more *'colorful'* and inspired by real-life experiences from the Kurdish perspective whereas Western interviewees used more technical terms to define the words and make sense of them. This suggests that the Kurdish interviewees relate to the terms on a more personal level whereas, for the Western interviewees, they were abstract descriptions of a concept.

5.2 Understanding of (mental health) Support

The most outstanding finding regarding the understanding of the support is the expectation on the part of the recipient. Kurdish professionals stated that the reality of the MHS often did not meet the expectations built by the patient. For example, patients often hoped to receive a form of medication, just like for a physical illness.

> *"They just want to go for a doctor, like just give me some pills."*
> (Interviewee 4, Kurdish Project Manager)

Another aspect where expectations and reality differed was the expected recovery time. Patients wanted a short-term treatment and sometimes even money for it since previous international humanitarian organizations offered participants to pay them (Interviewee 5). The gap between expectations and how MHS is designed is because there is a general lack of understanding of what mental health is and how it can impact daily life.

> *"Because psychology is somehow so new in our societies. No, they don't know."*
> (Interviewee 7, Kurdish Psychologist)

This increases the stigmatization of the support and makes it shameful to seek help and accept it. Culturally, it can be a shame to go to therapy as one Kurdish interviewee reported (Interviewee 4). Another Kurdish psychologist told a story in which members of the community approached him because of their sleeping disorder. They knew that they needed help and understood that there is *'something wrong'*. However, the Interviewee reported that he was approached in such a secretive way that it felt like *'dealing drugs'* (Interviewee 5). This is a great example of how the awareness of mental health issues among the communities slowly grows but the stigmatization as a barrier to seeking help is still standing strong.

Important factors mentioned that positively influence the effect of the support were *empathy; having a close relationship with the patient; ensuring that the patient knows it is not their fault; empowerment; a nice environment (respect & dignity); trust; raising awareness; give options; hope; gender perspective* and *to be creative* (see Appendix E).

Some of the aspects mentioned are dependent on the contextual understanding that outsiders naturally lack. For example, the empathy needed to put oneself in the shoes of the patient is

almost naturally given by Kurdish professionals since those lived similar experiences, as mentioned before. Moreover, how comfortable patients are feeling during a session to share their emotions is often dependent on how the therapist reacts to what is being told. An example given by a Kurdish psychologist was that when he is not surprised to see the patient crying, the patient understands that this is not something to be ashamed of (Interviewee 9). That requires having a close relationship with the patient which comes with trust. This can be somewhat challenging for a Western therapist with an individualistic and clinical stance in a collectivistic society where the relationship with the therapist needs to be closer and based on a common understanding (Interviewee 9).

The support is based on certain limitations. The next sub-sections will illustrate the understanding of support. Further its implications by describing the factors that influence it.

5.2.1 Use of Words

One aspect that makes MHS difficult for Western, as well as Kurdish therapists, is language. The Kurdish language does not offer enough words to describe aspects of mental health such as anxiety or stress or at least it does not have the large variety that English or Arabic offer. (Interviewee 6). In addition, there are fewer words in Kurdish to describe feelings which makes the actual communication during the support difficult (Interviewee 11), especially between different cultures and languages. However, this poses not only an issue for Western therapists but also for Kurdish professionals since, as already mentioned during the contextual analysis, in Iraqi Kurdistan different languages are spoken and the various dialects are so different that they cannot understand each other.

"I always tell them. If you don't understand me, even a word, please stop me and tell me. I will try to translate it to your accent if I don't know. I will translate it into Arabic. If I don't know that I can. I go and ask one of the members of the staff that I am working with."
(Interviewee 5, Kurdish Psychologist)

Further, it amplifies the stigmatization and shame of actually going to the provided support, since there are no resources in the form of publications in Kurdish where interested people could inform themselves (Interviewee 6). This also increases the gap between the expectations people have towards the offered support and the reality of it. When people cannot inform themselves, they are left in the dark.

5.2.2 Expression of Feelings

The expression of feelings is another aspect that influences the understanding of support from both sides. It became evident that the language used limits the possibility of describing how one feels. This could also be because feelings are just not so openly expressed as in the West.

When asked how feelings are expressed, Kurdish interviewees described it *as a sin; shame; showing feelings as weak; it is feminine, and that men are less likely to express feelings* (see Appendix E). Further, it became evident that the West pays more attention to the individuals' feelings unlike in the Kurdish society, which is more focused on collective well-being, as mentioned in the contextual analysis.

"Because their individual happiness is nothing compared to the collective happiness. So, this idea of focusing on the individual versus the collective just had completely different weight in it."

(Interviewee 12, German mental health project advisor)

The most prominent finding was the gender gap in expressing feelings. It was reported that women are more likely to express their feelings, at least to a close friend or family member, unlike men, who feel the pressure to be *'strong'*. Strong in the sense that the expression of feelings can be associated with weakness.

"Women are more able to verbalize their needs, verbalize share their emotions and feelings."

(Interviewee 10, American/Kurdish MHPSS Technical Advisor)

"When they cry or talk about emotions like you are less man."

(Interviewee 5, Kurdish Psychologist)

"Men in these cultures here, by the very definition of what is masculinity, they have to be strong, they have to be the provider, the protector, all these elements."

(Interviewee 12, German mental health project advisor)

In a society where men are the main decision-makers, this influences how the support is understood and accepted. Consequently, allowing support in one's life is seen as shameful and hardly accepted. That also influences the understanding of support from the women's

perspective since it can be considered a weakness (Interviewee 4). However, interviewees also reported that with the new generation a shift of perspective takes place, where the sharing and expression of feelings are more welcomed and accepted (which has not been the case for the previous generation and hence was not important in their upbringing).

"The younger generation is very open and very, very much sees the usefulness of processing things that have happened to them."
(Interviewee 9, Dutch/Canadian Mental Health Clinic Coordinator)

If one has not learned how to express their feelings and that it is okay to do so, consequently this person will have difficulties understanding the feelings of others. Thus, therapists who grew up in that environment need to unlearn this deeply rooted relationship toward feelings to be able to give support to others. One story that has been told is that a prospective psychologist during an internship was afraid to make a patient cry by asking the wrong questions (Interviewee 9). This is a strong indicator of how the expression of feelings and the acceptance of them influence the understanding and practiced support. This stands in close correlation to how relationships are formed within society, which will be discussed in the next sub-section.

