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Complete List of Authors:	Paudyal, Priyamvada; Brighton and Sussex Medical School Department of Primary Care and Public Health Tattan, Mais ; Brighton and Sussex Medical School Department of Primary Care and Public Health Cooper, Maxwell; Brighton and Sussex Medical School Department of Primary Care and Public Health
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A qualitative study on mental health and wellbeing of Syrian refugees and their coping mechanisms towards integration in the UK

Priyamvada Paudyal[1], Mais Tattan[1] and Max Copper[1]

[1]Department of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton UK

Corresponding Author: Dr Priyamvada Paudyal
Department of Primary Care and Public Health, Brighton and Sussex Medical School, Room 322, Watson Building, Village Way, Falmer, BRIGHTON, BN1 9PH, UK
+44 (0) 1273 644548; p.paudyal@bsms.ac.uk

Running Title: Mental health and wellbeing of Syrian refugees in the UK

Abstract

Objective: This study aimed to explore the mental well-being of Syrian refugees and identify their coping mechanisms and pathways towards integration into new communities.

Design: We conducted a qualitative study using in-depth semi-structured interviews.

Setting and Participants: Adult Syrian refugees (>18 years old) currently residing in South east of England.

Results: Twelve participants (three female and nine male) took part in the study, all were born in Syria and majority (n=9) were over 45 years of age. Our findings show that Syrian refugees face constant challenges as they try to integrate into a new society. Loss of and separation from loved ones as well as the nostalgia for the homeland were often cited as a source of psychological distress that created an overwhelming sense of sadness. Participants reported that they struggled for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities in their new setting. They believed in 'being their own doctor' and turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Conclusion: Past experiences and present challenges frame Syrian refugees' sense of well-being, impact use of healthcare and risk future mental health problems. It is hoped that this study will act as a catalyst for further research on this vulnerable group to promote integration, community support and culturally-sensitive mental health services.

Strengths and Limitations

- To the best of our knowledge, this is the first qualitative study conducted among Syrian refugees in the UK.
- The interviews were conducted fully in the language and dialect of the participating Syrian refugees.
- Although the study involved only twelve participants, the study gathered rich data, and themes identified in this study appear to be common in other refugee studies of different backgrounds.

Introduction

The Syrian refugee crisis is recognised as the biggest forced-displacement crisis the world has seen since the second world war,(1) and was declared by the United Nation High Commissioner for Refugees (UNHCR) as the biggest humanitarian crisis of our present time,(2). Since 2011, following the escalating conflict and violence in Syria, millions have been forced to flee their homes in search of safety and protection. The most recent estimates suggests that about 5.6 million Syrians have registered as refugees in neighbouring countries and an additional 6.6 million Syrians are internally displaced within the borders of Syria,(3).

Refugees are at risk of multiple traumatic experiences that impact their mental and physical health. These traumatic factors originate either in their home country, during their displacement journey or as part of the asylum process. Pre-immigration factors such as physical injury, near-death experiences, witnessing murder, bereavement (for example the traumatic loss of loved ones), imprisonment and torture are often associated with civil conflict,(4). Others encounter additional traumatic events during their journey to exile and as part of the settlement process. Evidence suggest that post-immigration stressors such as ethnic discrimination, harsh socio-economical living conditions, institutional accommodation, limited language skills and poor social support are detrimental to refugees' mental health and the impact may persist for years or possibly decades after resettlement to a new environment,(5-11). For such reasons, Syrian refugees have been found to live with hopelessness, fear and constant worries,(12).

In 2014 the United Kingdom (UK) launched its Syrian vulnerable person resettlement programme (VPR) aiming to resettle twenty thousand Syrian refugees across the country by the year 2020,(13). The crisis has been escalated recently with powerful images in the news and social media covering stories of desperate and vulnerable people trying to cross the English Channel to reach the UK. In this context, there is a need for further understanding of the impact of the current refugee crisis upon Syrians, particularly after resettlement. Most importantly there is a need to explore the coping mechanisms and resilience pathways of Syrian refugees to promote their wellbeing, integration, and transition into active members of society.

Numerous studies have reported on the prevalence of several mental health disorders amongst Syrian refugees,(14-16). Depression, anxiety and post-traumatic stress disorder (PTSD) are the most prevalent disorders amongst displaced individuals,(17). However, the existing literature is mostly comprised of quantitative studies and there is a clear need for undertaking a comprehensive qualitative research. Also, we are unaware of any published qualitative studies

specifically focussed on Syrian refugees in the UK. This study aimed to explore mental well-being of Syrian refugees, barriers to seeking mental health care services, coping mechanisms and pathways towards integration in new communities.

Methodology

This qualitative study was conducted in South East England using semi-structured interviews. Qualitative methods were selected as they allow in-depth understanding of practical issues through detailed exploration of individual's experiences, motives and opinions,(18). Participants were recruited via the contacts of language centres, community organisations and charities using purposive and snowballing sampling approach. Adult Syrian refugees (>18 years of age), currently living in South East England, and speaking Arabic or English were eligible for inclusion.

Participants were approached through the gatekeepers of the respective organisations and a snowballing technique was used to approach further possible participants. They were provided with participant information leaflets (PIL) in Arabic and English languages according to participants' preferences which provided detailed information about the study. Informed consent was obtained from participants after full explanation and reiteration of the information provided in the PIL.

A semi structured interview topic guide (Table 1) was constructed to explore understanding of mental health problems and beliefs about mental health and wellbeing, community support and coping mechanisms and access to healthcare services. Interviews were conducted between April-June 2019 in private rooms of community organisations and in public spaces such as parks. The interviewer (MT) is bilingual and shares the nationality and the language of the studied refugee participants (except the refugee status) and the interviews were conducted in Arabic and transcribed into English. Being an insider researcher has an advantage; they are trusted and accepted by the participants, and have greater understanding about the phenomena being studied. However, it can be argued that this could lead to a loss of objectivity and bias (19). Hence, prior to the data collection, the interviewer was trained to conduct the interviews in a neutral manner using open questions and encouraging the participants to express ideas and thoughts.

Data were analysed using thematic content analysis using Burnard's (20) method. It involved a systematic 14-part method of a step-by-step process of open coding and categorization. The

approach is used to evaluate and record the themes and issues highlighted in texts produced by the participants and categorized appropriately. The coding was done iteratively; random samples of the identified themes were discussed with the research team until an agreement was reached for the key themes.

Ethical approval was obtained from the Brighton and Sussex Medical School Research and Ethics Governance Committee (ER/BSMS9DAP/1).

Table1 – Topic guide used for the interview process

- Introduction
- Beliefs about mental health and wellbeing
  - Personal definition of mental health
  - Explore variation in mental health between individuals
  - Ways to help oneself to have good mental health
- Community Support and Coping Mechanism
  - Community in the UK and newly formed relationships
  - Emotional or physical challenges faced
  - Coping mechanisms to overcome the challenges
- Access to mental healthcare services
  - Understanding of mental health facilities in the UK
  - Barriers and facilitators in accessing mental health care

Results

The study's sample consisted of twelve refugee participants, three females and nine males. All participants were born in Syria and nine had moved to the UK less than five years ago. Three quarter of the participants (n=9) were over 45 years of age, nine were married with children, one separated and two single. Five participants were university graduates, six had school level education and one was illiterate.

Identified themes

Four major key themes were identified from the data analysis; Loss and Separation, struggling for connectedness in a culturally divided world, Health Beliefs and Practices, and Barriers to Healthcare Access. Several sub-themes emerged under each key theme and are elaborated upon using quotes. Listing of key themes and sub themes can be found in (Figure 1).

