Evaluating the Jiyan Therapy System: Enhancing Effectiveness for Future Advancements

Yasin Duman, PhD

Consultant

March 2025

Cite as: Duman, Y. (2025) *Evaluating the Jiyan Therapy System: Enhancing Effectiveness for Future Advancements*. Jiyan Foundation for Human Rights. https://jiyan.org/publications

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Abbreviations

AD	Adjustment disorder
APD	Antisocial personality disorder
ART	Art therapy
ASD	Autism spectrum disorder
AUD	Alcohol use disorder
CBT	Cognitive behavioural therapy
CREST	Cognitive Remediation and Emotion Skills Training
GAD	General anxiety disorder
MDE	Major depressive disorder
MHE	Manic and hypomanic episode
NET	Narrative exposure therapy
OCD	Obsessive-compulsive disorder
ODD	Oppositional defiant disorder
PAD	Panic disorder
PD	Psychotic disorder
PHQ15	Patient Health Questionnaire-15
PHQ9	Patient Health Questionnaire-9
PTSD	Post-traumatic stress disorder
S	Suicidality
SAD	Social anxiety disorder
SDQ	Strengths and difficulties questionnaire
SPH	Specific phobia

Figures, Maps, and Tables

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Executive Summary

This study investigates the impact of various therapy methods on mental health and psychosocial wellbeing among diverse displaced and local populations, including adults, children, and adolescents. The study utilized a mixed methods design to provide both a quantitative and qualitative understanding of mental health outcomes. Data were collected through two primary methods: 128 clinical assessments and 20 structured interviews. Clinical assessments, administered by trained psychotherapists, measured psychological well-being using standardized diagnostic tools like PHQ-9, PHQ-15, GAD-7, and SDQ. Qualitative data were gathered through voice-recorded interviews conducted with a diverse group of participants, capturing their lived experiences and perceptions of mental health challenges. The sample included individuals from different gender identities, age groups, and socio-economic backgrounds, reflecting the complex nature of the refugee, internally displaced, and local populations.

The study found significant improvements in mental health outcomes across different age groups and displaced and returnee populations, with adults experiencing reductions in depression and anxiety, and children and adolescents showing improved emotional wellbeing and behavioural functioning. The therapy methods also helped improve gender-specific physical symptoms, particularly in females.

However, the research also highlighted the persistent mental health challenges faced by displaced populations, specifically internally displaced persons (IDPs), who showed higher levels of depressive symptoms even after therapy. These findings emphasise the need for targeted and context-oriented interventions for displaced individuals and groups. Variations in therapy effectiveness, particularly in therapies like Narrative Exposure Therapy (NET) and Psychotherapy, suggest that different therapeutic approaches may be more effective for distinct psychosocial challenges, which necessitates further systematic exploration into how these therapies can be integrated or complement each other for optimal outcomes.

Based on the key findings and limitations of the evaluation, a comprehensive set of recommendations for Jiyan Foundation, government and non-governmental stakeholders, and organisations and institutions that provide MHPSS is presented at the end of the report. These recommendations will hopefully mitigate the existing practical challenges in this field.

1. Introduction

Both Iraq and Syria and their predominantly Kurdish populated areas, namely Kurdistan Region of Iraq (KRI) and Rojava (also known as North and East Syria) have suffered significantly from protracted conflicts that cause millions of people to be displaced within these countries as internally displaced persons (IDP) or externally as asylum seekers or refugees. The mental health and psychosocial wellbeing challenges faced by refugees, local populations, and internally displaced persons (IDPs) in those regions are multidimensional and deeply influenced by the region's socio-political context. The ongoing socio-political and economic struggles, along with cultural barriers and biases towards mental health, significantly impact psychological outcomes. Research indicates that both Syrian refugees and IDPs in Iraq and KRI are grappling with mental health and psychosocial issues. Since the onset of the Syrian civil war in 2011, which forced over half of the population to flee, including

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more than 6 million refugees, mental health challenges have escalated. Mahmood et al. (2019), for example, estimate the psychological consequences of this conflict among Syrian Kurdish refugees in Iraq, finding that 98.5% of participants had experienced at least one traumatic event, 86.3% had encountered multiple types, with approximately 60% exhibiting probable PTSD and 59.4% showing probable depression. Gender, length of time in the camp, upbringing, and the number of traumatic events were identified as significant predictors for these mental health conditions. Duman (2024) provides further evidence of mental health and psychosocial challenges IDPs, returnees, and local community members experience as a result of repeated displacements, security concerns, high unemployment, lack of access to essential services, and unaddressed psychosocial distress.

Studies also indicate that exposure to pre-, peri-, and post-displacement stressors contribute significantly to mental health issues, including post-traumatic stress disorder (PTSD) and depression among both refugee and internally displaced populations (Kizilhan, 2018; Semmlinger & Ehring, 2021; Tekin et al., 2016). The trauma experienced during conflict, coupled with the stress of displacement, creates a compounded effect on mental health, leading to increased psychological distress (Kip et al., 2020). Furthermore, studies have shown that refugees in non-Western countries, including Iraq, are less likely to seek psychopharmacological treatments, which may exacerbate their mental health conditions (Kip et al., 2020).

Table 1. Refugee population in Iraq, including KRI (UNHCR, 2025)

Country of origin	**Population**	**Percentage**
Syria	304,409	89.7%
Various	15,696	4.6%
Iran	9,504	2.8%
Turkey	8,071	2.4%
Sudan	1,619	0.5%

Barriers to accessing mental health services are also prominent in Iraq and KRI. Cultural stigma surrounding mental health issues often prevents individuals from seeking help (Lindegaard et al., 2019; Duman, 2024). Many refugees and IDPs lack knowledge about available mental health services, which is compounded by structural barriers such as inadequate healthcare infrastructure and insufficient coordination among service providers. The perception of mental health services as less effective compared to traditional or community-based support systems further discourages individuals from utilizing these services (Clough et al., 2022). Additionally, the lack of culturally competent care can hinder effective treatment, as many mental health interventions are not tailored to the specific cultural contexts of Kurdish and Iraqi populations (Bernardi et al., 2019).

Table 2. Internally displaced and returnee population across Iraq, including KRI (IOM, 2025)

Internally displaced persons	**Displacement movements**	**Returnee population**
1,031,475	1,124,000	4,927,890

The Jiyan Foundation for Human Rights, established in 2007 and based in Erbil, the Kurdistan Region of Iraq, is a non-governmental, non-profit organization dedicated to supporting survivors of human rights violations, defending fundamental freedoms, and promoting democratic values throughout the world, and its programs provide mental health, medical treatment and other support services to survivors of trauma, terror, domestic violence and human rights violations. The Foundation has 7 treatment centres, a clinic for Yazidi women and families (2014-25), a Healing

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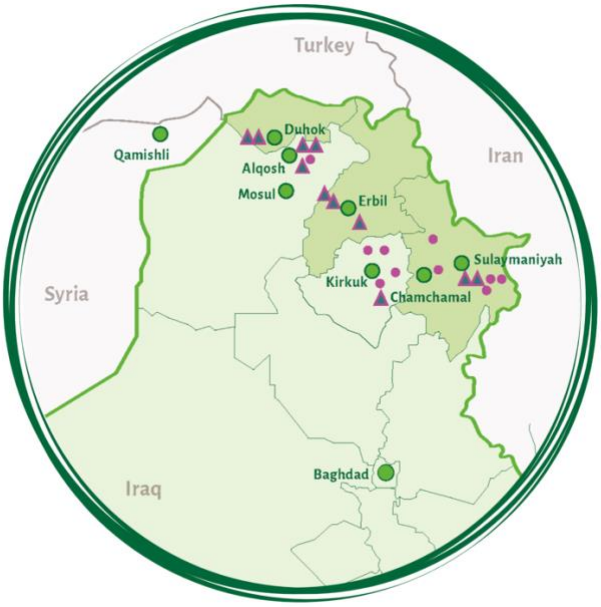
Garden and mobile teams helping survivors in 11 refugee and IDP camps and seven regions throughout Kurdistan-Iraq, Iraq, and Syria. Since 2005 these programs have supported over 100,000 survivors of trauma, terror, domestic violence and human rights violations in the region.



Map 1. Sites where the Jiyan Foundation provides services, including the evaluation locations.

This evaluation is conducted as part of a currently implemented project funded by Else Kröner-Fresenius-Stiftung, with the goal of strengthening mental health and psychosocial support capacity in Iraq. As part of this initiative, the foundation is establishing the Jiyan Institute for Mental Health. To ensure the success of this venture, the Foundation is focused on developing research to determine the necessary resources and strategies for effectively launching the Institute.

The Jiyan Institute for Mental Health, which is another key component of the same project, is dedicated to empowering mental health professionals in the KRI and Syria. For over a decade, the Foundation has been at the forefront of supporting survivors, promoting resilience, aiding refugees, and offering outstanding training and capacity-building programs across Iraq, the KRI, and Syria.

This evaluation focuses on six governorates and districts: Erbil, Sulaimania, Kirkuk, Duhok, Chamchamal, and Al-Qosh (see Map 1). It examines the effectiveness of six therapy methods: Cognitive Behavioural Therapy (CBT), Art Therapy (ART), Play Therapy, Psychotherapy (General Talk Therapy), Cognitive Remediation and Emotion Skills Training (CREST), and Narrative Exposure Therapy (NET) through individual accounts of therapy clients (n = 20) as well as individual case files (n = 140) retrieved from Jiyan Foundation's database.