5.2.3 Societal Relationships

As mentioned earlier, Iraqi Kurdistan is quite a hierarchical, male dominant society with collectivistic characteristics. That implies that, first of all, the support provider can be seen as someone superior; second, most men make the decisions; and third, that support can be understood as a rather collectivistic matter than individualistic. This suggests that it matters who provides the support, men or women, and who can be trusted (Interviewee 4). Another aspect in question is from whom support is expected and accepted. It does not always have to be necessarily a therapist. Often support can be demanded from a community religious leader, a friend, or a neighbor. Support can be seen as a family matter in a *'close society'* where "*everyone has a right to talk about your clothes, your hair (...)"*(Interviewee 5, Kurdish psychologist).

Consequences resulting from that are first that MHS does not necessarily have to be a one-on-one session with a therapist, but can also be community-based. Secondly, men as unaware decision makers influence women and their life and approach towards support as well. One interviewee indicated that a friend was unable to openly bring to the clinic her son, who needed psychological support because her husband would object and she might suffer the consequences

(Interviewee 6). Therefore, she had to do it secretly and less frequently. The fact that it is a son, a male, even as a child still conforms to the norms that 'men' are above that kind of support. That also confirms that the women's role is overlooked, even in such crucial matters as the need for psychological support for their joint children. Thus, a holistic shift in awareness towards MHS is difficult to achieve when men are further the main decision-makers in society and are the ones the least accepting of their feelings and support.

5.2.4 Attitudes to the Future

In the context of IDPs, the attitude towards the future is a very crucial aspect. As already described, IDPs are in an uncertain and unstable situation where the outlook of the future makes a central difference in how valuable MHS is seen. In this context, IDPs do not know what their future will look like and therefore, focus on more immediate needs such as food or shelter rather than a long-term aspect like mental health (Interviewee 11). Further, there is often no time to address a problem such as mental illness. People would need to actively participate in such support and take time out of their day, which is difficult while struggling to ensure that basic needs are met (Interviewee 12). This increases the lack of understanding of the *'necessity'* of the support. Further, an uncertain future can negatively influence the mental health state, as one interviewee addressed. She indicated that the aspect of waiting (e.g., waiting to get the necessary paperwork to start their future), can harm the IDP's mental health and well-being (Interviewee 11). This needs to be taken into consideration while analyzing the understanding of the offered support. Sometimes outer circumstances, such as time and living conditions, can be a barrier for people being able to take advantage of the support. Therefore, it is crucial to look at the context before designing mental health projects in IDP camps.

5.2.5 Understanding of Prevention

Time is consequently connected to the aspect of prevention and prevention in Iraqi Kurdistan is not as much practiced as in the West. Possibly due to the lack of outlook towards the future. Ideally, it should be part of the support since it is not only about the recovery of a mental illness, but also about the prevention of falling ill (Interviewee 1). The acknowledgment of it is dependent on the cultural context. Due to the factor of time, prevention is not something essential to the receiver, but very crucial in the eyes of the provider.

For the Western interviewees prevention mainly means taking care of oneself (Interviewee 9). Kurdish interviewees understand prevention in terms of awareness raising (Interviewee 2). Both

sides agree that prevention is a certainly crucial aspect of enhancing the understanding of mental health support. One of the main strategies named how to raise awareness was to use media and social media to reach as many people as possible since this is widely used among IDPs (Interviewee 6). In this regard, all of the Kurdish interviewees mentioned independently from each other the usefulness and popularity of social media. In their opinion people would respond better to short videos or tv series than to long articles, considering the attention span as well as the frequency of exposure (Interviewee 5).

Raising awareness, for example, about the impact of mental health issues on livelihoods as well as about the root causes of mental ill-health (Interviewee 10). Ideally, those campaigns would communicate some simple techniques for society to be more aware of their mental health state, and prevent suicides from happening, which increased a lot during the past years (Interviewee 6). Ultimately, they would appeal to the individual's own capacity to control and improve one's health, as mentioned in the conceptual background. The awareness campaigns should be addressed towards the general public and especially towards occupations that have a wider responsibility towards society, teachers for example (Interviewee 2).

Prevention strategies should come from people with authority and popularity, such as social media influencers, and be multidisciplinary by including not only the health sector but other authorities such as religious or community leaders (Interviewee 1). This is due to religion playing a crucial role within society and is often used as a coping mechanism.

"We included a Mullah to do that. Because you know, in our culture actually, they are listening or they will listen to the religious more than to the psychiatrist and the psychologist."

(Interviewee 1, Kurdish Doctor)

However, especially among religious leaders, mental health is seen as something either non-existing, not necessary, or highly stigmatized. This makes their inclusion even more valuable since, in such a hierarchical society as Iraqi Kurdistan, they are the ones whose approval is needed the most.

"(...)of them religious, man, they said, there are no mental diseases."

(Interviewee 1, Kurdish Doctor)

5.2.6 Understanding of Recovery

Religion, as well as a certain or safe future, plays an important positive role in the recovery process. Religious rituals, such as certain washing practices, can be helpful in terms of being a coping mechanism used as a support (Interviewee 6). Another interviewee highlighted that as long as a person has not regained control over their life, has no future, and does not feel safe, recovery is unlikely (Interviewee 12).

Keywords used to describe recovery were *having hope; trust; control your thoughts/mind; having a routine; a healthy coping mechanism; acceptance and a good environment* (see Appendix E). The term '*hope*', especially, was often used regarding the recovery process in terms of hoping for a better future (Interviewee 3). Thus, recovery in the Kurdish perspective has a lot to do with finding hope for a better outcome but also accepting the situation as it is and finding healthy coping mechanisms to do so.

The Western interviewees described recovery with similar keywords, such as *safety; trust; being able to manage alone; no more flashbacks; using techniques; accepting; new perspectives; letting go; moving forward, and being active* (see Appendix E). However, what it means to accept a certain situation and what exactly can give one hope is open for interpretation. For an interim conclusion, the next sub-section will answer the first two sub-research questions to then move on to presenting the findings for the main research question.

5.3 Answer to the First Two Sub-Research Questions

To conclude and answer the first two sub-research questions:

1. What is the (cultural) understanding of MHS from the Western perspective?
2. What is the (cultural) understanding of MHS from the Kurdish perspective?

The understanding of MHS from the Kurdish recipient perspective is to some extent lacking, stigmatized, and seen as a weakness as well as not essential. However, Kurdish professionals acknowledge the importance of such support and emphasize awareness campaigns as a prevention strategy. The expectation towards the support is a short-term medication to feel better. This does not meet the reality of the offered support which is often a long-term program

without any medication. The Western world does not have a better understanding of mental health but is more accustomed to mental health since it had more time to research and explore the term, which makes it less stigmatized. Language plays a crucial role in understanding and making sense of the support. Due to the limited words that can be used to explain the concept of mental health, which is mainly shaped by the English language, the stigmatization of the support increases as well as the lack of understanding of how the Western world makes sense of it.