Loss and Separation

Participants often perceived that loss of and separation from their family members was causing or aggravating their current psychological distress. These feelings were not limited to the ***loss*** of loved ones, but also the loss of material possessions, and connections to their home country in general:

> *"Sometimes when I remember my brother who passed away…makes me feel upset…like we were six people in the family... me, my mum, my dad, and my three siblings, a brother and two sisters… suddenly there was only me, my mum and my dad" (P9, M)*

One participant described the meaning of home to a Syrian family and the consequences of its loss:

"When you build a home it's like a celebration, it means you have established a residence, it means you have a family and you have a home! [...] *We worked for 17 years to create this home then we locked it and fled* [...] *these matters make you sad" (Participant 2, M)*

Separation from relatives or loved ones who remained back in the country was frequently described as painful. Despite their distance from Syria, migrants remained closely connected to the country and its people. The state of separation from home and loved ones could lead to strong emotions of sadness and joy:

> *"Any news that you hear about the country, whether it's small or big news, it hurts and disturbs the person's mental state, so you find us happy for their happiness and sad for their sadness or their suffering" (Participant 8, M)*

Other participants called for reunion with loved ones, stating that their mental health state would be resolved if they were able to be reunited with their family members:

"If a person could see his children… like for one of our children to come, we probably would not need a psychiatric doctor… you know? Isn't this right?" (Participant 5, F)

Struggling for connectedness in a culturally divided world: Participants commented on ***cultural differences*** and their difficulties in assimilating in the new environment in the new country. There were also comments on feelings of resistance to assimilation on the part of the

native population. Despite efforts by Syrians, the gap between the two cultures was considered large and reflected in behaviour and attire:

> *"Integration with the western society or the British community is almost too small… too small… and mostly it's from them, not us… I mean we try, but they as a society have their own costumes and traditions that are completely different than ours" (Participant 7, M)*

One part of this difference lay in divergent priorities in life between the two groups. There was a feeling that Syrians had to live with predicaments that were remote to White British people. Whilst Syrians faced diverse social challenges, native people only had to think about employment:

> *"We think of things they do not think about* [...] *I mean for us as citizens, we can worry about the financial situation, family situation, children, but as a western citizen maybe he would be worried more about his job. I do not see them worrying about the same things." (Participant 12, M)*

Almost all participants talked about how ***community connection*** is paramount in preserving the values and cultures of Syrian people as well as a place to share worries and experiences:

> *"We started gathering with the rest of the Syrian families or individuals* [...] *our encounters begin with one guy on the road or in a certain meeting, certain dinner at a restaurant, sometimes while we are walking we hear his accent so we stop him* [...] *we are trying as much as possible to gather these people to preserve our customs, traditions, heritage and association with our country" (Participant 8, M)*

They elaborated on the importance of establishing trusted connections in the community, either with people already in their lives or with new friends. Participants emphasized the significance of these connections in combating disturbances of emotions and stressors:

> *"Being with people with whom you feel loved from, this helps the person a lot to heal or to get out from the situation that he is in" (Participant 8, M)*

However, some participants had different point of view and remarked that the community feels ***dysfunctional***, as it contains people from different backgrounds with diverse perspectives:

"Not all the people who came from Syria have similar characteristics or the same culture, no! …Today they tell you, but we are a community and we should… ok I get it, but today what is happening -no disrespect- today you are gathering the criminal and the killer, and the doctor and the engineer, and the student and so on. You are putting them in one plate, and you tell us that we are a community, but correct we are a community, but all these ideas, how will you initiate communication between them?" (Participant 2, M)

Health Beliefs and Practices

Refugees shared their methods of self-help, or what some described as '***becoming their own doctor'***. Many shared stories on ways to apply that concept to try to help themselves heal and forget:

"The person is his own doctor. Whatever happens to you, support or help, if you were not helping yourself from the inside, you won't be able to succeed. You must keep combating in this life, there is no other way" (Participant 1, F)

Other expressed their desire to talk to trusted friends or loved ones as a form of therapy. They talked about how getting advice and input from loved ones strengthens the bonds of these relationships, and act as a source of releasing pent-up emotions:

"I won't let things pile up every day I mean…everyday, everyday, everyday, someone should talk to someone who they feel comfortable with…like your husband or son, daughter, anybody at home…everyday" (Participant 10, F)

Appreciation of the health benefits of ***nature*** even within urban parts of the UK was conveyed through the interviews and emphasis and encouragement to use nature as a form of healing was seen:

"I go to the sea and sit by the sea side, and I express my concerns to the sea, I speak to it. I go to the park, I try to get away from people" (Participant 8, M)

Others talked about resorting to ***faith*** or faith practices, and the ways these practices can alter their mood and help them:

"My mental state is better when I recite the Quran, I continue to do it, it provides comfort for me... Reciting the Quran is a comfort for me… Sometimes I listen to it on the phone, and this is honestly a comfort for me" (Participant 11, M)

A number of participants strongly emphasized that doing something you love is a way to improve mental health. The processes differ but commonly using hobbies, such as reading, writing or a playing a musical instrument:

Barriers to healthcare access

All refugees showed good knowledge of the healthcare system in general and how to access care facilities. However, there was a general hesitance in accessing mental health care facilities. Many participants apposed this idea of going to doctors from the UK for ***fear of being misunderstood***:

> "*No one would understand what we went through and the situation like you would…who did not witness it won't sympathise, yes, so it's hard for me to go and explain my mental status to a doctor, it's better to explain to God." (Participant 11, M)*

Another participant talked about how keeping emotions hidden affects and leaves them like a new looking phone, but without a battery:

> *"I feel that a person is just like the mobile phone where you have to always charge his battery, many times they tell me, wow you look fresh and active today, so I tell them I'm just like the newest version of iPhone, just without a battery" (Participant 8, M)*

Participants talked about how ***stigma*** affects their decision of resorting to mental health services, because of beliefs about mental health informed by growing up in Syria. These participants expressed their concerns of becoming a source of gossip and labelled as "crazy":

> *"Back in Syria, people are used to or have the assumption that people who go to psychiatrists have something wrong in their brains, crazy or something* [...] *so the majority of Syrian people are coy of going to the doctor or are not used to this habit, because we don't have something like that in Syria." (Participant 9, M)*

On the other hand, half of the participants strongly believed in the idea of breaking taboos regarding mental health. Five of them reported going to a mental health clinic previously in Syria, and four described going to a mental health clinic after moving to the UK:

> *"it is necessary to resort to psychiatric medicine… psychiatry is a normal thing and healthy* [...] *we have a misconception about it like it's for crazy people or so… no, no. On*

the contrary, it's something healthy and a person must resort to it whenever he feels the need to speak to someone" (Participant 7, M)

There was a consensus amongst all participants that learning the English ***language*** was, by far the most difficult barrier faced by the refugees, whether it was in their day-to-day life or in accessing medical health care:

"I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones [...] *the language." (Participant 7, M)*

Some commented on how the presence of translators can make the process of seeking health care tougher and that some information may get lost in the translation:

"For the translation I think it's not very helpful, sadly… I mean every expression or word I give out has a certain feeling to it, and for a translation it might not give out the proper meaning or it won't come out the intended way, I believe" (Participant 12, M)

"I told them also that the presence of a translator will not make me feel comfortable… sometimes you want to say personal things, or things straight from your heart, so to have a third person as a translator, it will be a bit difficult" (Participant 10, F)

Several refugees voiced their stories of struggle in learning the English language despite strenuous efforts, especially as the majority of participants were over 45 years of age. However, they all recognized that it is a necessary component for their integration and life in the UK.

Appreciation of the care received by refugees was a major part of each interview. Participants were grateful for all the efforts given to help them settle in and for the care given to their health:

"*What I have seen is that the health care services here are very attentive and they follow up patients* [...] *The health care system here is very nice. They follow up, since I came here, all the tests I need, the medications I require* [...]*Their health care system is excellent!" (Participant 1, F)*

Participants emphasised that treatment should be based on each case individually, as they believed that personalised care should be provided for them.