The objective of this task is to conduct research to assess the efficiency and effectiveness of the Jiyan therapy system, laying the foundation for the further development of Jiyan therapeutic approaches. The findings from this research will serve as a reference to identify both the strengths and weaknesses of the Jiyan therapy system, including aspects such as staff, methods, procedures,

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and knowledge. Based on these insights, we will be able to determine the resources that can be leveraged and those that require further improvement for this project.

2. Methodology

2.1. Research Design

This study adopted a mixed-methods research design, combining both qualitative and quantitative approaches to provide a comprehensive understanding of the mental health and psychosocial support (MHPSS) needs and outcomes within the target population. The use of mixed methods allows for a deeper exploration of complex issues by integrating the detailed, subjective insights gathered from qualitative data (e.g., interviews) with the objective, measurable outcomes provided by quantitative data (e.g., clinical assessments). The combination of these approaches enables a more holistic understanding of the mental health challenges faced by the population, while also facilitating the validation of findings across different data sources. This design enhances the robustness of the study's conclusions and offers a more nuanced perspective that purely qualitative or quantitative approaches alone might not provide.

2.2. Data Collection Methods

Data for this study were gathered using two main methods: in-person interviews and clinical assessments. Specifically, 20 in-depth interviews were conducted with clients, including 5 children and adolescents, and 15 adults (11 females and 4 males). Participants were selected from various locations, including Sulaimania, Al Qosh, Erbil, Kirkuk (with 3 participants from each area), as well as Chamchamal and Duhok (with 4 participants from each). Questions focused mainly on understanding the clients' experiences in and perceptions of effectiveness of therapy, client-therapist relationship, and the Foundation's service quality and areas for improvement. The interview questions were designed based on the Foundation's "intake forms" and the key assumptions of each therapy method, which are introduced in further detail below (see Section 3). The clients selected for interviews met criteria co-identified by the consultant and Chenar Seerwan, Head of Trauma Care and Health at the Foundation. Selection was based on careful consideration of the participant's gender, age, displacement group, and the therapy they received. All interviews were conducted in person, with no dropouts, in a room designated by the Foundation to ensure privacy and confidentiality. Interviewees were informed in advance of the interview location and time.

These interviews were predominantly conducted in Kurdish, with some also in Arabic to accommodate the linguistic diversity of the population. The interviews were voice-recorded to ensure accuracy in data collection and later transcription and analysis. These qualitative interviews aimed to capture the personal experiences and perceptions of participants regarding their mental health and psychosocial challenges. The interviews provided rich, narrative data on the participants' lived experiences, coping strategies, and expectations for mental health support. Interview questions for each therapy method and age group are attached in the Annex.

In addition to the interviews, 128 clinical assessments were conducted by trained psychotherapists from the Jiyan Foundation. These assessments focused on evaluating the psychological well-being of the participants using standardized diagnostic tools and clinical

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frameworks (e.g., PHQ9, PHQ15, GAD-7, SDQ, and SP). The assessments were randomly selected from the Foundation's database by the Foundation's M&E team based on the consultant's classification of therapy methods to ensure a broad representation of therapy types and approaches. To maintain objectivity and avoid potential bias in assessing the effectiveness of the therapy program, the consultant and the Foundation's therapists refrained from direct communication during the consultancy period. This separation was intended to prevent any unintentional influence on the consultant's analysis and to ensure that the evaluation remained independent and based solely on the data collected. By minimizing direct interaction, the assessment process upheld a neutral stance, avoiding any potential conflicts of interest or undue influence from those directly involved in delivering therapy.

However, the consultant and the Head of Trauma Care and Health maintained clear communication and collaboration through the M&E team for data retrieval and case selection. The qualitative and quantitative data were drawn from different clients, ensuring they were not directly related. These assessments were instrumental in quantifying the extent of mental health issues such as depression, anxiety, and PTSD, providing measurable data to complement the qualitative findings.

2.3. Sample

The sample of the clinical assessments includes individuals from diverse demographic backgrounds so that their responses reflect the complexity of the refugee, internally displaced, returnee, and local communities in the region. Participants whose case files were examined were selected based on their engagement with mental health services provided by the Jiyan Foundation and their diverse experiences of displacement. The child, adolescent, and adult clients randomly selected for this evaluation included those who have been experiencing diverse psychological disorders or mental health and psychosocial challenges.

Table 3. Demographics of the clinical sample (n = 128)

	Gender		Age			Displacement status		
Locations	Male	Female	0-9	10-17	18+	Refugee	IDP/Returnee	Local/host
Erbil	12	12	8	6	10	8	5	11
Sulaimania	4	9	8	-	5	8	4	1
Kirkuk	7	13	7	7	6		5	15
Duhok	12	12	8	6	10	6	10	8
Chamchamal	12	12	8	6	10			24
Al-Qosh	11	12	7	7	9	1	13/1	8

Table 4. Prevalence of disorders or mental health and psychosocial problems among adult sample

Disorder or problem	Frequency	Percentage
MDE – Major depressive disorder	40	56,34
PTSD – Posttraumatic stress disorder	9	12,68
GAD – General anxiety disorder	10	14,08
SAD – Social anxiety disorder	3	4,23
PD – Psychotic disorder	2	2,82
PAD – Panic disorder	2	2,82
S – Suicidality	1	1,41
MHE – Manic and hypomanic episode	1	1,41

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OCD – Obsessive compulsive disorder	1	1,41
AUD – Alcohol use disorder	1	1,41
APD – Antisocial personality disorder	1	1,41

Table 5. Prevalence of disorders or mental health and psychosocial problems among child and adolescent sample		
Disorder or problem	Frequency	Percentage
MDE – Major depressive disorder	17	16,04
ADHD - Attention deficit hyperactivity disorder	12	11,32
GAD – General anxiety disorder	12	11,32
AD – Adjustment disorder	12	11,32
PTSD – Posttraumatic stress disorder	10	9,43
Other	8	7,55
SED – Separation anxiety disorder	7	6,6
PD – Panic disorder	6	5,66
CD – Conduct disorder	5	4,72
SPH – Specific phobia	4	3,77
SAD – Social anxiety disorder	3	2,83
A – Agoraphobia	3	2,83
GD – Gender dysphoria	2	1,89
ASD – Autism spectrum disorder	1	0,94
ODD – Oppositional defiant disorder	1	0,94
Any psychotic disorder	1	0,94
Bed wetting	1	0,94
S – Suicidality	1	0,94

Many psychological disorders do not exist in isolation; rather, they frequently co-occur, creating complex clinical pictures that require a nuanced approach to diagnosis and treatment. In the provided data, multiple cases illustrate individuals experiencing more than one disorder at the same time. For example, combinations such as MDE-PTSD-CD and MDE-A-SED-PTSD-ADHD highlight the intricate ways in which mental health conditions interact. These overlaps demonstrate shared risk factors, such as genetic predisposition, trauma – including transgenerational trauma (see Kizilhan & Noll-Hussong, 2017), or environmental stressors, that contribute to multiple disorders developing simultaneously.

One particularly common pattern is the co-occurrence of mood disorders, anxiety disorders, and externalizing disorders. For instance, individuals with MDE often also experience GAD, PTSD, and ADHD. Depression and anxiety frequently co-occur because they share underlying cognitive and neurobiological mechanisms, including dysregulation of stress responses and neurotransmitter imbalances. Similarly, externalizing disorders such as CD and ODD appear alongside internalizing conditions like ADHD and PTSD, suggesting that early behavioural difficulties may increase susceptibility to later emotional distress.

Another notable pattern is the overlap between neurodevelopmental disorders and other psychiatric conditions. ASD and ADHD often appear together, leading to unique challenges in attention, social functioning, and emotional regulation. Disorders related to fear and trauma—such as SPH, SED, and PTSD—can cluster, which indicates a heightened sensitivity to stress and a predisposition to anxiety-

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related conditions. The inclusion of GD in some cases also highlights the mental health challenges faced by individuals struggling with gender identity, who may be at higher risk for depression, anxiety, and suicidality due to social stigma and discrimination.

Understanding these comorbidities is crucial for effective diagnosis and treatment planning. Traditional approaches that focus on treating one disorder at a time may not be sufficient when multiple conditions interact. Instead, clinicians often adopt integrated therapeutic strategies that address overlapping symptoms, such as CBT for both depression and anxiety, or multimodal interventions for ADHD and conduct-related disorders. In cases of severe or multiple co-occurring disorders, a combination of therapy, medication, and social or environmental support is often necessary to improve long-term outcomes.

2.4. Ethical Considerations

This study adhered to rigorous ethical standards to ensure the protection and well-being of all participants. Informed consent was obtained from all participants before their involvement in interviews or clinical assessments. For minors, consent was also obtained from their legal guardians. Participants were informed of the study's purpose, the voluntary nature of their participation, and their right to withdraw at any time without consequence.

Confidentiality and anonymity were prioritized throughout the study. All interview recordings and clinical assessments were stored securely, with access limited to authorized personnel only. Personal identifiers were removed during data analysis to ensure privacy. Additionally, participants were informed that their responses would be used solely for research purposes and that any identifying information would be kept confidential.

Given the sensitive nature of the topic, special consideration was given to participants who may have experienced trauma. Psychological support was available for participants who showed signs of distress during the interviews or assessments. The study also adhered to cultural sensitivities and ensured that data collection methods were respectful and responsive to the cultural contexts of the participants. The study was approved by the ethical review committee of the Jiyan Foundation, and all procedures followed the ethical guidelines for research involving vulnerable populations.