Further, the lack of expression of feelings, especially among men, but also women, perpetuates the stigma around mental health and makes MHS seen as a weakness, whereas most in the West there is a lot of attention towards feelings. The uncertain prospect of IDPs and the lack of outlook on the future makes long-term MHS seen as something not entirely essential. This has implications on whether prevention is seen as something necessary or valuable. In the West, there is high emphasis on prevention methods and Iraqi Kurdistan just started with awareness-raising campaigns. Lastly, how recovery is understood matters since it is the goal of mental health support. From the Kurdish perspective, religion plays an important role during recovery, as well as hope for a better future.

The understanding of MHS from the Western perspective is mainly shaped by extensive research and knowledge as the conceptual background highlighted. Mental health is increasingly gaining popularity and therefore has a high priority. The findings showed that not so much the different understanding of MHS is pivotal for the arising discrepancies, but more so the different experiences and contextual knowledge and thereby the communication of it. However, the nature of aid being intercultural makes an understanding of each other's experiences necessary. This has certain consequences as a result, especially on how MHS is being framed depending on the cultural context. This will be specified in the next sub-section leading up to answering the main research question:

"What are the consequences of the discrepancy between Western and local understanding and framing of Mental Health Support (MHS) in IDP camps in Iraqi Kurdistan?"

5.4 Consequence(s): Various Challenges

The consequences of the discrepancy between the Kurdish and Western understanding and framing of MHS, are various challenges, mostly for the Western part, but also on behalf of the Kurdish society. It takes time for the culturally different parts to understand each other. That does not only count for Western therapists or mental health workers, but also for Kurdish professionals. It was already mentioned that IDPs are not a homogenous group and consist of different ethnicities that speak different languages, which makes communication challenging. Practically that means that the person working in a different context first needs to take the time to get familiar with the community and its cultural norms and worldviews. Sometimes, a translator needs to be involved. This can be difficult in the sense that the translator should ideally be trained in the field of psychology to not only be able to translate words, but also the meaning of what was said.

"(...) that's a big barrier if you're doing intercultural work, and you have to ask so many questions to just understand a simple statement, that makes it very tedious for the person."
(Interviewee 9, Dutch/Canadian Mental Health Clinic Coordinator)

"It's not enough just to have a good translator who knows the language, they have to understand the field. So that it doesn't become just a translation of what is being said. But actually, in that context, what does it mean?"
(Interviewee 12, German Advisor for mental health projects)

Since this is often not feasible to do so, the quality of the offered support suffers and perpetuates the stigma even more. This results in people not acknowledging the offered support. One interviewee reported from the Western perspective that even when people from the community reach out for support, they get *'shitty service'* (Interviewee 12). '*Shitty service'* in the sense of culturally inappropriate support which does not manage to tackle the root cause of the person's suffering. This ultimately leads people to believe that any kind of support will not be helpful and prevent them from reaching out the next time. This can be communicated to friends and family who then also do not seek external support. And even though the provider of the support is aware of the cultural differences, it can be challenging to truly adapt and understand, due to the different life experiences. As one interviewee said herself: *"We are blind-sided often"* (Interviewee 12, German Advisor for mental health projects). This can only be avoided to a certain extent and the adaptation will be time-consuming no matter what.

Such cultural differences make the communication of the support and its goals difficult, so it is no wonder that expectations and reality drift apart and community acceptance is low. It can be challenging from the Western perspective to communicate a project to IDPs that the community understands in a way that they can decide whether they want to participate or not (Interviewee 12). Thus, the project design, process, and objectives need to meet the created expectations. Otherwise, the local community will unintentionally be let down. Further, the Western-provided solutions to the described problems in the context of Iraqi Kurdistan are often simply not suitable (Interviewee 9).

In addition, since MHS is more common in the West, Western psychologists talk openly about such issues and can lack the sensitivity the patient, who grew up in a more closed society, might need (Interviewee 9). Another example is that a therapist needs sensitivity to understand what laughing for instance means in the accordingly culture. It could be interpreted in various ways, such as making fun of someone, being insecure, or being happy. *"That is where the cultural adaptation comes in"* (Interviewee 9, Dutch/Canadian Mental Health Clinic Coordinator). Therefore, trust is an important factor in building that relationship between therapist and patient, which will take time (Interviewee 9).

One Kurdish mental health worker reported from experience that the biggest challenge for the NGO was to gain the trust of the project participants. Many thought that the project's purpose was to receive the participant's information to then share them with the public to get attention, but not to provide support (Interviewee 3). This stands in close correlation with how the support goals are communicated. The reputation of humanitarian aid programs is not always the best, to the extent that it prevents people from going, which makes trust building essential.

To build that trust and truly culturally adapt to the local context, therapists need to be very creative (Interviewee 4). Creative in the sense of providing the patient with enough options, a menu so to speak, for their decision-making process (Interviewee 9). Further, the cultural barrier can be overcome by creating a language that can be understood by both, the therapist and the patient. For example, using pictures or emojis to communicate during a session or designing games to strengthen the trust (Interviewee 5).

However, even though cultural adaptation and trust building is aspired to, it takes time. One interviewee reported that she felt some sort of disconnection towards her patients and "*everything fell into place once she really understood the context of Kurdistan"* (Interviewee 10, American/Kurdish MHPSS Technical Advisor). It approximately took one year with the help of her supervisors and asking questions to learn what interventions or treatments would not be culturally relevant and to adjust to what she learned in the West and the way she has been helping her clients there (Interviewee 10).

The aspect of time, sustainability, and cultural inappropriateness of the support and its consequences form the key theme of this sub-section. Those findings lead to the answer to the main research question. *"What are the consequences of the discrepancy between Western and local understanding and framing of Mental Health Support (MHS) in IDP camps in Iraqi Kurdistan?"* The next and final sub-section will aim to do so.

5.5 Answer to Main Research Question

This research has shown that mental health is important. Further, that mental health is important in Iraqi Kurdistan. MHS is shaped and understood differently according to the culture. There is a discrepancy between the Kurdish and Western cultures. The lack of understanding of what MHS means, and entails and how to communicate this in the respective cultural contexts is based on differences. Differences in expectations, knowledge, the words used to describe the concepts, outlooks towards the future, how to approach the support, the way of sense-making, the suitability of solutions to certain problems, the expression of feelings, how society supports each other, and the communication of it all.