Discussion:

To the best of our knowledge, this study is the first of its kind to be conducted in the UK. Our findings show that refugees face constant challenges as they try to integrate into a new society. Participants described loss of family members, separation from loved ones in Syria, nostalgia for the homeland as causes of psychological distress and an overwhelming sense of sadness. Struggle for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities were perceived to hinder effective integration. Participants believed in 'being their own doctor' and turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Participant narratives in this study reflected existing literature exploring mental health issues in Syrian refugees,(17, 21). Previous research on post immigration factors has highlighted related issues around cultural integration, loss of family and community support, discrimination and adverse political climate,(12, 22, 23). *Betancourt et al* (2015) highlight that many refugees perceive community support as essential to dealing with past and present difficulties,(24). Participants in the present study emphasised the importance of their community not just in coping, unity and support but also as a means to preserve traditions and common values. This finding reflects a desire for future generations to remain connected to the homeland. Many participants in *Betancourt's* study expressed concerns over division in the political, educational and personal stance of other members of their community. Some evidence of discord within the Syrian community was evident in our study. Such differences may lie in kinship groups or friendship networks within communities which exert a sense of obligation above that of a united community,(25).

Coping mechanisms affect the well-being and mental health status of individuals. Strategies reported among Syrian refugees elsewhere include active and passive ones: smoking, excessively watching the news, worrying, behavioural withdrawal and "doing nothing",(26). Participants in our study emphasised listening to their own body and trying to cope using non-clinical methods such as utilizing nature, faith practices and hobbies. Using nature for the purpose of improving mental health is an acknowledged concept, and several studies have mentioned its benefits,(27). *Barton and Pretty* (2010) highlighted the importance of "nature doses" and "green exercise" in the improvement of mental health and concluded that this approach constituted a means of delivering mental therapy efficiently and easily,(28).In recent

studies of Syrian refugees, faith was reported as a significant coping mechanism. *El-Khani et al* (2017) explored the coping mechanisms used by displaced Syrian refugee mothers in refugee camps and found that parents utilized adaptation to their circumstances, social support and maintained mental health using faith as a coping strategy,(29). Similar results were found by *Boswall & Al Akash* (2015) who conducted an ethnographic study on Syrian women in Jordan and found that reading the Quran and practising faith was among the most common coping mechanisms,(30).

Literature shows that one of the biggest barriers to accessing healthcare in refugee communities is the language barrier,(12, 31-33) and this was also replicated in our study. Participants commented on the complications created by the presence of an interpreter, and raised concerns around poor quality translation as well as confidentiality. One study in the United States on refugees' access to healthcare found that language issues do not only affect access to care and doctor-patient relationship, but also restricts the ability to read and understand medical instructions and pharmaceutical prescriptions,(34). In order to secure the correct diagnosis as well as treatment delivery, interpreters who are familiar with the language and medical terminology need to be consulted. However, the presence of interpreters poses an ethical dilemma of confidentiality breaches and risks altering the relationship between refugee patient and the attending physicians,(35). The lack of adequate interpretation complicates patient encounters and generates fewer empathetic responses from the healthcare provider. In addition to decreasing rapport, it reduces patient satisfaction and increases unintentional medical error,(36-38). Furthermore, refugees who suffer from PTSD tend to endure greater difficulties in learning the foreign language spoken at the resettlement destination,(39) Hence, bridging the cultural and linguistic differences is integral to improving health care access of refugees to eliminate disparities for immigrants and refugees,(40, 41).

A further barrier to mental healthcare access by refugees is the stigma,(12). Our study revealed conflicting views on the value of psychiatry: some participants out rightly rejected mental healthcare treatment for the fear of being stigmatised whereas others viewed stigma an out of date misconception. In Syria and neighbouring countries, it is socially acceptable to express sensitive emotions and emotional suffering. However, labelling those emotions with medical terminologies of distress or as mental health illnesses can lead to shame or embarrassment to the sufferer or their family by being referred to as "mad" or "crazy",(42). One way to address stigma within refugee populations is through the work of community groups. *Palmer and Ward* (2007) suggested that these groups can assume the role of mediators between the refugee

service users and the healthcare establishment in order to combat the negative implications of stigma,(43). In addition, it has been shown that mental health awareness programmes can reduce stigma if provided outside mental health setting, such as in general medical clinics, community centres, schools and women's groups, etc. (42).

Fear of being misunderstood by service care providers was also suggested by refugees as a barrier to accessing mental health facilities, "no one would understand" being a phrase repeated by participants. *Asgary and Segar* (2011) found similar barriers in their study on refugee and asylum seekers' healthcare access,(44). A potential solution to this problem would be the involvement of cultural consultants with backgrounds and experience in immigrant and refugee communities in order to provide accurate assessment and improved services to specific communities,(45). It is crucial for mental health professionals and healthcare service providers to understand that Syrian refugees have a concept of mental illness and psychosocial wellbeing that is rooted deeply in existing social, cultural and religious traditions,(46, 47). Despite the aforementioned barriers, participants showed an overall good knowledge about the UK National Health Service and how to navigate appointments and receive prescriptions. This finding is in contrast with the results of *Renner et al (2020)* in Germany and *Saechao et al* (2011) in the United States who reported a general lack of knowledge of the new healthcare system,(12, 48).

Strengths and limitations

A major strength of this study is that it was conducted fully in the language and dialect of the participating Syrian refugees. In approaching this study, the researcher adopted the philosophy of Asselin (2003) that recommended that an insider researcher should approach a project with "eyes open" and gathered data while assuming no previous knowledge of the phenomenon being studied,(49). This study, however has some limitations. One of the limitations of this study is the small number of participants. The recruitment was undertaken during the months of May and June which coincided with Ramadan (the month of fasting in the Muslim faith), and the Eid celebration (breaking of the fast). This might have affected participants' availability and participation decision. Nevertheless, the main objective of qualitative research, regardless of sample size, is not to produce the most generalizable or statistically significant findings, but to provide valuable data upon which future assessments can be built,(50). Findings cannot be generalized to other refugee communities residing in other parts of the world. However, many of the themes identified in this study appear to be common in other refugee studies of different backgrounds.

Conclusion

This study aimed to explore the mental health and wellbeing of Syrian refugees in the UK, their access to the healthcare system, and integration pathways into wider society. This revealed that mental health distress was understood by participants in terms of separation, loss and a struggle for connectedness. Many factors were found to be helpful or used as coping mechanisms by the refugee community, such as family, nature, faith and various hobbies. However, multiple barriers to accessing healthcare system were found, in particular stigma, fear of being misunderstood, and language competence. While some of the interviewed refugees had successfully accessed mental health services, they noted issues and constraints that reduced the perceived value of such care. Syrian refugees have become an integral component within British society and it is hoped that this study constitutes a catalyst for further research on this vulnerable group to ensure their proper integration to the UK community.