3. Overview of Psychotherapies Assessed

3.1. Psychotherapy

Psychotherapy is a structured treatment approach that helps individuals address emotional, psychological, and behavioural challenges through various techniques, such as cognitive-behavioural therapy, psychodynamic therapy, and humanistic therapies. It aims to improve individuals' understanding of their thoughts, feelings, and behaviours while developing coping strategies to manage mental health difficulties. This approach is particularly crucial for displaced populations, such as refugees and internally displaced persons (IDPs), who often experience significant psychological distress due to trauma, loss, and instability (Ceballos et al., 2016). Key to its success is the therapeutic alliance—the relationship between therapist and client—which contributes to trust and engagement, particularly for displaced individuals who may have experienced betrayal or loss of trust (Gibbons et al., 2012).

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Cultural sensitivity is essential when providing psychotherapy to displaced individuals, as therapists must understand and respect cultural differences to ensure relevant and effective treatment. Beitel et al. (2018) emphasize the importance of cultural competence when working with underserved populations, and this is especially pertinent for refugees and IDPs. The integration of diverse therapeutic techniques, drawing from various therapeutic modalities, can further enhance the effectiveness of psychotherapy in addressing the complex needs of displaced populations. Overall, psychotherapy plays a critical role in addressing the psychological impact of trauma and instability, supporting the resilience and wellbeing of displaced individuals.

3.2. Cognitive Behavioural Therapy (CBT)

CBT is a structured, goal-oriented psychotherapy that addresses dysfunctional emotions, behaviours, and cognitions by challenging negative thought patterns. It is highly effective for treating various mental health disorders, including anxiety, depression, and PTSD (Deacon & Abramowitz, 2004; Kim et al., 2016; Areas et al., 2021). The therapy can be delivered in various formats, such as individual or group sessions and internet-based platforms, with comparable efficacy to traditional face-to-face therapy (Yoo, 2021; Frenette et al., 2023; Basile et al., 2022). CBT has also been adapted for specific populations, including children with complex intellectual disabilities and individuals with conditions like tinnitus (Hronis et al., 2024; Andersson & Kaldo, 2003). This adaptability and flexibility are key strengths of CBT, allowing it to meet the unique needs of diverse client groups.

However, CBT has its limitations. Critics argue that it primarily addresses symptom management and may neglect deeper psychological issues, such as past trauma (Areas et al., 2021; Okamoto & Kazantzis, 2021). Additionally, CBT's effectiveness varies, with 30% to 50% of individuals not experiencing significant improvement (Areas et al., 2021; Okamoto & Kazantzis, 2021). Factors such as the complexity of the disorder, client engagement, and therapist skill can influence outcomes (Kim et al., 2016; Redd, 2004). The therapy's structured nature may also be unsuitable for clients who benefit from a more exploratory approach, and challenges like the reliance on homework assignments can hinder progress for those with severe symptoms (Cronin et al., 2015; Okamoto & Kazantzis, 2021). Moreover, the success of CBT is heavily dependent on a strong therapeutic alliance, and any rupture in this relationship can negatively impact treatment (Okamoto & Kazantzis, 2021; Cronin et al., 2015). Thus, while CBT remains a widely used and effective modality, its limitations suggest the need for integrating it with other approaches to address both symptoms and underlying psychological issues.

3.3. Art therapy

Art therapy is a powerful psychological intervention that leverages creative expression to facilitate emotional recovery and resilience. Unlike traditional talk therapy, which relies on verbal articulation, art therapy provides a non-verbal medium through which individuals can communicate and process their emotions. This makes it particularly beneficial for displaced populations, including refugees and IDPs, who frequently experience trauma, loss, and cultural dislocation.

Trauma survivors often struggle with verbalizing their experiences due to the overwhelming emotional burden or cultural differences in expressing distress. Art therapy offers an alternative means of communication, allowing individuals to externalize their emotions through artistic expression. Maddox et al. (2024) highlight how art therapy creates a safe, supportive environment where trauma survivors can process their experiences, ultimately leading to improved emotional

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regulation and quality of life. By providing an outlet for symbolic expression, art therapy enables individuals to reconstruct their narratives in a way that contributes to recovery and resilience.

Displaced individuals often suffer from high levels of psychological distress, including anxiety, depression, and PTSD. Research by Cowling and Anderson (2023) demonstrates that art therapy interventions, particularly those involving expressive arts such as painting, movement, and music, have led to significant reductions in PTSD symptoms among refugee children. This aligns with the work of Qiu et al. (2017), who describe art therapy as a means of enhancing emotional communication and achieving a sense of connection among individuals who have experienced isolation and displacement.

A unique advantage of art therapy is its incorporation of playfulness and creativity, which are essential for emotional expression and recovery. Orkibi (2013) emphasizes that playfulness promotes spontaneity and resilience, helping displaced individuals reconnect with their emotions and identities. This is particularly relevant for children and adolescents, who may struggle to engage in conventional therapeutic approaches. Through artistic play, displaced individuals can explore their emotions in a low-pressure, supportive environment that helps improve wellbeing.

Art therapy is not solely about artistic expression; it also incorporates narrative techniques that facilitate meaning-making. Haeyen et al. (2024) highlight the integration of traumatic memories with positive experiences through storytelling and visual representation, enhancing self-compassion and emotional stability. For displaced individuals who face fragmented identities due to forced migration, this narrative integration can be instrumental in rebuilding a coherent sense of self.

3.4. Play Therapy

Play therapy is an effective therapeutic approach that utilizes play as a medium for communication and emotional expression, particularly beneficial for children who struggle to articulate their feelings verbally. This modality is especially useful for displaced populations, such as refugees and IDPs, who often face trauma and emotional distress. Play therapy provides a safe and supportive environment where children can process their experiences, develop coping strategies, and regain a sense of agency. Research supports its effectiveness, such as a randomized controlled trial by Schottelkorb et al. (2012), which demonstrated the positive impact of Child-Centred Play Therapy (CCPT) in reducing PTSD symptoms among refugee children. The non-directive nature of play therapy, which allows children to express themselves at their own pace, is also particularly valuable for those who feel a loss of control, as noted by Stutey et al. (2016).

Cultural sensitivity is crucial in the application of play therapy for displaced populations. Studies by Kwon and Lee (2018) and Killian et al. (2017) emphasize the importance of culturally responsive approaches to enhance therapeutic outcomes for refugee children. Tailoring play therapy to the cultural backgrounds and experiences of the children ensures greater engagement and effectiveness. Additionally, while the literature does not directly support claims about play therapy's role in social skills development, it is well-documented that play therapy helps children improve emotional regulation and interpersonal skills, which are often compromised by trauma. This is especially critical for displaced children, who may struggle with feelings of isolation and disconnection. Overall, play therapy plays a key role in addressing the psychological needs of displaced children, improving emotional recovery, resilience, and long-term well-being.

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3.5. Cognitive Remediation and Emotion Skills Training (CREST)

CREST is an innovative therapeutic approach designed to improve cognitive functioning and emotional regulation, particularly for individuals with mental health challenges. By integrating cognitive remediation with emotion skills training, CREST aims to address cognitive deficits while improving emotional awareness and regulation. This dual focus is particularly important for displaced individuals, such as refugees and IDPs, who often face significant psychological distress due to trauma, loss, and instability. The cognitive remediation component is based on the understanding that cognitive deficits can hinder emotional processing and overall psychological well-being. Research has shown that improving cognitive functioning through remediation can, in turn, enhance emotional regulation, making it a promising intervention for addressing the complex psychological needs of displaced populations.

Emotion skills training within the CREST framework is vital for teaching individuals how to recognize, understand, and manage their emotions effectively, a skillset that is crucial for displaced individuals often experiencing emotional dysregulation due to traumatic experiences. The study by Tchanturia et al. (2015) provides evidence that CREST can significantly improve emotion processing and regulation in individuals with anorexia nervosa, suggesting its potential applicability to other populations facing similar emotional challenges, such as refugees and IDPs. The integration of cognitive and emotional skills training can help to build resilience in these individuals. However, cultural sensitivity must be prioritized in the implementation of CREST to ensure its effectiveness, as understanding the cultural backgrounds of displaced individuals is essential for successful therapeutic outcomes. As the mental health needs of refugees and IDPs continue to grow, CREST offers a comprehensive approach to healing and resilience, addressing both cognitive and emotional challenges in a way that promotes long-term psychological well-being.

3.6. Narrative Exposure Therapy (NET)

NET is a structured, short-term therapeutic approach specifically designed to treat individuals suffering from PTSD and other trauma-related symptoms. It is particularly effective for those who have experienced multiple traumatic events, such as refugees and IDPs escaping from wars and conflicts. NET combines exposure therapy with narrative techniques, allowing individuals to create a coherent narrative of their life, with a focus on traumatic events. This process aids in processing trauma, integrating past experiences, and reducing the emotional distress associated with those memories. Studies, including a meta-analysis by Raghuraman et al. (2020), have demonstrated that NET can significantly alleviate PTSD and depression symptoms, improving overall mental health outcomes. This makes it an invaluable intervention for displaced populations, who often face complex and compounded trauma histories. The structured nature of NET ensures that therapists can guide clients through recounting their traumatic experiences in a safe, supportive environment, crucial for those dealing with the emotional weight of their past.