Due to those discrepancies, certain consequences in the form of challenges emerge. First, time needs to be taken into consideration for the culturally different part to adapt to the local context which is secondly often not possible, and therefore culturally inappropriate support is being offered, which perpetuates the stigmatization of the support even more. Third, not only support can be culturally inappropriate, but also the communication of it leads to failed information about the support's goals. Fourth, consequently, reality does not meet the expectations of the support, which, fifth, leads to low community acceptance. Sixth, due to cultural differences, offered solutions to contextual-dependent problems can be culturally irrelevant. Seventh, the provider of the support can lack sensitivity to such problems as well as to culturally dependent behavior. Eighth, trust building is crucial for the recipient to accept support and be able to open

up, which is necessary for the support to be a success and represents whose expertise is valued. Ninth, creativity is an essential skill to be able to adapt to cultural needs and truly understand the patient. Tenth, the need to make support as local as possible is essential (see Table 2). Local professionals are more respected, by nature culturally accepted, and can design a familiar practice, as the findings demonstrated. They share similar experiences and can relate to their patients on a level culturally-different professionals cannot.

Table 2: Results - Consequences

Consequences
1. It takes time for a culturally different person to adapt to the local context. (if even possible)
2. Culturally inappropriate offered support, which perpetuates its stigmatization of it.
3. Communication of what the support's goals are, fails to reach the receiver.
4. Expectations of the support do not meet the reality.
5. Community acceptance is low.
6. Offered solutions during the support are not suitable for the type of problems the context gives away.
7. Lack of sensitivity to culturally dependent behavior.
8. Trust building is crucial.
9. Creativity is an important skill the provider needs to have.
10.Need to localize the support.

Potential lessons learned from such consequences, recommendations, and the need for future research will be given in the next chapter to answer the last sub-research question (What potential lessons learned can be identified?) and conclude the overall research project. Further, an outlook on the future will be given, as well as a reflection on the research as a whole and some practical limitations.

6. Conclusion - Lessons Learned and Recommendations

To conclude, currently, mental health projects in IDP camps lack sustainability, practicality, and cultural appropriateness. For humanitarian aid to fulfill its purpose, there needs to be a shift in how this work is realized, by decolonizing aid, which means localizing and including. From this point of view, humanitarian aid programs should recognize the individuals' resilience by strengthening local capacities. This incorporates a shift in how MHS is being approached within the context of IDP camps.

To answer the third sub-research question, a potential lesson learned from this research project is the aspect of the longevity of mental health projects (see Appendix E). Many interviewees criticized the period of such projects as being a maximum of one year. However, this is not enough time to culturally adapt to the context, gain the trust of the participants, and tackle the root causes of their suffering. Short-term projects lead to patients being left in limbo meaning that tackled problems are not followed up which can cause relapses. However, the support's goal is to enhance one's resilience, the *'ability to adapt'*, and to do so, all aspects of resilience have to be tackled simultaneously and not in stages. That includes prevention and recovery and makes the necessity of a long-term project inevitable.

The offered support creates a sort of dependency which makes a funding-dependent project not ideal and certainly static. When the money stops flowing the project will stop and the participants will be left on their own. Once it has been decided on one specific project proposal by the donor there is little attention to adjusting to occurring issues once the project has started. If the support would come from within the community, the sustainability of the support would be naturally given and the negative consequences of donor dependencies would fade away.

There is a call to localize mental health support. To assist people while recovering, it is important to understand how they make sense of the world and its meaning, which this research project showcased. Outsiders, in the sense of being culturally and contextually different, will have difficulties relating to the affected people, since they tend to fall back on their own culturally shaped frameworks, based on personal worldviews, values, and mostly Westernized professional training. Often, mental health workers lack the knowledge and skills to provide appropriate support and there are not enough qualified therapists available who culturally understand the disaster-affected area. To truly localize the support, more local professionals need to be available. This begins with more local educational opportunities being offered. As mentioned in the findings, only one master's program is accessible to Iraqi Kurdistan. If more

programs would open up, more qualified local therapists would be available, making it unnecessary for culturally different therapists to fly in and run the project. Further, education in terms of awareness could be enhanced in schools so the interest in such topics can be shaped from an early age.

Women empowerment projects can also tackle the issue of the large stigmatization of mental health preventing the support to be local. As discussed in the results section, men still have power over women and make decisions for them. This leads to a one-sided judgment of such issues and prevents women from taking an active part in civil society, e.g. becoming a therapist. Women empowerment can generate a more diverse and inclusive view on mental health, including the feminine perspective. A multidisciplinary and inclusive approach is certainly needed since the results showed that it truly matters who provides the support. Whether it is a woman or a man, a person from the same culture, or a person who is respected. Those go hand in hand. Based on the findings it can be assumed that a person from the same culture will be more respected and trusted.

For the support to be accepted and to create a sense of belonging, the entire society needs to be involved and especially those who are highly respected. That includes religious leaders since religion has a high significance in Iraqi Kurdistan. Until now, most religious leaders expressed their disapproval towards recognizing mental ill-health as part of the health sector and denied its existence. However, without their approval or confirmation, there will always be a large part of society left that does not '*believe*' in mental health. Inclusion can achieve a holistic shift in awareness towards mental health and its support.

Even though local support is needed and wanted, the findings also showcased the limitations that come with it. In a society where many people are traumatized, due to the history of the country, mental health is stigmatized and feelings are hardly expressed. This naturally leads to therapists being traumatized and stigmatized as well. This does not automatically negatively influence the support, but it also needs to be acknowledged that therapists can be helpless as well due to the severity of the cases. Thus, self-care for the therapists themselves is essential, and the acceptance that sometimes there is no solution. This needs to be recognized by the humanitarian sector when creating and implementing such projects.

This research project achieved its objective by demonstrating the importance of truly understanding the local context first when creating a mental health project that should be implemented in a culturally different country and by illustrating the consequences that come with not paying attention to them. The research gave an insight into what factors can play a

crucial role when wanting to understand the culturally shaped knowledge about mental health and how support is accepted in Iraqi Kurdistan.

The potential lessons learned and recommendations that came out of it are issues that will take a long time to be solved, such as enhancing the education programs or involving women in civil society. Those are the underlying aspects that make it challenging to achieve a fully local-based approach that can overcome all the identified challenges mentioned in the previous chapter. In the meantime, it is essential to be aware of contextual and cultural differences. The humanitarian sector ideally should acknowledge the negative consequences it can have by adapting to the local circumstances as well as shifting whose expertise is valued by putting the focus back on local capacities. Adapting to the local situation, besides from context-familiarization, would for example entail offering support that is based on anonymity, bears the necessary sensitivity when talking about mental health issues, and communicates that accordingly to the target group. Further, the new generation in Iraqi Kurdistan will create a shift in values, attitudes, and norms, benefitting mental health. Special attention must be paid to those who have the opportunity to be heard and to develop themselves.