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Figure 1: List of key themes and subthemes

Loss and separation	*Struggling for connectedness in a culturally divided world*	*Health beliefs and practices*	*Barriers to healthcare access*
• *Loss of family members/possesions* • *Separation from family/friends/birth country*	• *Cultural differences* • *Community connections* • *Disfunctional Communities*	• *Becoming their own doctor* • *Practising faith* • *Getting out in the nature*	• *Fear of being misunderstood* • *Stigma around mental health* • *Language barrier*

Figure 1: List of key themes and subthemes

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 1
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 2
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Page 3
Purpose or research question - Purpose of the study and specific objectives or questions	Page 3- Page 4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Page 4
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 4, Page13-Page 14
Context - Setting/site and salient contextual factors; rationale**	Page 4-5
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Page 4
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 5
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Pages 4-5

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Pages 4-5
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 4, Page 5, Page 13
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Pages 4- 5
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Pages 4- 5
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 5

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 5-11
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 6-11

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 11-14
Limitations - Trustworthiness and limitations of findings	Pages 13-14

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 14
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 14

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

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A qualitative study on mental health and wellbeing of Syrian refugees and their coping mechanisms towards integration in the UK

Priyamvada Paudyal[1], Mais Tattan[1] and Max Cooper[1]

[1]Department of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton UK

Corresponding Author: Dr Priyamvada Paudyal
Department of Primary Care and Public Health, Brighton and Sussex Medical School, Room 322, Watson Building, Village Way, Falmer, BRIGHTON, BN1 9PH, UK
+44 (0) 1273 644548; p.paudyal@bsms.ac.uk

Running Title: Mental health and wellbeing of Syrian refugees in the UK

Abstract

Objective: This study aimed to explore the mental well-being of Syrian refugees and identify their coping mechanisms and pathways towards integration into new communities.

Design: Qualitative study using in-depth semi-structured interviews.

Setting and Participants: Adult Syrian refugees (>18 years old) currently residing in South east of England.

Results: Twelve participants (three women and nine men) took part in the study, all were born in Syria and the majority (n=9) were over 45 years of age. Our findings show that Syrian refugees face constant challenges as they try to integrate into a new society. Loss of and separation from loved ones as well as the nostalgia for the homeland were often cited as a source of psychological distress that created an overwhelming sense of sadness. Participants reported that they struggled for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities in their new setting. They believed in 'being their own doctor' and turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Conclusion: Past experiences and present challenges frame Syrian refugees' sense of well-being, impact use of healthcare and risk future mental health problems. It is hoped that this study will act as a catalyst for further research on this vulnerable group to promote integration, community support and culturally-sensitive mental health services.

Strengths and Limitations

- To date, this is the first qualitative study conducted among Syrian refugees in the UK.
- The interviews were conducted fully in the language and dialect of the participating Syrian refugees.
- This study is limited by its small sample size (n=12). However, the study gathered rich data, and Identified themes in this study align with the findings of previous research on refugees of different backgrounds

Introduction

The mass movement of Syrian refugee is recognised as the biggest forced-displacement predicament the world has seen since the second world war,(1) and was declared by the United Nation High Commissioner for Refugees (UNHCR) as the biggest humanitarian crisis of our present time,(2). Since 2011, following the escalating conflict and violence in Syria, millions have been forced to flee their homes in search of safety and protection. The most recent estimates suggests that about 5.6 million Syrians have registered as refugees in neighbouring countries and an additional 6.6 million Syrians are internally displaced within the borders of Syria,(3).

Refugees are at risk of multiple traumatic experiences that impact their mental and physical health. These traumatic factors originate from their home country, during their displacement journey or as part of the asylum process. Pre-immigration factors such as physical injury, near-death experiences, witnessing murder, bereavement (for example the traumatic loss of loved ones), imprisonment and torture are often associated with civil conflict,(4). Others encounter additional traumatic events during their journey to exile and as part of the settlement process. Evidence suggest that post-immigration stressors such as ethnic discrimination, harsh socio-economical living conditions, institutional accommodation, limited language skills and poor social support are detrimental to refugees' mental health and the impact may persist for years or possibly decades after resettlement to a new environment,(5-12). For such reasons, Syrian refugees have been found to live with hopelessness, fear and constant worries,(13).

The majority of those who seek asylum in the United Kingdom (UK) come from countries that are in the midst of conflict,(14). Previous research on refugees in the UK have concluded that one in six refugees develops severe health problem that could permanently affect their quality of life,(15). Further research have found that asylum seekers face worse outcomes than the UK population on almost all measures of health and wellbeing,(16). Symptoms of anxiety, depression, post-traumatic stress disorder (PTSD) and agoraphobia have been reported amongst this population,(17) and it has been estimated that up to two thirds of refugees in the UK experience anxiety or depression,(18). In 2014, the UK launched its Syrian vulnerable person resettlement programme (VPR) aiming to resettle twenty thousand Syrian refugees across the country by the year 2020,(19). The crisis has been escalated recently with powerful images in the news and social media covering stories of desperate and vulnerable people trying to cross the English Channel to reach the UK,(20). In this context, there is a need for further understanding of the impact of the current refugee crisis upon Syrians, particularly after

resettlement. Most importantly there is a need to explore the coping mechanisms and resilience pathways of Syrian refugees to promote their wellbeing, integration, and transition into active members of society.

Numerous studies have reported on the prevalence of several mental health disorders amongst Syrian refugees,(21-23). Depression, anxiety and PTSD were found to be the most prevalent disorders amongst displaced individuals,(24). However, the existing literature is mostly comprised of quantitative studies and there is a clear need for undertaking a comprehensive qualitative research. This study aimed to explore mental well-being of Syrian refugees, barriers to seeking mental health care services, coping mechanisms and pathways towards integration in new communities.

Methodology

This qualitative study was conducted in South East England using semi-structured interviews. Qualitative methods were selected to allow in-depth understanding of practical issues through detailed exploration of individual's experiences, motives and opinions,(25). Participants were recruited via the contacts of language centres, community organisations and charities using purposive and snowballing sampling approach. This method was chosen as purposive sampling involves identifying and selecting individuals or groups that are knowledgeable or have experienced the studied phenomenon. Adult Syrian refugees (>18 years of age), currently living in South East England, and speaking Arabic or English were eligible for inclusion. For ethical reasons, details of participants' past mental health diagnoses were not collected.

Participants were approached through the gatekeepers of the respective organisations and a snowballing technique was used to approach further possible participants. They were provided with participant information leaflets (PIL) in the Arabic and English languages according to participants' preferences, which provided detailed information about the study. Thirty potential participants were invited to participate. Of these, thirteen agreed to participate and one participant withdrew before the start of the interviews. Altogether, twelve participants comprised the sample for this study.

Due to the vulnerable nature of the topic and the predicament of participants, no incentive was offered while inviting potential participants; participation was entirely voluntary and the right to withdraw was available at any point. Informed consents were obtained from participants after full explanation and reiteration of the information provided in the PIL.

A semi structured interview topic guide (Table 1) was constructed to explore their understanding of mental health problems and beliefs about mental health and wellbeing, community support, coping mechanisms and access to healthcare services. Interviews were conducted between April-June 2019 in a location of the participant's choice. Six interviews were conducted in private spaces within community organisations, and the other six were conducted in open public spaces chosen by participants, such as public parks. All interviews were conducted in Arabic, transcribed verbatim and the scripts were then translated into English.

Data was analysed using thematic content analysis following Burnard's,(26) method. This involves a systematic 14-part method of step-by-step process of open coding and categorization. The approach is used to evaluate and record the themes and issues highlighted in texts produced by the participants and categorized appropriately. The coding was done iteratively; random samples of the identified themes were discussed with the research team until agreement was reached for the key themes. Ethical approval was obtained from the Brighton and Sussex Medical School Research and Ethics Governance Committee (ER/BSMS9DAP/1).

The researcher who collected the data (MT) is bilingual and shares the nationality and the language of the studied refugee participants (except the refugee status). This requires a reflection on the insider-outsider qualitative researcher approach. Being an insider researcher has advantages; they are trusted and accepted by the participants, and have greater understanding about the phenomena being studied. However, it can be argued that this could lead to a loss of objectivity and bias,(27). Hence, prior to the data collection, the researcher adopted the philosophy of Asselin 2003 which recommends the insider researcher to approach research while assuming no previous knowledge of the studied phenomenon,(28). The researcher was also trained to conduct the interviews in a neutral manner using open questions and encouraging the participants to express ideas and thoughts.