Beyond reducing PTSD symptoms, NET has also been linked to promoting post-traumatic growth, a key benefit for displaced individuals working to rebuild their lives after trauma. Zang et al. (2013) found that NET not only reduced PTSD symptoms among adult survivors of the Sichuan earthquake but also facilitated personal growth, allowing participants to develop new perspectives on life. This aspect of NET is especially pertinent for refugees and IDPs, who may struggle to find meaning after experiencing overwhelming hardship. NET's adaptability is further supported by research on its application to various displaced populations. For example, Onyut et al. (2005) highlighted the

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success of NET in addressing trauma symptoms in child war survivors in an African refugee settlement. Additionally, Bedard-Gilligan et al. (2022) emphasized the importance of culturally adapting NET to meet the specific needs of tribal communities and ensure the therapy resonates with clients' lived experiences and backgrounds. Such cultural sensitivity enhances trust and engagement, ultimately improving treatment outcomes. Moreover, integrating NET with other therapeutic approaches can further enhance its effectiveness, as noted by Crombach and Siehl (2018), providing a comprehensive framework for addressing the complex psychological needs of displaced individuals. As the mental health needs of displaced populations continue to rise, NET offers a structured, compassionate, and adaptable therapeutic approach to recovery and resilience.

4. Findings and Analysis

4.1. Quantitative data

4.1.1. Adults

The key findings of the evaluation show that overall applied therapy methods have helped the adult clients make significant progress in their mental health and psychosocial wellbeing. More specifically, the study examined depression scores (PHQ-9) before and after an intervention in 49 adults. On average, scores dropped significantly from 14.71 before to 3.19 after, indicating a shift from moderate to minimal/no depression. This change was statistically significant ($t=13.91$, $p<0.001$). This provides strong evidence that the change is a result of the intervention rather than chance. The intervention (applied therapy methods) had a large effect size (Cohen's $d=2.66$), which suggests a substantial impact in reducing depression symptoms. Essentially, the intervention was effective in meaningfully lowering depression scores in the group studied.

Table 6. Descriptive statistics of adult sample (PHQ9) (n = 49)		
	PHQ-9 Before	PHQ-9 After
Mean	14.71	3.19
Standard Deviation	5.89	2.59
Minimum Score	1	0
Maximum Score	25	12

A similar trend is observed in the PHQ-15 scores. On average, scores dropped significantly from 13.06 before to 4.67 after, indicating a notable reduction in reported physical symptoms. This change was statistically significant ($t=10.37$, $p<0.001$). This provides strong evidence that the change is a result of the intervention rather than chance. Furthermore, the intervention had a large effect size (Cohen's $d=1.50$), which suggests a substantial impact in reducing physical symptom scores in the group studied. Essentially, the intervention was effective in meaningfully lowering physical symptom scores as measured by the PHQ-15.

Table 7. Descriptive statistics of adult sample (PHQ15) (n = 49)		
	PHQ-15 Before	PHQ-15 After
Mean	13.06	4.67
Standard Deviation	6.43	3.82
Minimum Score	0	0
Maximum Score	24	14

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To analyse the differences in depressive (PHQ-9) and physical (PHQ-15) symptoms based on displacement status (IDP, refugee, local/host Community), a descriptive analysis and ANOVA tests were conducted on the provided data. The groups had unequal sample sizes, with IDPs being the largest group (n=20) and refugees the smallest (n=5). It should be noted that such unequal sample sizes reduce statistical power and increase sensitivity to assumption violations, potentially affecting the reliability of comparisons. The results showed significant differences between the groups in both PHQ-9 and PHQ-15 scores before the intervention ($p<0.001$ for both). Post-hoc tests revealed that IDPs had significantly higher PHQ-9 scores (indicating more depressive symptoms) compared to both local/host community and refugees. Similarly, IDPs had significantly higher PHQ-15 scores (indicating more physical symptoms) compared to the other two groups. After the intervention, the differences in PHQ-9 scores remained significant ($p<0.001$), while the differences in PHQ-15 scores were no longer significant ($p=0.109$). These findings suggest that while the intervention was effective in reducing symptoms for all groups, IDPs continued to experience significantly more depressive symptoms compared to the other groups.

After conducting independent t-tests, the analysis revealed that there were no statistically significant gender differences in PHQ-9 scores before the intervention ($p=0.916$) or after the intervention ($p=0.297$). However, there was a statistically significant gender difference in PHQ-15 scores before the intervention ($p=0.045$), with females reporting higher physical symptoms. After the intervention, there was no statistically significant gender difference in PHQ-15 scores ($p=0.208$). In other words, after the intervention, the significant difference in physical symptoms between males and females was no longer present.

The research examined anxiety scores (GAD-7) before and after an intervention (e.g. therapy). Due to missing data, we are only able to analyse 24 pairs of scores. On average, scores dropped significantly from 8.00 before to 2.29 after, indicating a notable reduction in reported anxiety symptoms. This change was statistically significant ($t=4.79$, $p<0.001$), which provides strong evidence that the change is a result of the intervention rather than chance. Furthermore, the intervention had a large effect size (Cohen's $d=1.02$), suggesting a substantial impact in reducing anxiety symptoms in the analysed group. Essentially, the intervention was effective in meaningfully lowering anxiety scores as measured by the GAD-7.

Table 8. Descriptive statistics of adult sample (GAD-7) (n = 24)

Statistic	GAD-7 Before	GAD-7 After
Mean	8.00	2.29
Standard Deviation	5.37	2.87
Minimum Score	0	0
Maximum Score	20	12

4.1.2. Children and adolescents

The analysis of the Strengths and Difficulties Questionnaire (SDQ) with children and adolescents revealed a statistically significant decrease in SDQ scores from "Before" to "After" ($t(60) = 5.619$, $p < 0.001$). Specifically, the mean SDQ score before the intervention was 20.31, while the mean score after the intervention was 9.87. This highly significant p-value ($p = 3.32e-07$) indicates that the observed reduction in SDQ scores is unlikely to have occurred by chance. In other words, it suggests

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that the intervention (e.g. therapies) had a substantial and statistically significant impact on reducing SDQ scores. Due to missing data, the analysis was performed only on 61 complete pairs of scores.

Table 9. Descriptive statistics of child and adolescent sample (SDQ) (n = 61)		
Statistic	SDQ Before	SDQ After
Mean	20.31	9.87
Standard Deviation	7.67	6.80
Minimum Score	6	0
Maximum Score	38	30

Similarly, a paired t-test was conducted to examine the difference in PS scores before and after an intervention. Descriptive statistics revealed that the mean PS score before the intervention was 6.16 (SD=2.09), while the mean score after the intervention was 8.22 (SD=2.44). The test revealed a statistically significant increase in PS scores from "Before" to "After" ($t(49) = -5.732$, $p < 0.001$). Specifically, the highly significant p-value ($p = 1.09e-06$) indicates that the observed increase in PS scores is unlikely to have occurred by chance, suggesting that the intervention had a substantial and statistically significant impact on increasing PS scores.

Table 10. Descriptive statistics of child and adolescent sample (PS) (n = 50)		
Statistic	PS Before	PS After
Mean	6.16	8.22
Standard Deviation	2.09	2.44
Minimum Score	2	1
Maximum Score	10	10

The changes in SDQ scores before and after an intervention (e.g. therapies) across three displacement status groups were examined. Paired t-tests revealed a significant reduction in SDQ scores from "Before" to "After" within each group: Local/host community ($t = 4.88$, $p < 0.001$), IDP ($t = 2.11$, $p = 0.048$), and Refugees ($t = 2.46$, $p = 0.025$). However, an ANOVA test found no statistically significant difference in the amount of change in SDQ scores between the groups ($F = 2.25$, $p = 0.113$). Additionally, an independent samples t-test comparing the change in SDQ scores between the Local/host community and IDP groups showed no significant difference ($t = 0.61$, $p = 0.543$). These results suggest that while all three groups experienced a statistically significant reduction in SDQ scores, the magnitude of this reduction was not significantly different between the groups.

The impact of various psychotherapy methods (ART, CBT, CREST, NET, Play therapy, Psychotherapy, and CBT) on SDQ scores is investigated. An ANOVA test revealed a statistically significant difference in the change of SDQ scores between the methods ($F = 10.97$, $p < 0.001$). Post-hoc Tukey's HSD analysis showed significant differences between several pairs of methods. Specifically, ART differed significantly from CBT (mean difference = -3.79, $p < 0.001$), NET (mean difference = -5.00, $p < 0.001$), and Psychotherapy (mean difference = -6.50, $p < 0.001$), with ART showing less reduction in SDQ scores compared to these methods. Additionally, CREST differed significantly from NET (mean difference = -3.50, $p = 0.0246$), indicating NET was more effective in reducing SDQ scores than CREST. These results suggest that NET and Psychotherapy were more effective in reducing SDQ scores compared to ART, while other significant differences were observed between CREST and NET.

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The change in SDQ scores between males and females shows that the mean change was 6.0 for males (boys) and 6.34 for females (girls), which indicates a slight average decrease in SDQ scores for both genders. An independent samples t-test was conducted to determine if there was a statistically significant difference in the change of SDQ scores between males and females. The results showed no significant difference ($t = -0.16$, $p = 0.87$). This suggests that the observed difference in mean change scores between males and females is likely due to chance, and there is no significant gender-based difference in the reduction of SDQ scores.

4.2. Qualitative data

The analysis of the in-person interviews with clients indicate that they, particularly adults, initially faced challenges but eventually reported significant benefits from the therapy. Many expressed "relief" through discussing their challenges and engaging in therapy practices, which helped them with behavioural and perceptual transformations. They gained a deeper understanding of their personal struggles and coping mechanisms, which helped them establish a greater sense of control, security, and normalcy.