As the limitations already pointed out, this research project is based on a single case study, making it impossible to generalize for the entire society in Iraqi Kurdistan. The research can only grasp the complexity of one very well-defined single case which then can be used as a start to broader research. Therefore, future research is needed to expand and explore the insights given. This project focused on the provider's view of things due to ethical reasons. Interesting to know would be the recipient’s view in a large-scale study on mental health, taking on an intersectional perspective. In addition, to take it one step further from what this research has criticized, the sustainability and cultural aspects of such projects could be explored to answer the research question of how to ensure sustainable and culturally appropriate MHS in IDP camps as well as in the host community.

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Appendix A

Interview Protocol - Western humanitarian aid worker

Research Question: What are the consequences of the discrepancy between Western and local understanding and framing of mental health support in IDP camps in Iraqi Kurdistan?

Goal of the Interview: To find out -

1.1 What is the (cultural) understanding of mental health support (trauma & recovery) from the Western perspective?

Role of the interviewee: Western humanitarian aid worker in the context of mental health projects

Questions

Introduction

1. Where do you work? *(Introduction question)*

    1.1 What is your role in the organization?

Approach of Mental Health Support

2. What educational background do you have? *(Introduction question)*

    2.1 Where did you gain the appropriate training in order to be qualified to deal with mental illness?

    2.2 How do you characterize the field in which you were trained in or currently practice?

    2.3 How do you ensure, as a cultural being, to recognize your own assumptions, attitudes, and beliefs that influence your perception of and interactions with individuals who are ethnically and racially different from you?

    2.4 How do you ensure culturally appropriate support?

Goal: Is there a gap between the frameworks of the training and personal assumptions?

Based on: *Article: Conceptualizing Trauma and Resilience Across Diverse Contexts (Tummala-Narra, P, 2007).*

3. Who do you mostly work with? *(Main question)*

4. If you go back to one of the projects you have been involved in - in regard to mental health? - What tools were provided to assess the mental health state of the beneficiaries (e.g. guidelines)? (*Main question*)

Goal: Imposed guidelines?

Based on: *Article - Humanitarian aid workers' knowledge of minority cultures in Iraqi Kurdistan (Msall, K. A., 2018).*

4.1 What were barriers for you, being a Westerner in a Kurdish context, in order to support the beneficiaries to your standards?

Goal: Cultural appropriateness?

5. In your opinion, what are key competencies, skills, and capabilities that someone needs in your profession in order to be able to provide culturally appropriate (mental health) support?

Goal: What are other important factors?

Unpack Cultural Understanding – *based on the article: Making Sense of Culture (Patterson, O., 2014).*

6. How would you describe mental (ill) health? *(Main question)*

6.1 How would you describe trauma? (*Follow up*)

6.2 What is your understanding of recovery? (*Follow up*)

6.2.1 From your experience, what are the good, effective and sustainable ways to recover (e.g., safety, trust)? In other words, what mostly helps those you work with? (*Follow up*)

6.2.2 What does it mean (for the patient/beneficiary) to be recovered 'from' a mental illness?

6.3 What is your understanding of being resilient in relation to mental health? What makes one person resilient and another not so? (*Follow up*)

6.3.1 What do you think can be done by the support system (humanitarian aid workers, camp management etc.) to prevent mental illness from emerging, for those who are not affected yet?

6.4 How do the people you are helping explain to themselves what happened to them? What meaning or reasoning do they assign to it? – Fate, God's will, injustice, what? (*Follow up*)

6.3.2 What are their coping strategies? (*Follow up*)

Goal: To what extent does the belief system play a role in how people understand/value mental health (e.g., experience trauma; recover)?

Based on: *Article - Mental health literacy: focus on developing countries (Ganasen, K. A. et al., 2008).*

Article - *A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model (Hwang, W. C., et al., 2008).*

6.4 How are feelings expressed in the cultural context you work in? (*Main question*)

- 6.4.1 Are feelings openly expressed? (*Follow-up*)
- 6.4.2 Are people comfortable in expressing and showing their feelings openly with others? (*Follow-up*)
- 6.4.3 Or are they shown and expressed in intimate circles of trust? (*Follow-up*)
- 6.4.4 If so, which feelings are expressed openly and which ones are reserved for close intimate circles? (*Follow-up*)
- 6.4.5 Further focusing on trauma and recovery, can you elaborate on these in the context of the above questions? (*Follow-up*)

6.5 Is there a stigma around mental health? (*Main question*)
6.6 How does it manifest in society? (*Main question*)
6.7 Why do you think is there such a stigma around mental health in this context? (*Main question*)

6.7.1 What consequences does that have on the provided support?

Goal: What is the cultural understanding of mental health (in different steps). What defines the culture in this aspect?

Based on: *Article: Trauma and disasters in social and cultural context (Kirmayer, L. J., et al., 2010).*

7. In your experience, how does the country's history, shaped by various wars (Iran/Iraq war; Civil war; Genocide in Halabja) and fight for independence, have an impact on how mental health is understood? (Needed?)

Goal: To what extent does the context change the understanding?

Language

8. In every language, there are certain terms and words that are hard to translate to another language. For example, in German…….. this could loosely mean……. but not quite the same. What terms or words related to mental health, trauma, and recovery did you come across, that are hard, if not impossible, to translate to any other language especially standard psychiatric and psychology terminology and vice versa? (*Follow up*)

Goal: Is there a language barrier? Aspects that cannot be expressed in English?

Based on: *Article - Talking science and wishing for miracles: Understanding cultures of mental health practice (Lakeman, R., 2013).*

Wrap up

9. Do you have any other comments?
10. And do you have any other questions for me?
11. Do you think I might have missed certain questions I should have asked?
12. Would you advise me to ask more specific questions to the next interviewee?

Appendix B

Interview Protocol – Western professional/researcher

Research Question: What are the consequences of the discrepancy between Western and local understanding and framing of mental health support in IDP camps in Iraqi Kurdistan?

Goal of the Interview: To find out -

1.1 What is the (cultural) understanding of mental health support (trauma & recovery) from the Western perspective?

Role of the interviewee: Western professional/researcher in regard to mental health

Questions

Introduction

1. Where do you work? *(Introduction question)*

   1.1 What is your role in the institution? (*Follow up*)

2. What educational background do you have? *(Introduction question)*

   2.2 How do you characterize the field in which you were trained in or currently practice? - "in which tradition of psychiatry or psychology were you trained?" (*Follow up*)

   2.3 How do you ensure, as a cultural being, to recognize your own assumptions, attitudes, and beliefs that influence your perception of and interactions with individuals who are ethnically and racially different from you? (*Follow up*)

   2.4 How do you ensure culturally appropriate support? (*Follow up*)

Goal: Is there a difference between educational background and training (if Western) and own personal assumptions?