Patient and Public Involvement: Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Table1 – Topic guide used for the interview process

- Introduction
- Beliefs about mental health and wellbeing
  - Personal definition of mental health
  - Explore why some people have good mental health and others do not
  - Ways to help oneself to have good mental health
- Community Support and Coping Mechanism
  - Community in the UK and newly formed relationships
  - Emotional or physical challenges faced
  - Coping mechanisms to overcome the challenges
- Access to mental healthcare services
  - Understanding of mental health facilities in the UK
  - Barriers and facilitators in accessing mental health care

Results

The study's sample consisted of twelve refugee participants, three women and nine men. All participants were born in Syria and nine had moved to the UK less than five years ago. Three quarter of the participants (n=9) were over 45 years of age, nine were married with children, one separated and two single. Five participants were university graduates, six had school level education and one was illiterate. Average time for residing in the UK was 3.8 years, range ((3 months- 10 years)

Table 2: Demographic characteristics of participants

Participant	Country of Birth	Time residing in the UK (years)	Age bracket	Gender	Relationship status	Highest level of education
1	Syria	0-4	40-49	Female	Married	University
2	Syria	0-4	40-49	Male	Married	University
3	Syria	0-4	60-69	Male	Married	School
4	Syria	0-4	50-59	Male	Married	School
5	Syria	0-4	70-79	Female	Married	Illiterate
6	Syria	0-4	60-69	Male	Married	University
7	Syria	5-10	40-49	Male	Separated	School
8	Syria	5-10	50-59	Male	Married	University
9	Syria	0-4	18-29	Male	Single	School
10	Syria	0-4	30-39	Female	Married	School
11	Syria	0-4	40-49	Male	Married	School
12	Syria	5-10	18-29	Male	Single	University

Identified themes

Four major key themes were identified from the data analysis; Loss and Separation, struggling for connectedness in a culturally divided world, Health Beliefs and Practices, and Barriers to Healthcare Access. Several sub-themes emerged under each key theme and are elaborated upon using quotes. Listing of key themes and sub themes can be found in (Figure 1).

Loss and Separation

Participants often perceived that loss of and separation from their family members was causing or aggravating their current psychological distress. These feelings were not limited to the ***loss*** of loved ones, but also the loss of material possessions, and connections to their home country in general:

"Sometimes when I remember my brother who passed away…makes me feel upset…like we were six people in the family... me, my mum, my dad, and my three siblings, a brother and two sisters… suddenly there was only me, my mum and my dad" (Participant 9, Man)

One participant described the meaning of home to a Syrian family and the consequences of its loss:

"When you build a home it's like a celebration, it means you have established a residence, it means you have a family and you have a home! [...] *We worked for 17 years to create this home then we locked it and fled* [...] *these matters make you sad" (Participant 2, Man)*

Separation from relatives or loved ones who remained back in the country was frequently described as painful. Despite their distance from Syria, migrants remained closely connected to the country and its people. The state of separation from home and loved ones could lead to strong emotions of sadness and joy:

"Any news that you hear about the country, whether it's small or big news, it hurts and disturbs the person's mental state, so you find us happy for their happiness and sad for their sadness or their suffering" (Participant 8, Man)

Other participants called for reunion with loved ones, stating that their mental health state would be resolved if they were able to be reunited with their family members:

"If a person could see his children… like for one of our children to come, we probably would not need a psychiatric doctor… you know? Isn't this right?" (Participant 5, Woman)

Struggling for connectedness in a culturally divided world: Participants commented on ***cultural differences*** and their difficulties in assimilating in the new environment in the new country. There were also comments on feelings of resistance to assimilation on the part of the native population. Despite efforts by Syrians, the gap between the two cultures was considered large and reflected in behaviour and attire:

"Integration with the western society or the British community is almost too small… too small… and mostly it's from them, not us… I mean we try, but they as a society have their own costumes and traditions that are completely different than ours" (Participant 7, Man)

One part of this difference lay in divergent priorities in life between the two groups. There was a feeling that Syrians had to live with predicaments that were remote to White British people. Whilst Syrians faced diverse social challenges, native people only had to think about employment:

> *"We think of things they do not think about* [...] *I mean for us as citizens, we can worry about the financial situation, family situation, children, but as a western citizen maybe he would be worried more about his job. I do not see them worrying about the same things." (Participant 12, Man)*

Almost all participants talked about how ***community connection*** is paramount in preserving the values and cultures of Syrian people as well as a place to share worries and experiences:

> *"We started gathering with the rest of the Syrian families or individuals* [...] *our encounters begin with one guy on the road or in a certain meeting, certain dinner at a restaurant, sometimes while we are walking we hear his accent so we stop him* [...] *we are trying as much as possible to gather these people to preserve our customs, traditions, heritage and association with our country" (Participant 8, Man)*

They elaborated on the importance of establishing trusted connections in the community, either with people already in their lives or with new friends. Participants emphasized the significance of these connections in combating disturbances of emotions and stressors:

> *"Being with people with whom you feel loved from, this helps the person a lot to heal or to get out from the situation that he is in" (Participant 8, Man)*

However, some participants had different point of view and remarked that the community feels ***dysfunctional***, as it contains people from different backgrounds with diverse perspectives:

> *"Not all the people who came from Syria have similar characteristics or the same culture, no! …Today they tell you, but we are a community and we should… ok I get it, but today what is happening -no disrespect- today you are gathering the criminal and the killer, and the doctor and the engineer, and the student and so on. You are putting them in one plate, and you tell us that we are a community, but correct we are a community, but all these ideas, how will you initiate communication between them?" (Participant 2, Man)*

Health Beliefs and Practices

Refugees shared their methods of self-help, or what some described as '***becoming their own doctor'***. Many shared stories about applying that concept to try to help themselves heal and to forget:

> *"The person is his own doctor. Whatever happens to you, support or help, if you were not helping yourself from the inside, you won't be able to succeed. You must keep combating in this life, there is no other way" (Participant 1, Woman)*

Other expressed their desire to talk to trusted friends or loved ones as a form of therapy. They talked about how getting advice and input from loved ones strengthens the bonds of these relationships, and act as a source of releasing pent-up emotions:

> *"I won't let things pile up every day I mean…everyday, everyday, everyday, someone should talk to someone who they feel comfortable with…like your husband or son, daughter, anybody at home…everyday" (Participant 10, Woman)*

Appreciation of the health benefits of ***nature*** even within urban parts of the UK was conveyed through the interviews and emphasis and encouragement to use nature as a form of healing was seen:

> *"I go to the sea and sit by the sea side, and I express my concerns to the sea, I speak to it. I go to the park, I try to get away from people" (Participant 8, Man)*

Others talked about resorting to ***faith*** or faith practices, and the ways these practices can alter their mood and help them:

> *"My mental state is better when I recite the Quran, I continue to do it, it provides comfort for me... Reciting the Quran is a comfort for me… Sometimes I listen to it on the phone, and this is honestly a comfort for me" (Participant 11, Man)*

A number of participants strongly emphasized doing something you enjoy as a way to improve mental health. Examples included hobbies, such as reading, writing or a playing a musical instrument:

Barriers to healthcare access

All refugees showed good knowledge of the healthcare system in general and how to access care facilities. However, there was a general hesitance towards accessing mental health care

services. Many participants apposed this idea of consulting white British doctors for ***fear of being misunderstood***:

> "*No one would understand what we went through and the situation like you would…who did not witness it won't sympathise, yes, so it's hard for me to go and explain my mental status to a doctor, it's better to explain to God." (Participant 11, Man)*

Another participant talked about how keeping emotions hidden created a difference between internal and external appearances. This was compared to a new looking phone, but with no battery inside:

> *"I feel that a person is just like the mobile phone where you have to always charge his battery, many times they tell me, wow you look fresh and active today, so I tell them I'm just like the newest version of iPhone, just without a battery" (Participant 8, Man)*

Participants talked about how ***stigma*** affects their decision to approach mental health services, because of beliefs about mental health informed by growing up in Syria. These participants expressed their concerns of becoming a source of gossip and being labelled as "crazy":

> *"Back in Syria, people are used to or have the assumption that people who go to psychiatrists have something wrong in their brains, crazy or something* [...] *so the majority of Syrian people are coy of going to the doctor or are not used to this habit, because we don't have something like that in Syria." (Participant 9, Man)*

On the other hand, half of the participants strongly believed in the notion of breaking taboos regarding mental health. Five of them reported going to a mental health clinic previously in Syria, and four described going to a mental health clinic after moving to the UK:

> *"it is necessary to resort to psychiatric medicine… psychiatry is a normal thing and healthy* [...] *we have a misconception about it like it's for crazy people or so… no, no. On the contrary, it's something healthy and a person must resort to it whenever he feels the need to speak to someone" (Participant 7, Man)*

There was a consensus amongst all participants that learning the English ***language*** was, by far the most difficult barrier faced by the refugees, whether it was in their day-to-day life or in accessing medical health care:

> *"I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones* [...] *the language." (Participant 7, Man)*

Some commented on how the presence of translators can make the challenges of seeking health care tougher and that some information could get lost in the translation:

> *"For the translation I think it's not very helpful, sadly… I mean every expression or word I give out has a certain feeling to it, and for a translation it might not give out the proper meaning or it won't come out the intended way, I believe" (Participant 12, Man)*

> *"I told them also that the presence of a translator will not make me feel comfortable… sometimes you want to say personal things, or things straight from your heart, so to have a third person as a translator, it will be a bit difficult" (Participant 10, Woman)*

Several refugees voiced their stories of struggle in learning the English language despite strenuous efforts, especially as the majority of participants were over 45 years of age. However, they all recognized that it is a necessary component for their integration and life in the UK.

Appreciation of the care received by refugees was a major part of each interview. Participants were grateful for all the efforts given to help them settle in and for the care given to their health:

> "*What I have seen is that the health care services here are very attentive and they follow up patients* [...] *The health care system here is very nice. They follow up, since I came here, all the tests I need, the medications I require* [...]*Their health care system is excellent!" (Participant 1, Woman)*

Participants emphasised that treatment should be based on each case individually. In this way, personalised care was presented as important – and something that should be provided – to Syrian refugees.

Discussion:

This study is the first of its kind to be conducted in the UK. Our findings show that refugees face constant challenges as they try to integrate into a new society. Participants described loss of family members, separation from loved ones in Syria, nostalgia for the homeland as causes of psychological distress and an overwhelming sense of sadness. Struggle for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities were perceived to hinder effective integration. Participants believed in 'being their own doctor' and

turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Participant narratives in this study reflected existing literature exploring mental health issues in Syrian refugees,(24, 29). Previous research on post immigration factors has highlighted related issues around cultural integration, loss of family and community support, discrimination and adverse political climate,(13, 30, 31). *Betancourt et al* (2015) report that many refugees perceive community support as essential to dealing with past and present difficulties,(32). Participants in the present study emphasised the importance of their community not just in coping, unity and support but also as a means to preserve traditions and common values. This finding reflects a desire for future generations to remain connected to the homeland. Many participants in *Betancourt's* study expressed concerns over division in the political, educational and personal stance of other members of their community. Some evidence of discord within the Syrian community was evident in our study. Such differences may lie in kinship groups or friendship networks within communities which exert a sense of obligation above that of national identity,(33).

Coping mechanisms affect the well-being and mental health status of individuals. Strategies reported among Syrian refugees elsewhere include active and passive ones: cigarette smoking, excessively watching the news, worrying, behavioural withdrawal and "doing nothing",(34). Participants in our study emphasised listening to their own body and trying to cope using non-clinical methods such as utilizing nature, faith practices and hobbies. Using nature for the purpose of improving mental health is a recognised coping strategy, and several studies suggest that it indeed offers benefits,(35). *Barton and Pretty* (2010) highlighted the importance of "nature doses" and "green exercise" in the improvement of mental health and concluded that this approach constituted a means of promoting mental therapy efficiently and easily,(36).In recent studies of Syrian refugees, faith was reported as a significant coping mechanism. *El-Khani et al* (2017) explored the coping mechanisms used by displaced Syrian refugee mothers in refugee camps and found that parents utilized adaptation to their circumstances, social support and maintained mental health using faith as a coping strategy,(37). Similar results were found by *Boswall & Al Akash* (2015) who conducted an ethnographic study on Syrian women in Jordan and found that reading the Quran and practising faith was among the most common coping mechanisms,(38). This is also shown by *Hirschman 2004* on his study of immigrants in the United States, which concluded that faith and religious practices provide ethnic communities

with refuge from the hostility and discrimination from the host society as well as opportunities for economic mobility and social recognition,(39)

Literature shows that one of the biggest barriers to accessing healthcare in refugee communities is the language barrier,(12, 13, 40-42) and this was also replicated in our study. Participants commented on the complications created by the presence of an interpreter, and raised concerns around poor quality translation as well as confidentiality. One study in the United States on refugees' access to healthcare found that language issues do not only affect access to care and doctor-patient relationship, but also restrict the ability to read and understand medical instructions and pharmaceutical prescriptions,(43). In order to secure the correct diagnosis as well as treatment delivery, interpreters who are familiar with the language and medical terminology need to be consulted. However, the presence of interpreters poses an ethical dilemma of confidentiality breaches and risks altering the relationship between refugee patient and attending physician,(44). *Fatahi et al 2010* in their study on Kurdish refugees in Sweden found that participants expressed fear, suspicion and lack of confidence in interpreters,(45). *Bhatia and Wallace 2007* found similar results in their study in the UK along with other barriers that refugees face accessing mental healthcare services, for example stigma and lacking support of a refugee-dedicated agency,(46). Lack of adequate interpretation complicates patient encounters and elicits fewer empathetic responses from the healthcare provider. In addition to decreasing rapport, it reduces patient satisfaction and increases unintentional medical error,(47-49). Furthermore, refugees who suffer from PTSD tend to endure greater difficulties in learning the foreign language spoken at the resettlement destination,(50) Hence, bridging cultural and linguistic differences is integral to improving health care access of refugees to eliminate disparities for immigrants and refugees,(51, 52).

A key barrier to mental healthcare access by refugees is the stigma,(13). Our study revealed conflicting views on the value of psychiatry: some participants out rightly rejected mental healthcare treatment for fear of being stigmatised whereas others viewed stigma as an out of date misconception. In Syria and neighbouring countries, it is socially acceptable to express sensitive emotions and emotional suffering. However, labelling those emotions with medical terminologies of distress or as mental health illnesses can lead to shame or embarrassment to the sufferer or their family by being referred to as "mad" or "crazy",(53). One way to address stigma within refugee populations is through the work of community groups. *Palmer and Ward* (2007) suggested that these groups can assume the role of mediators between refugee service users and the healthcare establishment in order to combat the negative implications of

stigma,(54). In addition, it has been shown that mental health awareness programmes can reduce stigma if provided outside mental health setting, such as in general medical clinics, community centres, schools and women's groups,(53).