As the quotes below demonstrate, different therapy methods provided varying degrees of impact. NET, for example, facilitated the processing of painful memories, while CBT helped clients manage anxiety and obsessive behaviours. Art and Play Therapy contributed to emotional regulation and improved social interactions, particularly among children and adolescents.

> *"NET helped me narrate and process my life story, from childhood to the present. Talking about my experiences, especially the painful ones, allowed me to understand them better and gain relief. The most helpful part was expressing my emotions and experiences. The therapist listened to me attentively, giving me the space to release my pain. This helped reduce my sadness and suicidal thoughts." - Female, 35. Al Qosh.*

The relationship between clients and therapists was generally perceived as positive. Therapists were described as supportive, caring, and respectful. Clients appreciated the collaborative approach in determining therapy methods and felt that their opinions were valued in the process. Trust and openness were built over time, which enhanced engagement in therapy and contributed to its effectiveness.

> *"I describe her [CBT therapist] as kind, calm, and understanding person, and her guidance helped me greatly… At first, I thought I could never change, but she helped me build trust and confidence. Her techniques work for me, whatever she says I trust her, and I do what she says if I can. But, if I can't do it, like doing exercise 5 times a day I discuss it with her… She guided me with care, like helping me manage my diabetes and suggesting helpful exercises for my back pain." - Female, 53. Duhok.*

Clients valued the accessibility, inclusivity, and diverse range of services provided by the Foundation, including psychotherapy, medical support, and legal assistance. This is in line with the widely accepted core principles of providing MHPSS, namely "multi-layered and integrated support" (IASC, 2007:9). The presence of child-friendly spaces also encouraged caregiver participation. However, several concerns were raised regarding the need for extended therapy sessions,

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consistent access to therapy services despite funding challenges, and additional medical and financial support to further enhance the well-being of clients.

> *"If I didn't trust this place [Jiyan Foundation's centre], I wouldn't come for [CBT] sessions. I'm not exaggerating when I say I brought more than 10 people to this centre because of the benefits I received here, and the benefited a lot from Jiyan Foundation as well. The first thing is that their services are free. The second thing is the environment. What happens to you on the outside is very different. The people here understand you, and you don't need to explain yourself over and over. They truly understand. … For a period, the centre was closed for two to three months because they didn't have funding. I felt very bad during that time because I needed a session with my therapist, but there was no place to go. I couldn't go to Sulaimania or Erbil to see a psychiatrist or psychotherapist and start all over again. It was very difficult for me, so this place is essential and needs to exist." - Female, 27. Kirkuk.*

The study demonstrates the effectiveness of the Foundation's therapy program in improving clients' psychological well-being. Strong therapist-client rapport, tailored and person-centred interventions, and practical support emerged as key factors contributing to positive outcomes. Nevertheless, further attention is needed to address funding sustainability, integrated care approaches, and long-term impact assessments to enhance the design and delivery of services.

5. Discussion

The key findings from this study provide strong evidence that applied therapy methods have a meaningful and substantial impact on mental health and psychosocial wellbeing for both adults and children/adolescents. The overall reduction in depressive and anxiety symptoms, as well as physical distress, shows the effectiveness of therapeutic interventions in promoting mental health recovery. These improvements are important not only because they demonstrate the potential of therapy in alleviating emotional and physical symptoms but also because they offer valuable insights into the broader applicability of these interventions across different groups and age ranges.

The significant reductions in depressive and anxiety symptoms among adults show that the therapy methods were successful in addressing core mental health challenges. These findings are crucial as they demonstrate that such interventions can lead to substantial improvements, shifting individuals from moderate to minimal or no depression, and helping to reduce anxiety. This is particularly relevant given the growing global focus on mental health, as it emphasizes that well-structured therapeutic approaches can lead to measurable improvements in mental wellbeing, even in the face of challenging life circumstances.

Additionally, the reduction in physical symptoms associated with depression further strengthens the argument for the holistic effectiveness of the interventions. Many mental health issues, particularly depression and anxiety, are often accompanied by physical distress. Addressing both psychological and physical symptoms through therapy can improve overall quality of life, making these findings especially important for guiding treatment protocols in mental health care.

In the context of children and adolescents, the significant improvement in emotional and behavioural functioning, as evidenced by the SDQ scores, suggests that therapy can effectively

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reduce the difficulties young people face in managing emotions, behaviour, and relationships. This is particularly important in settings where young individuals may have experienced trauma, such as displaced populations or those living in conflict zones. By reducing these difficulties, therapeutic interventions help foster better social integration, emotional regulation, and overall developmental outcomes.

The study also highlights the impact of displacement on mental health, with IDPs consistently showing higher levels of depressive symptoms compared to other groups. This finding suggests that displacement—likely linked to trauma, loss, and ongoing instability—remains a significant stressor, even after therapeutic interventions. While the therapy was effective in reducing symptoms across all groups, the persistence of higher depressive symptoms in IDPs calls attention to the need for more targeted interventions. These might include trauma-specific therapies or support systems that focus on the unique challenges faced by displaced individuals.

This insight is particularly important because it shows that while therapy can lead to positive changes, external factors like displacement may require additional or different therapeutic strategies. A broader understanding of the ongoing struggles faced by displaced populations is crucial for creating more comprehensive mental health care models.

The analysis of gender differences further adds to the findings, particularly in the context of physical symptoms. While females reported more physical symptoms at baseline, the intervention seemed to reduce the gender gap by post-treatment, indicating that therapy can help alleviate these gender-specific challenges. This shift is important because it suggests that therapeutic interventions may not only be effective in reducing symptoms overall, but also in promoting gender equity in mental health outcomes. However, the lack of significant gender differences in depressive symptoms (PHQ-9) before or after the intervention suggests that depression, regardless of gender, may respond similarly to the therapy methods. This finding is beneficial as it reinforces the generalizability of these interventions across genders, ensuring that both men and women can benefit equally from treatment.

While the findings are promising, several areas require further investigation. For instance, the unequal sample sizes between the different groups (IDPs, refugees, and local/host communities) may have impacted the statistical power of some comparisons, particularly when examining group differences in symptom reduction. Future studies could aim to balance these groups to improve the reliability of comparisons and gain a clearer understanding of how different population groups respond to therapy.

Moreover, while the intervention was effective for all groups, the persistence of depressive symptoms among IDPs suggests that additional support systems or targeted interventions may be necessary. Future research could explore specific interventions designed for displaced populations, such as trauma-focused therapies or culturally sensitive approaches, to better address the unique needs of these individuals.

The variation in the effectiveness of different therapy methods also warrants further exploration. The findings suggest that certain therapies, such as NET, may be more effective in addressing certain psychosocial difficulties compared to others. Further studies could delve deeper into why these methods are more effective and whether a combination of therapies could provide even greater benefits, especially for individuals dealing with trauma or complex mental health issues.

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Beyond symptom reduction, the study highlights the broader psychosocial benefits of therapy. Clients expressed deep appreciation for the supportive and empathetic relationships they developed with therapists. The therapeutic alliance, characterized by trust and mutual understanding, emerged as a crucial factor in facilitating engagement and long-term psychological improvement. The accessibility of free mental health services and a welcoming environment were also highly valued, demonstrating the importance of community-based, client-centred approaches in mental health care.

Despite the overwhelmingly positive outcomes, the study also identifies areas requiring further attention. The interruptions in service due to funding constraints underscore the necessity of sustainable financial support for mental health programs. Ensuring consistent access to therapy is critical for maintaining and building upon the progress achieved. Additionally, an integrated care approach that combines mental health support with medical and financial assistance would further enhance the well-being of clients, particularly those facing displacement and economic hardships.

In conclusion, this study highlights the significant positive impact that therapy can have on improving mental health and psychosocial functioning across diverse groups. However, the findings also point to areas for improvement, particularly regarding the persistent mental health challenges faced by displaced populations and the varying effectiveness of different therapy methods. Moving forward, more research is needed to develop and test tailored interventions that consider the unique needs of specific groups, especially those affected by displacement and trauma. Additionally, exploring the potential for combining therapeutic methods may offer more comprehensive solutions to address the complex nature of mental health challenges. By addressing these gaps, future studies can continue to enhance the effectiveness and accessibility of mental health interventions.

6. Limitations concerning data and analysis

Missing data and unequal sample sizes are significant limitations in this research, as they can reduce statistical power, introduce bias, and limit the ability to draw reliable conclusions from the data. Missing data poses several challenges in research, such as reducing the sample size, which decreases statistical power. In the case of measuring GAD-7 before and after therapies, the intended sample size was reduced to 24 complete pairs. It can also introduce bias if the missing data are not randomly distributed, for example, if individuals with higher anxiety scores are more likely to drop out, potentially underestimating the true effect of the intervention. Furthermore, missing data results in a loss of valuable information, limiting the conclusions that can be drawn. Many statistical tests assume complete data, so missing data can violate these assumptions and lead to inaccurate results. Additionally, it becomes more difficult to generalize the findings to the broader population.

Another significant limitation of this analysis is the substantial disparity in sample sizes across the therapy groups. This imbalance raises concerns about statistical power, particularly for the smaller groups, potentially hindering our ability to detect true differences in treatment effectiveness. Furthermore, the assumption of homogeneity of variances, crucial for many comparative statistical tests, becomes more difficult to validate with such unequal group sizes. Consequently, a direct comparison of the therapy methods' efficacy in reducing depression symptoms was deemed unreliable and therefore not conducted. Future studies should aim for more balanced group sizes to facilitate robust comparative analyses.