Based on: – *Article: Conceptualizing Trauma and Resilience Across Diverse Contexts (Tummala-Narra, P, 2007).*

3. Who do you mostly work with? *(Main question)*

4. If you go back to one of the projects you have been involved in - in regard to mental health? - What tools were provided to assess the mental health state of the beneficiaries (e.g., guidelines)? (*Main question*)

Goal: Imposed guidelines?

Based on: *Article: Humanitarian aid workers' knowledge of minority cultures in Iraqi Kurdistan (Msall, K. A., 2018).*

5. What were the barriers for you, being a Westerner in a Kurdish context, in order to support the beneficiaries to your standards? (*Follow up*)

Goal: Cultural appropriateness?

6. In your opinion, what are key competencies, skills, and capabilities that someone needs in your profession in order to be able to provide culturally appropriate (mental health) support? (*Main question*)

Unpack Cultural Understanding – *based on the article: Making Sense of Culture (Patterson, O., 2014).*

7. In your expertise, how would you describe mental (ill) health? (*Main questions*)

    7.1 How would you describe trauma? (*Follow up*)

    7.2 What is your understanding of recovery? (*Follow up*)

        7.2.1 From your experience, what are the good, effective and sustainable ways to recover (e.g., safety, trust)? In other words, what mostly helps those you work with? (*Follow up*)

        7.2.2 What does it mean (for the patient) to be recovered 'from' a mental illness? (*Follow up*)

    7.3 What is your understanding of being resilient in relation to mental health? What makes one person resilient and another not so? (*Follow up*)

    7.4 What do you think can be done by the support system (humanitarian aid workers, camp management etc.) to prevent mental illness from emerging, for those who are not affected yet? (*Follow up*)

    7.5 How do the people you are helping explain to themselves what happened to them? What meaning or reasoning do they assign to it? – Fate, God's will, injustice, what? (*Follow up*)

        7.5.1 What are their coping strategies? (*Follow up*)

Goal: To what extent does the belief system play a role in how people understand/value mental health (e.g., experience trauma; recover)?

Based on: *Article - Mental health literacy: focus on developing countries countries (Ganasen, K. A. et al., 2008).*

Article - *A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model (Hwang, W. C., et al., 2008).*

7.6 How are feelings expressed in the cultural context you work in? (*Follow up*)

- 7.6.1 Are feelings openly expressed? (*Follow-up*)
- 7.6.2 Are people comfortable in expressing and showing their feelings openly with others? (*Follow-up*)
- 7.6.3 Or are they shown and expressed in intimate circles of trust?
- 7.6.4 If so, which feelings are expressed openly and which ones are reserved for close intimate circles? (*Follow-up*)
- 7.6.5 Further focusing on trauma and recovery, can you elaborate on these in the context of the above questions? (*Follow-up*)

7.7 Is there a stigma around mental health? (*Main questions*)
7.8 How does it manifest in society? (*Main questions*)
7.9 Why do you think is there such a stigma around mental health in your context? (*Main questions*)

Goal: What is the cultural understanding of mental health (in different steps)?

Based on: *Article - Trauma and disasters in social and cultural context (Kirmayer, L. J., et al., 2010).*

8. In your experience, how does the country's history, shaped by various wars (Iran/Iraq war; Civil war; Genocide in Halabja) and fight for independence have an impact on how mental health is understood*?* (*Main question*)

Goal: To what extent does the context change the understanding (in this specific case)?

Language

9. In every language, there are certain terms and words that are hard to translate to another language. For example, in German…….. this could loosely mean……. but not quite the same. What terms or words related to mental health, trauma, and recovery did you come across, that are hard, if not impossible, to translate to any other language especially standard psychiatric and psychology terminology, and vice versa? (*Follow up*)

Goal: Aspects that cannot be expressed in English?

Based on**:** *Article - Talking science and wishing for miracles: Understanding cultures of mental health practice (Lakeman, R., 2013).*

Wrap-up

10. Do you have any other comments?
11. And do you have any other questions for me?
12. Do you think I might have missed certain questions I should have asked?
13. Would you advise me to ask more specific questions to the next interviewee?

Appendix C

Interview Protocol - Kurdish humanitarian aid worker

Research Question: What are the consequences of the discrepancy between Western and local understanding and framing of mental health support in IDP camps in Iraqi Kurdistan?

Goal of the Interview: To find out -

1.2 What is the (cultural) understanding of mental health support (trauma & recovery) from the Kurdish perspective?

Role of the interviewee: Kurdish humanitarian aid worker in the context of mental health projects

Questions

Introduction

1. Where do you work? *(Introduction question)*

1.1 What is your role in the organization? (*Follow up*)

Approach of Mental Health Support

2. What educational background do you have? *(Introduction question)*

2.1 Where did you gain the appropriate training in order to be qualified to deal with mental illness? (*Follow up*)

2.2 How do you characterize the field in which you were trained in or currently practice? (*Follow up*)

Goal: Is there a gap between the frameworks of the training and personal assumptions?

Based on:– *Article: Conceptualizing Trauma and Resilience Across Diverse Contexts (Tummala-Narra, P, 2007).*

3. Who do you mostly work with? *(Main question)*

3.1 If you go back to one of the projects you have been involved in - in regard to mental health - What tools were provided to assess the mental health state of the beneficiaries (e.g., guidelines)? (*Main question*)

Goal: Imposed guidelines?

Based on: - *Article: Humanitarian aid workers' knowledge of minority cultures in Iraqi Kurdistan (Msall, K. A., 2018).*

4. What were barriers for you in order to help the beneficiaries to your standards? (*Main question*)

Goal: Cultural appropriateness?

5. In your opinion, what are key competencies, skills, and capabilities that someone needs in your profession in order to be able to provide culturally appropriate (mental health) support? (*Main question*)

Goal: What are other important factors?