Fear of being misunderstood by service care providers was also suggested by refugees as a barrier to accessing mental health facilities, "no one would understand" being a phrase repeated by participants. *Asgary and Segar* (2011) found similar barriers in their study on refugees and asylum seekers' healthcare access,(55). A potential solution to this problem would be the involvement of cultural consultants with backgrounds and experience in immigrant and refugee communities in order to provide accurate assessment and improved services to specific communities,(56). It is crucial for mental health professionals and healthcare service providers to understand that Syrian refugees have a concept of mental illness and psychosocial wellbeing that is rooted deeply in longstanding social, cultural and religious traditions,(57, 58). Despite the aforementioned barriers, our participants showed an overall good knowledge about the UK National Health Service and how to navigate appointments and access medications. This finding is in contrast with the results of *Renner et al (2020)* in Germany and *Saechao et al* (2011) in the United States who reported a general lack of knowledge of the new healthcare system,(13, 59).

Strengths and limitations

A major strength of this study is that it was conducted fully in the language and dialect of participants. In approaching this study, the researcher adopted the philosophy of Asselin (2003) that recommended that an insider researcher should approach a project with "eyes open" and gather data while assuming no previous knowledge of the phenomenon being studied,(28). This study, however, also has limitations. One limitation is the small number of participants (n=12). Of the twelve participants interviewed in this study, only three were females. Although this might have led to the underrepresentation of the female experience, this proportion is broadly representative of the refugee population in the UK as the Refugee Council UK suggest that only 26% of the asylum seeking applications are made by women,(60). Recruitment was undertaken during the months of April-June which coincided with Ramadan (the month of fasting in the Muslim faith), and the Eid celebration (breaking of the fast). This might have influenced participants' decision whether to participate. Nevertheless, the main objective of qualitative research, regardless of sample size, is not to produce a generalisable or statistically significant outcome, but to elicit rich data upon which future enquiry can be undertaken,(61). Another

limitation is that the findings of this study may not be generalised to other refugee communities residing in other countries. However, many of the themes identified in this study appear to be common in other refugee studies of different backgrounds. A further limitation is presented in the fact that past mental health diagnoses among participants was not recorded. This decision was made on grounds of ethics, confidentiality and to promote recruitment. Participant recruitment from this vulnerable group was anticipated to be challenging. Therefore, only basic demographic data were collected in order to promote recruitment and anonymity. This approach inevitably risks participants appearing homogenous. Given the extent of trauma experienced by Syrians and the widespread challenges of integration, it was concluded that all participants would offer valuable narratives. We recognise that for some this could be vicarious in origin but consider it valid because of the close-knit nature of Syrian refugee families/communities and evidence that refugees frequently share experiences/perceptions, (59).

Conclusion

Findings of this study shed light on the predicament of Syrian refugees in the UK, whose wellbeing and mental healthcare experiences remain unstudied during integration into the UK society. Participants discussed about mental health distress, especially in terms of separation, loss and a struggle for connectedness. Many factors were found to be helpful or used as coping mechanisms by the refugee community, such as family, nature, faith and pursuing hobbies. However, multiple barriers to accessing healthcare system were identified, in particular stigma, fear of being misunderstood, and language competence. While some of the interviewed refugees had successfully managed to access mental health services, they reported beliefs and challenges that reduced the perceived value of such care. Syrian refugees have become an integral component within British society and it is hoped that this study can serve as a catalyst for further research on this vulnerable group to ensure their proper integration to the UK society.

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Figure 1: List of Key themes and Subthemes

Loss and separation	Struggling for connectedness in a culturally divided world	Health beliefs and practices	Barriers to healthcare access
• Loss of family members/possesions • Separation from family/friends/birth country	• Cultural differences • Community connections • Disfunctional Communities	• Becoming their own doctor • Practising faith • Getting out in the nature	• Fear of being misunderstood • Stigma around mental health • Language barrier

Figure 1: List of key themes and subthemes

Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 2
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 2
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Page 3- page 4
Purpose or research question - Purpose of the study and specific objectives or questions	Page 4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Page 4,5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 5
Context - Setting/site and salient contextual factors; rationale**	Pages 4
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Page 4
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 5
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Page 5

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Page 5
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 4 Page 6 Table-2 in page 6
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 5
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 5
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 5

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 7-12
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 6-12

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 12- page 14
Limitations - Trustworthiness and limitations of findings	Page14-page 15

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 16
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 16

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

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A qualitative study on mental health and wellbeing of Syrian refugees and their coping mechanisms towards integration in the UK

Priyamvada Paudyal[1], Mais Tattan[1] and Max Cooper[1]

[1]Department of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton UK

Corresponding Author: Dr Priyamvada Paudyal
Department of Primary Care and Public Health, Brighton and Sussex Medical School, Room 322, Watson Building, Village Way, Falmer, BRIGHTON, BN1 9PH, UK
+44 (0) 1273 644548; p.paudyal@bsms.ac.uk

Running Title: Mental health and wellbeing of Syrian refugees in the UK

Abstract

Objective: This study aimed to explore the mental well-being of Syrian refugees and identify their coping mechanisms and pathways towards integration into new communities.

Design: Qualitative study using in-depth semi-structured interviews.

Setting and Participants: Adult Syrian refugees (>18 years old) currently residing in South east of England.

Results: Twelve participants (three women and nine men) took part in the study, all were born in Syria and the majority (n=9) were over 45 years of age. Our findings show that Syrian refugees face constant challenges as they try to integrate into a new society. Loss of and separation from loved ones as well as the nostalgia for the homeland were often cited as a source of psychological distress that created an overwhelming sense of sadness. Participants reported that they struggled for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities in their new setting. They believed in 'being their own doctor' and turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Conclusion: Past experiences and present challenges frame Syrian refugees' sense of well-being, impact use of healthcare and risk future mental health problems. It is hoped that this study will act as a catalyst for further research on this vulnerable group to promote integration, community support and culturally-sensitive mental health services.

Strengths and Limitations

- To date, this is the first qualitative study conducted among Syrian refugees in the UK.
- The interviews were conducted fully in the language and dialect of the participating Syrian refugees.
- This study is limited by its small sample size (n=12). However, the study gathered rich data, and Identified themes in this study align with the findings of previous research on refugees of different backgrounds

Introduction

The mass movement of Syrian refugee is recognised as the biggest forced-displacement predicament the world has seen since the second world war,(1) and was declared by the United Nation High Commissioner for Refugees (UNHCR) as the biggest humanitarian crisis of our present time,(2). Since 2011, following the escalating conflict and violence in Syria, millions have been forced to flee their homes in search of safety and protection. The most recent estimates suggests that about 5.6 million Syrians have registered as refugees in neighbouring countries and an additional 6.6 million Syrians are internally displaced within the borders of Syria,(3).

Refugees are at risk of multiple traumatic experiences that impact their mental and physical health. These traumatic factors originate from their home country, during their displacement journey or as part of the asylum process. Pre-immigration factors such as physical injury, near-death experiences, witnessing murder, bereavement (for example the traumatic loss of loved ones), imprisonment and torture are often associated with civil conflict,(4). Others encounter additional traumatic events during their journey to exile and as part of the settlement process. Evidence suggest that post-immigration stressors such as ethnic discrimination, harsh socio-economical living conditions, institutional accommodation, limited language skills and poor social support are detrimental to refugees' mental health and the impact may persist for years or possibly decades after resettlement to a new environment,(5-12). For such reasons, Syrian refugees have been found to live with hopelessness, fear and constant worries,(13).