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7. Recommendations

To enhance the effectiveness of its therapy program, the Foundation should consider expanding specific interventions, particularly for internally displaced populations who continue to experience heightened levels of depressive symptoms. Implementing trauma-focused therapies such as Eye Movement Desensitization and Reprocessing (EMDR) and expanding the existing Narrative Exposure Therapy (NET) could offer more targeted support to individuals dealing with severe psychological distress. At the same time, ensuring consistent access to therapy is essential. Service interruptions due to funding constraints must be addressed by forging long-term partnerships with donors, NGOs, and government agencies to create a more sustainable financial model.

Given the variation in therapy outcomes, the Foundation may also benefit from tailoring its therapeutic approaches to better suit individual needs. Exploring hybrid therapy models that integrate multiple methods could help maximize treatment effectiveness. Additionally, facilitating strong therapist-client relationships should remain a priority. Providing therapists with ongoing training in culturally sensitive care and empathetic engagement can further support the already strong therapeutic alliance, which has been shown to play a crucial role in recovery. Furthermore, adopting an integrated care model that combines mental health services with medical, social, and financial support could significantly improve overall well-being, particularly for internally displaced individuals who often face multiple intersecting challenges.

For stakeholders such as government agencies, NGOs, and mental health organizations, investing in sustainable funding for community-based mental health programs should be a top priority. Mental health initiatives cannot thrive on short-term or inconsistent financial support. Policies that allocate long-term funding will ensure that vulnerable populations continue to receive the help they need without disruption. Strengthening community-based support networks is equally important. Encouraging the formation of local mental health champions can help extend the reach of services while also working to reduce stigma around seeking psychological support.

A targeted approach is particularly necessary when addressing the mental health challenges of displaced populations. Governments (Iraq and KRI) organizations must develop mental health strategies that recognize the lasting impact of displacement, loss, and instability. Implementing specialized programs that incorporate trauma-informed care will ensure that the unique needs of these populations are met. Additionally, gender-specific considerations should not be overlooked. Since the study highlights differences in how physical symptoms present among men and women, ensuring that interventions address these disparities will help promote equity in mental health outcomes. Beyond clinical care, forming and/or improving broader psychosocial support systems—such as peer support groups and community-driven/based mental health initiatives—can help individuals sustain their recovery over time.

Future studies should focus on addressing some of the limitations observed in the current analysis. One key area of improvement is achieving more balanced sample sizes when examining different population groups. Ensuring that IDPs, refugees, and local/host communities are more equally represented will allow for more reliable comparisons and a clearer understanding of therapy effectiveness across groups. Additionally, further investigation into the variability in therapy effectiveness is needed. Understanding why certain therapeutic methods work better for specific psychosocial difficulties will allow practitioners to refine their approaches and potentially develop more targeted interventions.

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Long-term follow-up studies would also provide valuable insights into whether the improvements observed in therapy are sustained over time. This would help in determining whether periodic booster sessions or additional forms of support are necessary. Researchers should also explore how therapy models can be adapted to different cultural contexts to ensure they remain relevant and effective for diverse populations. Employing mixed-methods research, which combines quantitative analysis with qualitative insights, will further enrich our understanding of therapy experiences and the broader impact of mental health interventions.

Wider stakeholders, including community leaders, advocacy groups, and policymakers, also have a role to play in strengthening mental health initiatives. Raising awareness about the importance of mental health care through community outreach and education can help combat stigma and encourage more individuals to seek help. At the same time, improving multi-sector collaboration between mental health services, educational institutions, and employment programs can create a more supportive environment for individuals recovering from psychological distress.

Policy development should also focus on addressing the specific needs of displaced populations. Recognizing the long-term mental health effects of displacement and ensuring that support services are embedded in resettlement and integration programs will be crucial in promoting well-being. Additionally, leveraging digital solutions, such as teletherapy or mobile-based mental health resources, can improve accessibility for individuals in remote or underserved areas. Finally, involving families, schools, and workplaces in mental health initiatives can help build a more inclusive support system and ensure that individuals undergoing therapy receive ongoing encouragement and understanding from their social environments.

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Annexes

Annex 1: Questions for adolescent (10-17) interviewees who attended art therapy sessions

Thank you for joining this interview. We're talking to young people like you to understand how the art therapy program has helped. During our conversation, I'll ask you about your experiences with art therapy, how it may have impacted your well-being, and your thoughts on the support offered by the therapists and the organization. This is not a test; rather, we value your honest reflections and feedback, which will help improve the program for others. Everything you share will be treated confidentially and used only to strengthen our support services. Please feel free to take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

1. How old are you?
2. Who do you live with at home?
3. What do you like to do for fun?

Part 2. Questions on the Therapy Experience

1. What types of art activities did you do in therapy? Which ones did you find most helpful?
2. How did expressing yourself through art affect the way you felt about difficult memories, emotions, or thoughts?
3. Was there anything that you found challenging in the art therapy sessions? If yes, how did the therapist help you through it?
4. Did making art help you understand your feelings or think about things in a new way? If yes, can you give an example?
5. What language (e.g., Soranî, Kurmancî, Arabic) did you and your therapist use during the sessions? Did that language help you express yourself fully?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel that art therapy helped you reduce feelings of sadness, fear, or stress? Could you share an example?
2. In what ways, if any, has art therapy helped improve your relationships with family or friends?
3. Have you noticed any lasting changes in how you feel, think or behave, even after completing art therapy?

Part 4. Questions on the Therapist's Role and Skills

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1. How would you describe your relationship with the therapist who led your art therapy sessions? Did they make you feel comfortable and respected?

2. Did you and the therapist decide on the types of art activities together, or did the therapist choose for you?

3. Was the therapist attentive to your needs and helpful in responding to any questions or concerns you had?

Part 5. Questions on the Organization's Service Quality

1. Did you feel comfortable and happy coming to the place where you did art therapy? Why or why not?

2. If you could change one thing about the art therapy sessions, what would you change?

3. What would you tell another child who might be thinking about doing art therapy?

4. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 2: Questions for adult interviewees who attended art therapy sessions

Thank you for agreeing to take part in this interview. We are conducting a comprehensive assessment of the art therapy program provided by Jiyan Foundation to understand how effective it has been in supporting individuals like yourself. During our conversation, I'll ask you about your experiences with art therapy, how it may have impacted your well-being, and your thoughts on the support offered by the therapists and the organization. This is not a test; rather, we value your honest reflections and feedback, which will help improve the program for others. Everything you share will be treated confidentially and used only to strengthen our support services. Please feel free to take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

4. What is your age?

5. What is your gender?

6. What is your marital status?

7. What is your displacement situation now (e.g., refugee, IDP, returnee, local/host community)?

8. (If refugee) What is your country of origin?

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9. Which language(s) do you feel most comfortable using?

10. What is the highest level of education you have completed?

11. What is your employment status? (e.g., employed, unemployed, seeking employment)

Part 2. Questions on the Therapy Experience

1. Can you describe how art therapy has impacted the way you see or understand your life story and past experiences?

2. What specific aspects of creating art or using art did you find most helpful or meaningful in dealing with difficult emotions or experiences?

3. How did the process of expressing yourself through art make you feel, especially when reflecting on or exploring challenging memories, feelings, or thoughts?

4. How do you feel art therapy has influenced your ability to regulate or manage your emotions or cope with stress in your daily life?

5. What challenges, if any, did you encounter during your art therapy sessions? How did the therapist support you through those moments?

6. What language was the therapy sessions in (e.g., Soranî, Badinî, Arabic, English)?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel that art therapy helped you reduce feelings of distress, fear, or sadness in your daily life? If so, could you share some examples?

2. In what ways, if any, has art therapy contributed to improvements in your relationships or interactions with others around you?

3. Have you noticed any lasting changes in yourself or in how you feel, even after completing art therapy sessions?

Part 4. Questions on the Therapist's Role and Skills

1. How would you describe your relationship with the therapist who guided you through art therapy?

2. Did you and the therapist decide together what method will be used in the sessions? Please explain why and why not?

3. Was the therapist attentive to your needs and responsive to your concerns throughout the therapy process? Can you provide any examples?

Part 5. Questions on the Organization's Service Quality

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1. How accessible and supportive was the organization in helping you begin and continue art therapy sessions?

2. What kinds of additional support, if any, did the organization provide that made you feel comfortable and engaged in art therapy?

3. Did you feel that the organization respected your needs, preferences, and boundaries throughout your experience with art therapy? If so, how?

4. What improvements would you suggest to Jiyan Foundation to enhance its support to people like yourself?

5. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 3: Questions for child (0-9) interviewees who attended art therapy sessions

Introduction (For Parent/Caregiver):

Thank you for allowing your child/child you provide care to participate in this conversation. Our goal is to understand how well the art therapy program has helped children. We will ask simple, friendly questions about their experience with the therapy, how they felt about it, and their interactions with the therapist. The child's responses will help us improve the program for other children in similar situations. Please feel free to support the child in answering any questions. We will prefer to hear from them first but if the child is not able to express themselves, please help us by giving the answers instead of them.

Part 1. Demographic Questions

1. How old are you?

2. Who do you live with at home?

3. What do you like to do for fun?

4. What do you remember about coming to the sessions with the therapist?

Part 2. Questions on the Therapy Experience

1. What kinds of things did you do in art therapy? Can you tell me about one of the art activities you liked?

2. How did making art, like drawing or painting, make you feel? Did it help you feel happier, safer, or maybe calm?

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3. Was there anything that you found hard or a little scary in art therapy? What did the therapist do to help you?