Unpack Cultural Understanding – *based on the article: Making Sense of Culture (Patterson, O., 2014).*

6. How would you describe mental (ill) health? *(Main question)*

6.1 How would you describe trauma? (*Follow up*)

6.2 What is your understanding of recovery? (*Follow up*)

6.2.1 From your experience, what are the good, effective and sustainable ways to recover (e.g., safety, trust)? In other words, what mostly helps those you work with? (*Follow up*)

6.2.2 What does it mean (for the patient) to be recovered 'from' a mental illness? (*Follow up*)

6.3 What is your understanding of being resilient in relation to mental health? What makes one person resilient and another not so? (*Follow up*)

6.3.1 What do you think can be done by the support system (humanitarian aid workers, camp management etc.) to prevent mental illness from emerging, for those who are not affected yet? (*Follow up*)

6.4 How does suffering look like for you? (*Follow up*)

6.5 How do the people you are helping explain to themselves what happened to them? What meaning or reasoning do they assign to it? – Fate, God's will, injustice, what? (*Follow up*)

6.6 What are their coping strategies? (*Follow up*)

Goal: To what extent does the belief system play a role in how people understand/value mental health (e.g., experience trauma; recover)?

Based on: *Article - Mental health literacy: focus on developing countries (Ganasen, K. A. et al., 2008).*

Article - *A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model (Hwang, W. C., et al., 2008).*

7. How are feelings expressed in your culture? (*Main question*)

7.1 Are feelings openly expressed? (*Follow up*)
7.2 Are people comfortable in expressing and showing their feelings openly and indiscriminately with others? (*Follow up*)
7.3 Or are they shown and expressed in intimate circles of trust? (*Follow up*)
7.4 If so, which feelings are expressed openly and which ones are reserved for close intimate circles? (*Follow up*)
7.5 Further focusing on trauma and recovery, can you elaborate on these in the context of the above questions? (*Follow up*)

8. Is there a stigma around mental health? (*Main question*)
9. How does it manifest in society? (*Main question*)
10. Why do you think is there such a stigma around mental health in your context? (*Main question*)

11. What consequences does that have on the provided support? (*Main question*)

Goal: What is the cultural understanding of mental health? What defines the culture in this aspect?

Based on:– *Article: Trauma and disasters in social and cultural context (Kirmayer, L. J., et al., 2010).*

12. How does your country's history, shaped by various wars (Iran/Iraq war; Civil war; Genocide in Halabja) and fight for independence, have an impact on how you understand mental health? (*Main question*)

Goal: To what extent does the context change the understanding?

Language

13. In every language, there are certain terms and words that are hard to translate to another language. For example, in German…….. this could loosely mean……. but not quite the same. What terms or words related to mental health, trauma, and recovery in your language that are hard, if not impossible, to translate to any other language especially standard psychiatric and psychology terminology and vice versa? (*Follow up*)

Goal: Is there a language barrier? Aspects that cannot be expressed in English?

Based on:– *Article: Talking science and wishing for miracles: Understanding cultures of mental health practice (Lakeman, R., 2013).*

Wrap up

14. Do you have any other comments?
15. And do you have any other questions for me?
16. Do you think I might have missed certain questions I should have asked?
17. Would you advise me to ask more specific questions to the next interviewee?

Appendix D

Interview Protocol – Kurdish professional/researcher

Research Question: What are the consequences of the discrepancy between Western and local understanding and framing of mental health support in IDP camps in Iraqi Kurdistan?

Goal of the Interview: To find out -

1.2 What is the (cultural) understanding of mental health support (trauma & recovery) from the Kurdish perspective?

Role of the interviewee: Kurdish professional/researcher in regard to mental health

Questions

Introduction

1. Where do you work? *(Introduction question)*

   1.2 What is your role in the institution? (*Follow up*)

2. What educational background do you have? *(Introduction question)*

   2.1 How do you characterize the field in which you were trained in or currently practice? - "in which tradition of psychiatry or psychology were you trained?" (*Follow up*)

Goal: Is there a difference between educational background and training (if Western) and own personal assumptions?

Based on:– *Article: Conceptualizing Trauma and Resilience Across Diverse Contexts (Tummala-Narra, P, 2007).*

3. Who do you mostly work with? *(Main question)*

4. If you go back to one of the projects you have been involved in - in regard to mental health? - What tools were provided to assess the mental health state of the beneficiaries (e.g., guidelines)? (*Main question*)

Goal: Imposed guidelines?

Based on: - *Article: Humanitarian aid workers' knowledge of minority cultures in Iraqi Kurdistan (Msall, K. A., 2018).*

Goal: Cultural appropriateness?

5. In your opinion, what are key competencies, skills, and capabilities that someone needs in your profession in order to be able to provide culturally appropriate (mental health) support? (*Main question*)

Unpack Cultural Understanding – *based on the article: Making Sense of Culture (Patterson, O., 2014).*

6. In your expertise, how would you describe mental (ill) health? (*Main questions*)

    6.1 How would you describe trauma? (*Follow up*)

    6.2 What is your understanding of recovery? (*Follow up*)

        6.2.1 From your experience, what are the good, effective and sustainable ways to recover (e.g., safety, trust)? In other words, what mostly helps those you work with? (*Follow up*)
        6.2.2 What does it mean (for the patient) to be recovered 'from' a mental illness? (*Follow up*)

7. What is your understanding of being resilient in relation to mental health? (*Follow up*)

    7.1 What do you think can be done by the support system (humanitarian aid workers, camp management, etc.) to prevent mental illness from emerging, for those who are not affected yet? (*Follow up*)

    7.2 How does suffering look like for you? (*Follow up*)

    7.3 How do the people you are helping explain to themselves what happened to them? What meaning or reasoning do they assign to it? – Fate, God's will, injustice, what? (*Follow up*)

        7.3.1 What are their coping strategies? (*Follow up*)

Goal: To what extent does the belief system play a role in how people understand/value mental health (e.g., experience trauma; recover)?

Based on: *Article - Mental health literacy: focus on developing countries (Ganasen, K. A. et al., 2008).*

Article - *A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health (CIMH) model (Hwang, W. C., et al., 2008).*

8. How are feelings expressed in your culture? (*Main question*)

    8.1 Are feelings openly expressed? (*Follow up*

    8.2 Are people comfortable in expressing and showing their feelings openly and indiscriminately with others? (*Follow up*)

8.3 Or are they shown and expressed in intimate circles of trust? (*Follow up*)

8.4 If so, which feelings are expressed openly and which ones are reserved for close intimate circles? (*Follow up*)

8.5 Further focusing on trauma and recovery, can you elaborate on these in the context of the above questions? (*Follow up*)

9. Is there a stigma around mental health? (*Main question*)
10. How does it manifest in society? (*Main question*)
11. Why do you think is there such a stigma around mental health in your context? (*Main question*)

Goal: What is the cultural understanding of mental health?