4. Did you have a favorite piece of art that you made during therapy? Why was it special?

5. Did the therapist talk to you in a language that was easy for you to understand? What language (e.g., Soranî, Kurmancî, Arabic) was that?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel happier or less scared now because of art therapy? Can you tell me about a time you felt this way?

2. Has art therapy helped you feel better when you're with family or friends? Can you tell me more about this?

3. Do you still feel the same way about art therapy, even now that the sessions have ended? Why or why not?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist who did art therapy with you? Did they make you feel happy, safe, or comfortable?

2. Did the therapist listen to you when you wanted to say something or ask a question?

3. Was there anything the therapist did that you liked or that made you feel good during the sessions?

Part 5. Questions on the Organization's Service Quality

1. Did you feel comfortable and happy coming to the place where you did art therapy? Why or why not?

2. What would you tell another child who might be thinking about doing art therapy?

3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 4: Questions for adolescent (10-17) interviewees who attended CBT sessions

Thank you for participating in this interview. We want to understand how Cognitive Behavioural Therapy (CBT) has helped young people like you. During our conversation, I'll ask you about your

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experiences with art therapy, how it may have impacted your well-being, and your thoughts on the support offered by the therapists and the organization. This is not a test; rather, we value your honest reflections and feedback, which will help improve the program for others. Everything you share will be treated confidentially and used only to strengthen our support services. Please feel free to take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

1. How old are you?
2. Who do you live with at home?
3. What do you like to do for fun?

Part 2. Questions on the Therapy Experience

1. What activities or conversations in CBT did you find most helpful or memorable?
2. How did it feel to talk with the therapist about your thoughts and feelings?
3. Did the therapist teach you any new ways to think or deal with problems? If so, which ones were most helpful?
4. In what ways did CBT change how you think about or react to difficult situations?
5. Have you noticed anything from therapy that helps you manage your emotions more easily day-to-day?
6. Were there any specific exercises or techniques in CBT that you found especially useful? If yes, can you give an example?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel that CBT has helped you feel less anxious, stressed, or upset in your daily life? Can you share an example?
2. How, if at all, has CBT made a difference in your relationships with family or friends?
3. Do you feel any lasting benefits from CBT now that the sessions have ended? If so, what are they?

Part 4. Questions on the Therapist's Role and Skills

1. How would you describe your relationship with the therapist who worked with you in CBT?
2. Did you and the therapist decide together what method will be used in the sessions?
3. Did the therapist respond to your questions and concerns in a way that was helpful to you? Can you give any examples?

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Part 5. Questions on the Organization's Service Quality

1. How did you feel about the location where CBT sessions were held? Was it a comfortable space for you?

2. Did the organization provide any extra support that made you feel more at ease in the therapy program?

3. Did you feel that the organization respected your preferences and needs throughout the therapy process? If yes, can you give an example?

4. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 5: Questions for adult interviewees who attended CBT sessions

Thank you for agreeing to take part in this interview. We are conducting a comprehensive assessment of the Cognitive Behavioural Therapy (CBT) program provided by Jiyan Foundation to understand how effective it has been in supporting individuals like yourself. During our conversation, I'll ask you about your experiences with CBT, how it may have impacted your well-being, and your thoughts on the support offered by the therapists and the organization. This is not a test; rather, we value your honest reflections and feedback, which will help improve the program for others. Everything you share will be treated confidentially and used only to strengthen our support services. Please feel free to take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

1. What is your age?

2. What is your gender?

3. What is your marital status?

4. What is your displacement situation now (e.g., refugee, IDP, returnee, local/host community)?

5. (If a refugee) What is your country of origin?

6. Which language(s) do you feel most comfortable using?

7. What is the highest level of education you have completed?

8. What is your employment status? (e.g., employed, unemployed, seeking employment)

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Part 2. Questions on the Therapy Experience

1. How has CBT influenced your understanding of your life experiences and challenges?
2. Which parts of CBT did you find most useful or impactful in helping you manage your issues?
3. How did it feel to discuss and work through your thoughts and behaviors during CBT?
4. In what ways has CBT helped you change or reshape your thinking around difficult situations?
5. How has CBT affected your ability to regulate your emotions in everyday life?
6. Did you find the structured activities or exercises in CBT helpful or meaningful? If yes, can you give an example?
7. What challenges, if any, did you face during CBT sessions, and how did the therapist help you work through them?
8. What language was primarily used in your therapy sessions (e.g., Soranî, Badinî, Arabic, English)?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel that CBT has helped you reduce feelings of stress, anxiety, or negative emotions in your daily life? Could you give an example?
2. How, if at all, has CBT improved your relationships or the way you interact with others?
3. Have you noticed any lasting changes or benefits since completing CBT sessions?

Part 4. Questions on the Therapist's Role and Skills

1. How would you describe your relationship with the therapist who guided you through CBT?
2. Did you and the therapist make decisions together about the approaches or techniques used in sessions? Why or why not?
3. Was the therapist responsive to your needs and supportive throughout the CBT process? Could you provide a specific example?

Part 5. Questions on the Organization's Service Quality

1. How easy and supportive was the organization in helping you start and continue CBT sessions?
2. Did the organization provide any additional resources or support that made you feel more comfortable?

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3. Do you feel the organization respected your preferences and needs during your CBT experience? Why and why not?

4. What improvements would you suggest to enhance the organization's support for people undergoing CBT?

5. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 6: Questions for child (0-9) interviewees who attended CBT sessions

Introduction (For Parent/Caregiver):

Thank you for allowing your child/child you provide care to participate in this conversation. Our goal is to understand how well the Cognitive Behavioural Therapy (CBT) program has helped children. I will ask simple, friendly questions about their experience with the therapy, how they felt about it, and their interactions with the therapist. The child's responses will help us improve the program for other children in similar situations. Please feel free to support the child in answering any questions. We will prefer to hear from them first but if the child is not able to express themselves, please help us by giving the answers instead of them.

Part 1. Demographic Questions

1. How old are you?

2. Who do you live with at home?

3. What do you like to do for fun?

4. What do you remember about coming to the sessions with the therapist?

Part 2. Questions on the Therapy Experience

1. Can you tell me what you liked most about the time with the therapist?

2. Was there a story or game that you enjoyed during your time with the therapist?

3. How did you feel when talking about things that made you feel sad or scared?

4. Did you have a favourite part of the therapy sessions? What was it?

Part 3. Questions on the Therapy's Effectiveness

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1. Since you started going to the sessions, have you noticed any changes in how you feel when you're sad or upset?

2. How do you feel now when you remember things that used to make you feel scared?

3. Is it easier for you to talk about your feelings now compared to before?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist? Did they seem nice or kind?

2. Did the therapist listen to you when you wanted to talk about something?

3. What did the therapist do that made you feel safe and comfortable?

Part 5. Questions on the Organization's Service Quality

1. Did you feel comfortable coming to the place where the therapy happened?

2. Was there anything at the therapy place that you really liked (like toys, games, or a friendly helper)?

3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 7: Questions for adolescent (10-17) interviewees who attended CReST sessions

Introduction:

Thank you for agreeing to participate in this interview. We're learning more about how the CReST Therapy program has helped young people like you. I'll be asking questions about your time with CReST, how it's affected your feelings, and your thoughts about the therapist and the organization. Your answers will help improve the program for others. Please answer as openly as you feel comfortable and let us know if you have any questions or want a break.

Part 1. Demographic Questions

1. How old are you?

2. Who do you live with at home?

3. What do you like to do for fun?

Part 2. Questions on the Therapy Experience

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1. What do you remember most about your time in CReST sessions?

2. Was it hard or easy for you to talk about your life and experiences during therapy?

3. What was it like to go through your challenges with the therapist? Did it help you feel differently about anything?

4. Was there a particular part of the sessions that you found most helpful?

Part 3. Questions on the Therapy's Effectiveness

1. Since you started CReST, have you noticed any changes in how you feel or how you deal with difficult memories and bodily sensations?

2. Do you think CReST helped you feel better, more comfortable, or in control of your emotions? Can you give an example?

3. How has CReST affected your relationships with people close to you (like family or friends)?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist's way of listening and helping you?

2. Did the therapist make you feel comfortable and respected?

3. Did the therapist explain things in a way that made sense to you?

Part 5. Questions on the Organization's Service Quality

1. Did the organization provide any extra support or resources to you or your family? If yes, what were they?

2. Was it easy for you to keep attending the therapy sessions? Why or why not?

3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 8: Questions for adult interviewees who attended CReST sessions

Thank you for agreeing to take part in this interview. We are conducting a comprehensive assessment of the CReST Therapy program provided by the Jiyan Foundation to understand its impact on individuals like yourself. During our conversation, I'll ask you about your experiences with CReST, how it may have influenced your well-being, and your thoughts on the support offered by the therapists and the organization. This is not a test; rather, we value your honest reflections and feedback, which will help improve the program for others. Everything you share will be treated

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confidentially and used only to enhance our support services. Please feel free to take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

1. What is your age?
2. What is your gender?
3. What is your marital status?
4. What is your displacement situation now (e.g., refugee, IDP, returnee, local/host community)?
5. (If refugee) What is your country of origin?
6. Which language(s) do you feel most comfortable using?
7. What is the highest level of education you have completed?
8. What is your employment status? (e.g., employed, unemployed, seeking employment)

Part 2. Questions on the Therapy Experience

1. Can you describe how CReST Therapy has impacted the way you understand your personal experiences and relationships?
2. Which specific aspects of CReST Therapy did you find most helpful or meaningful in managing trauma and stress?
3. How did focusing on bodily sensations and reactions during sessions affect your understanding or processing of past experiences?
4. In what ways did CReST Therapy help you feel more connected to your inner resources or strengths?
5. How do you feel CReST Therapy has influenced your ability to manage emotions and reactions in your daily life?
6. Did you find it helpful to use specific techniques or exercises to address bodily responses to stress? Why or why not?
7. What challenges, if any, did you encounter during CReST sessions, and how did the therapist help you address them?
8. What language was used during the therapy sessions (e.g., Soranî, Badinî, Arabic, English)?

Part 3. Questions on the Therapy's Effectiveness

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1. Do you feel that CReST Therapy has helped you reduce stress or trauma-related reactions in your daily life? If so, could you share some examples?

2. In what ways, if any, has CReST contributed to positive changes in your relationships or interactions with others?

3. Have you noticed any lasting changes or benefits from the therapy after completing CReST sessions?

Part 4. Questions on the Therapist's Role and Skills

1. How would you describe your relationship with the therapist who guided you through CreST Therapy?

2. Did you and the therapist decide together what method will be used in the sessions? Please explain why and why not?

3. Was the therapist attentive to your needs and responsive to your concerns throughout the therapy process? How so?

Part 5. Questions on the Organization's Service Quality

1. How accessible and supportive was the organization in helping you start and continue CReST sessions?

2. What kinds of additional support, if any, did the organization provide that helped you feel comfortable and engaged in CReST Therapy?

3. Did you feel the organization respected your personal needs and preferences throughout your experience with CReST? If yes, can you give an example?

4. What improvements would you suggest to the Jiyan Foundation to better support individuals in similar situations?

5. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 9: Questions for child (0-9) interviewees who attended CReST sessions

Introduction (For Parent/Caregiver):

Thank you for allowing your child/child you provide care to participate in this conversation. Our goal is to understand how well the CReST Therapy program has helped children. We will ask simple, friendly questions about their experience with the therapy, how they felt about it, and their

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interactions with the therapist. The child's responses will help us improve the program for other children in similar situations. Please feel free to support the child in answering any questions. We will prefer to hear from them first but if the child is not able to express themselves, please help us by giving the answers instead of them.

Part 1. Demographic Questions

1. How old are you?
2. Who do you live with at home?
3. What do you like to do for fun?
4. What do you remember about coming to the sessions with the therapist?

Part 2. Questions on the Therapy Experience

1. Was there a story or game that you enjoyed during your time with the therapist?
2. What parts of CReST Therapy did you like the most?
3. Did you enjoy the fun activities that helped you with your body feelings? Why did you like or not like them?
4. How did paying attention to your body help you understand your feelings better?

Part 3. Questions on the Therapy's Effectiveness

1. Do you think CReST Therapy helped you feel less stressed or scared? Can you share a story?
2. How has CReST Therapy affected your relations with your friends and family?
3. Have you seen any good changes in yourself after finishing CReST Therapy?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist? Did they seem nice or kind?
2. Did the therapist listen to you when you wanted to talk about something?
3. What did the therapist do that made you feel safe and comfortable?

Part 5. Questions on the Organization's Service Quality

1. Did you feel comfortable coming to the place where the therapy happened?
2. Was there anything at the therapy place that you really liked (like toys, games, or a friendly helper)?

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3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 10: Questions for child (0-9) interviewees who attended EMDR sessions

Introduction (For Parent/Caregiver):

Thank you for allowing your child/child you provide care to participate in this conversation. Our goal is to understand how well the EMDR Therapy program has helped children. We will ask simple, friendly questions about their experience with the therapy, how they felt about it, and their interactions with the therapist. The child's responses will help us improve the program for other children in similar situations. Please feel free to support the child in answering any questions. We will prefer to hear from them first but if the child is not able to express themselves, please help us by giving the answers instead of them.

Part 1. Demographic Questions

1. How old are you?
2. Who do you live with at home?
3. What do you like to do for fun?
4. What do you remember about coming to the sessions with the therapist?

Part 2. Questions on the Therapy Experience

1. Can you tell me what you liked most about the time with the therapist?
2. Was there a story or game that you enjoyed during your time with the therapist?
3. How did you feel when talking about things that made you feel sad or scared?
4. Was there anything the therapist did that made you feel safe or comfortable?
5. Did you have a favourite part of the therapy sessions? What was it?

Part 3. Questions on the Therapy's Effectiveness

1. Since you started going to the sessions, have you noticed any changes in how you feel when you're sad or upset?
2. How do you feel now when you remember things that used to make you feel scared?

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3. Is it easier for you to talk about your feelings now compared to before?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist? Did they seem nice or kind?
2. Did the therapist listen to you when you wanted to talk about something?
3. What did the therapist do that made you feel safe and comfortable?

Part 5. Questions on the Organization's Service Quality

1. Did you feel comfortable coming to the place where the therapy happened?
2. Was there anything at the therapy place that you really liked (like toys, games, or a friendly helper)?
3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 11: Questions for adolescent (10-17) interviewees who attended EMDR sessions

Introduction:

Thank you for agreeing to participate in this interview. We're learning more about how the EMDR Therapy program has helped young people like you. I'll be asking questions about your time with EMDR, how it's affected your feelings, and your thoughts about the therapist and the organization. Your answers will help improve the program for others. Please answer as openly as you feel comfortable and let us know if you have any questions or want a break.

Part 1. Demographic Questions

1. How old are you?
2. Who do you live with at home?
3. What do you like to do for fun?

Part 2. Questions on the Therapy Experience

1. What do you remember most about your time in EMDR sessions?
2. Was it hard or easy for you to talk about your life and experiences during therapy?

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3. What was it like to go through your story with the therapist? Did it help you feel differently about anything?

4. Was there a particular part of the sessions that you found most helpful?

Part 3. Questions on the Therapy's Effectiveness

1. Since you started EMDR, have you noticed any changes in how you feel or how you deal with difficult memories?

2. Do you think EMDR helped you feel better, more comfortable, or in control of your emotions? Can you give an example?

3. How has EMDR affected your relationships with people close to you (like family or friends)?

Part 4. Questions on the Therapist's Role and Skills

1. What did you think about the therapist's way of listening and helping you?

2. Did the therapist make you feel comfortable and respected?

3. Did the therapist explain things in a way that made sense to you?

Part 5. Questions on the Organization's Service Quality

1. Did the organization provide any extra support or resources to you or your family? If yes, what were they?

2. Was it easy for you to keep attending the therapy sessions? Why or why not?

3. Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

Annex 12: Questions for adult interviewees who attended EDMR sessions

Thank you for taking part in this interview. We are evaluating the EMDR therapy program provided by Jiyan Foundation to understand how it has impacted individuals like you. In our discussion, I'll ask about your experiences with EMDR, its effects on your well-being, and your views on the support from the therapists and the organization. This is not a test; we appreciate your honest insights, which will help us improve the program for others. Your responses will remain confidential and will only be used to enhance our support services. Please take your time and let us know if you have any questions or need a break at any point.

Part 1. Demographic Questions

1. What is your age?
2. What is your gender?
3. What is your marital status?
4. What is your displacement situation now (e.g., refugee, IDP, returnee, local/host community)?
5. (If refugee) What is your country of origin?
6. Which language(s) do you feel most comfortable using?
7. What is the highest level of education you have completed?
8. What is your employment status? (e.g., employed, unemployed, seeking employment)

Part 2. Questions on the Therapy Experience

1. How has EMDR therapy influenced the way you view your life story and past events?
2. Which aspects of EMDR did you find most beneficial in working through your trauma?
3. How did it feel to revisit and discuss your life story, especially when addressing traumatic experiences?
4. In what ways did EMDR help you see difficult memories from a different perspective?
5. How has EMDR affected your ability to manage emotions in daily life?
6. What challenges did you face during EMDR sessions, and how did your therapist help you work through them?
7. Which language was used in your therapy sessions (e.g., Soranî, Badinî, Arabic, English)?

Part 3. Questions on the Therapy's Effectiveness

1. Do you feel that EMDR helped reduce distress or traumatic feelings in your daily life? Could you provide an example?
2. Has EMDR affected your relationships or interactions with others? If so, in what ways?
3. After completing EMDR, did you notice any lasting changes, even beyond the therapy sessions?

Part 4. Questions on the Therapist's Role and Skills

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1. How would you describe your relationship with the therapist who supported you in EMDR?

2. Did you and your therapist decide together on what therapy method will be used in the sessions?

3. Was your therapist attentive to your needs and responsive to your concerns throughout the therapy? How did they show this?

Part 5. Questions on the Organization's Service Quality

1. How accessible and supportive was the organization in helping you start and continue EMDR sessions?

2. What additional support, if any, did the organization provide to make you feel comfortable and engaged during EMDR?

3. Did you feel that the organization respected your preferences and needs during your experience with EMDR? If yes, can you give an example?

4. What suggestions would you make to the Jiyan Foundation to improve its support for individuals like yourself?

5. Thank you for your responses. My final question is: Is there anything else you'd like to share before we finish?Thank you for all the answers you provided. This is my last question for you today. Is there anything else you want to share with us? Anything you want to say before we finish this session.

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