Based on: *Article- Trauma and disasters in social and cultural context (Kirmayer, L. J., et al., 2010).*

12. How does your country's history, shaped by various wars (Iran/Iraq war; Civil war; Genocide in Halabja) and fight for independence have an impact on how you understand mental health? (*Main question*)

Goal: To what extent does the context change the understanding (in this specific case)?

Language

13. In every language, there are certain terms and words that are hard to translate to another language. For example, in German…….. this could loosely mean……. but not quite the same. What terms or words related to mental health, trauma, and recovery in your language that are hard, if not impossible, to translate to any other language especially standard psychiatric and psychology terminology and vice versa? (Follow up)

Goal: Aspects that cannot be expressed in English?

Based on**:** *Article - Talking science and wishing for miracles: Understanding cultures of mental health practice (Lakeman, R., 2013).*

Wrap-up

14. Do you have any other comments?
15. And do you have any other questions for me?
16. Do you think I might have missed certain questions I should have asked?
17. Would you advise me to ask more specific questions to the next interviewee?

Appendix E [2]

Coding Guideline

		Coding Guideline	
Main Category	**Definition**	**Prime Example (Keywords)**	**Coding Rule**
C1: Mental Health	Definition/ Understanding of Mental Health	**K:** multidisciplinary; being active; to develop; having relationships (with yourself and others) ; agency; lack of knowledge/understanding; crazy; a sin; affects body & mind; it's a weakness **W:** realise own ability; balance; on a daily basis; in connection to resilience & capacity; to be able to cope; feeling positive; to function; to take care of one self	**Describing:** Mental Health State - Needs
C2: Resilience	Definition/ Understanding of Resilience	**K:** withstanding; environment; education; perspective; filling your emptiness; have a plan (control); on a daily basis, get more resilient the more negative events you experience; to not be afraid; restore; being confident; to deal; to accept; overcome problems; be prepared; know how to express the feelings; anticipation of your reaction; adaptation; being active **W:** coping; make own decisions; bounce back; knowledge (about yourself); support; control; accept; faith; flexibility; strength; a characteristic; capacity; mobiles resources; personality; a resource that is limited (gets worn down); empowered	**Describing**: Withstanding a situation/ Adaptation to new situation (environment) - Needs
C3: Trauma	Definition/ Understanding of Trauma	**K:** shock; life threatening; levels of trauma; short term vs. Long term; something that stays (scar); sudden; not controllable; fear; a sensation; language issue; normalised **W:** different level of severity; term is used too much	**Describing:** Trauma/ Traumatic experiences
C4: Support	Definition/ Understanding of Support	**K:** Expectation: taking medicine (needing to do the work by themselves) ; short-term procedure; (getting paid); importance of empathy (knowing that feelings cannot be easily expressed); Religion is linked to mental health in the sense of recovery or coping mechanism (needs to be taken into account); people are getting used to offered support; difficult to listen; shameful to go to therapy; have a close relationship to the patient; ensuring that the patient knows it is not their fault; empower; nice environment; trust; raise awareness and give opportunities; hope; very new; gender perspective; creation of sort of a dependency; give options; be creative; lack of understanding; weakness; a place with respect & dignity **W:** give options; self-care; individualistic; clinical; not counsel only advise; involvement of support system of the individual; hope; change of perspective; teach strategies to deal with stress; control	**Describing:** Various Forms of Support/ Expectations/ Needs
C5: Use of words	What words are used to describe/explain Mental Health Support? What are limitations?	**K:** Lack of words that can be used to describe mental health and feelings; language as a barrier to understand each other and to find information; lost in translation.	**Describing:** Language in relation to Mental Health Support
C6: Expression of feelings	How are feelings expressed?	**K:** a sin; shame; showing feelings is weak, is feminine, difficult for men (trust can be helpful) -- > increases the pressure; new generation is more open; lack of awareness; more attention on feelings in the West **W:** gender difference (women express more easily); difficulties to understand feelings (from others); difficult to cope; no time to reflect; psychosomatic symptoms; more weight towards the collective happiness; expression and relationship of feelings also depends on childhood and how aware the family is; older generation is more closed up; more awareness in correlation with education	**Describing:** Expression of feelings
C7: Societal relationships	How are relationships are formed? What value do they have in society?	**K:** hierarchy; being different is difficult; *'close'* society; close relationships are important; relationship between wife & husband	**Describing:** Any form of human relationships
C8: Attitude to the future	How important is the future perspective?	**K**: no future planning/perspective; waiting (in IDP camps); crisis situation; no time/stability	**Describing**: A future perspective
C9: Prevention	Definition/ Understanding of Prevention	**K:** increasing awareness among all levels of society; inclusive approach; using social media and TV channels; accessible information; normalisation **W**: awareness raising; taking care of one self	**Describing:** Prevention (strategies)
C10: Recovery	Definition/ Understanding of Recovery	**K:** having hope; trust; control your thoughts/mind; having a routine; a healthy coping mechanism; acceptance; environment **W:** safety; trust; being able to manage alone; no more flashbacks; using techniques; accept; new perspectives; let got & move forward; being active	**Describing:** Recovery/ Coping mechanisms
C11: Challenges	What are challenges/barriers for the offered support?	**K:** new discipline; lack of (qualified) staff; normalisation; access to support; to identity root problems ; lack of awareness; different levels of education (therapist has to be very creative); everyone is traumatised; not enough information; stigma; lack of services; different expectations on both sides; differences how people support each other; lack of trust towards NGO's; sustainability of projects can be questioned; feeling shame when asking for support **W**: takes time to understand; blind sided; sustainability of project; individualistic; men are less likely to access support; pressure from donors; end goal is lost; communicating the project (it's goals/expectation etc.) so it is understood; translations; no access to support; neglect host community; low understanding of how to implement the support into the community; community acceptance; active listening; language barrier; communication of expectations; underestimate the concept; lack of educational; instability of offered support; increase stigma with low quality support; time consuming; how to adapt culturally?; solutions to those problems are unsuitable here	**Describing**: Challenges in relation to Mental Health Support
C12: Consequences	What are the direct consequences of the challenges/differences in understanding?	More support needed; less words to communicate; be more sensitive; cultural adaptation; not to make assumptions; time consuming (relationship building); trying to find out what is culturally appropriate	**Describing**: Consequences in regard to the different understanding
C13: Lessons Learned	What are lessons learned?	Inclusive approach (involve everyone); building a network; more specialised resources; anonymous support; a therapist from the same culture; be careful about how to talk about mental health; communication	**Describing**: Lessons Learned in regard to *'failed'* Mental Health Support

[2] ***'K'*** refers to the Kurdish perspective – ***'W'*** refers to the Western perspective (including interviewees views on Kurdish perspective)