The majority of those who seek asylum in the United Kingdom (UK) come from countries that are in the midst of conflict,(14). Previous research on refugees in the UK have concluded that one in six refugees develops severe health problem that could permanently affect their quality of life,(15). Further research have found that asylum seekers face worse outcomes than the UK population on almost all measures of health and wellbeing,(16). Symptoms of anxiety, depression, post-traumatic stress disorder (PTSD) and agoraphobia have been reported amongst this population,(17) and it has been estimated that up to two thirds of refugees in the UK experience anxiety or depression,(18). In 2014, the UK launched its Syrian vulnerable person resettlement programme (VPR) aiming to resettle twenty thousand Syrian refugees across the country by the year 2020,(19). The crisis has been escalated recently with powerful images in the news and social media covering stories of desperate and vulnerable people trying to cross the English Channel to reach the UK,(20). In this context, there is a need for further understanding of the impact of the current refugee crisis upon Syrians, particularly after

resettlement. Most importantly there is a need to explore the coping mechanisms and resilience pathways of Syrian refugees to promote their wellbeing, integration, and transition into active members of society.

Numerous studies have reported on the prevalence of several mental health disorders amongst Syrian refugees,(21-23). Depression, anxiety and PTSD were found to be the most prevalent disorders amongst displaced individuals,(24). However, the existing literature is mostly comprised of quantitative studies and there is a clear need for undertaking a comprehensive qualitative research. This study aimed to explore mental well-being of Syrian refugees, barriers to seeking mental health care services, coping mechanisms and pathways towards integration in new communities.

Methodology

This qualitative study was conducted in South East England using semi-structured interviews. Qualitative methods were selected to allow in-depth understanding of practical issues through detailed exploration of individual's experiences, motives and opinions,(25). Participants were recruited via the contacts of language centres, community organisations and charities using purposive and snowballing sampling approach. This method was chosen as purposive sampling involves identifying and selecting individuals or groups that are knowledgeable or have experienced the studied phenomenon. Adult Syrian refugees (>18 years of age), currently living in South East England, and speaking Arabic or English were eligible for inclusion. For ethical reasons, details of participants' past mental health diagnoses were not collected.

Participants were approached through the gatekeepers of the respective organisations and a snowballing technique was used to approach further possible participants. They were provided with participant information leaflets (PIL) in the Arabic and English languages according to participants' preferences, which provided detailed information about the study. Thirty potential participants were invited to participate. Of these, thirteen agreed to participate and one participant withdrew before the start of the interviews. Altogether, twelve participants comprised the sample for this study.

Due to the vulnerable nature of the topic and the predicament of participants, no incentive was offered while inviting potential participants; participation was entirely voluntary and the right to withdraw was available at any point. Informed consents were obtained from participants after full explanation and reiteration of the information provided in the PIL.

A semi structured interview topic guide (Table 1) was constructed to explore their understanding of mental health problems and beliefs about mental health and wellbeing, community support, coping mechanisms and access to healthcare services. Interviews were conducted between April-June 2019 in a location of the participant's choice. Six interviews were conducted in private spaces within community organisations, and the other six were conducted in open public spaces chosen by participants, such as public parks. All interviews were conducted in Arabic, transcribed verbatim and the scripts were then translated into English.

Data was analysed using thematic content analysis following Burnard's,(26) method. This involves a systematic 14-part method of step-by-step process of open coding and categorization. The approach is used to evaluate and record the themes and issues highlighted in texts produced by the participants and categorized appropriately. The coding was done iteratively; random samples of the identified themes were discussed with the research team until agreement was reached for the key themes.

The researcher who collected the data (MT) is bilingual and shares the nationality and the language of the studied refugee participants (except the refugee status). This requires a reflection on the insider-outsider qualitative researcher approach. Being an insider researcher has advantages; they are trusted and accepted by the participants, and have greater understanding about the phenomena being studied. However, it can be argued that this could lead to a loss of objectivity and bias,(27). Hence, prior to the data collection, the researcher adopted the philosophy of Asselin 2003 which recommends the insider researcher to approach research while assuming no previous knowledge of the studied phenomenon,(28). The researcher was also trained to conduct the interviews in a neutral manner using open questions and encouraging the participants to express ideas and thoughts.

Patient and Public Involvement: Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Table1 – Topic guide used for the interview process

- Introduction
- Beliefs about mental health and wellbeing
  - Personal definition of mental health
  - Explore why some people have good mental health and others do not
  - Ways to help oneself to have good mental health
- Community Support and Coping Mechanism
  - Community in the UK and newly formed relationships
  - Emotional or physical challenges faced
  - Coping mechanisms to overcome the challenges
- Access to mental healthcare services
  - Understanding of mental health facilities in the UK
  - Barriers and facilitators in accessing mental health care

Results

The study's sample consisted of twelve refugee participants, three women and nine men (Table 2). All participants were born in Syria and nine had moved to the UK less than five years ago. Three quarter of the participants (n=9) were over 45 years of age, nine were married with children, one separated and two single. Five participants were university graduates, six had school level education and one was illiterate. Average time for residing in the UK was 3.8 years, range ((3 months- 10 years) (Table 2).

Table 2: Demographic characteristics of participants

Participant	Country of Birth	Time residing in the UK (years)	Age bracket	Gender	Relationship status	Highest level of education
1	Syria	0-4	40-49	Female	Married	University
2	Syria	0-4	40-49	Male	Married	University
3	Syria	0-4	60-69	Male	Married	School
4	Syria	0-4	50-59	Male	Married	School
5	Syria	0-4	70-79	Female	Married	No Schooling
6	Syria	0-4	60-69	Male	Married	University
7	Syria	5-10	40-49	Male	Separated	School
8	Syria	5-10	50-59	Male	Married	University
9	Syria	0-4	18-29	Male	Single	School
10	Syria	0-4	30-39	Female	Married	School
11	Syria	0-4	40-49	Male	Married	School
12	Syria	5-10	18-29	Male	Single	University

Identified themes

Four major key themes were identified from the data analysis; Loss and Separation, struggling for connectedness in a culturally divided world, Health Beliefs and Practices, and Barriers to Healthcare Access. Several sub-themes emerged under each key theme and are elaborated upon using quotes. Listing of key themes and sub themes can be found in (Figure 1).

Loss and Separation

Participants often perceived that loss of and separation from their family members was causing or aggravating their current psychological distress. These feelings were not limited to the ***loss*** of loved ones, but also the loss of material possessions, and connections to their home country in general:

"Sometimes when I remember my brother who passed away…makes me feel upset…like we were six people in the family... me, my mum, my dad, and my three siblings, a brother and two sisters… suddenly there was only me, my mum and my dad" (Participant 9, Man)

One participant described the meaning of home to a Syrian family and the consequences of its loss:

"When you build a home it's like a celebration, it means you have established a residence, it means you have a family and you have a home! [...] *We worked for 17 years to create this home then we locked it and fled* [...] *these matters make you sad" (Participant 2, Man)*

Separation from relatives or loved ones who remained back in the country was frequently described as painful. Despite their distance from Syria, migrants remained closely connected to the country and its people. The state of separation from home and loved ones could lead to strong emotions of sadness and joy:

"Any news that you hear about the country, whether it's small or big news, it hurts and disturbs the person's mental state, so you find us happy for their happiness and sad for their sadness or their suffering" (Participant 8, Man)

Other participants called for reunion with loved ones, stating that their mental health state would be resolved if they were able to be reunited with their family members:

"If a person could see his children… like for one of our children to come, we probably would not need a psychiatric doctor… you know? Isn't this right?" (Participant 5, Woman)

Struggling for connectedness in a culturally divided world: Participants commented on ***cultural differences*** and their difficulties in assimilating in the new environment in the new country. There were also comments on feelings of resistance to assimilation on the part of the native population. Despite efforts by Syrians, the gap between the two cultures was considered large and reflected in behaviour and attire:

"Integration with the western society or the British community is almost too small… too small… and mostly it's from them, not us… I mean we try, but they as a society have their own costumes and traditions that are completely different than ours" (Participant 7, Man)

One part of this difference lay in divergent priorities in life between the two groups. There was a feeling that Syrians had to live with predicaments that were remote to White British people. Whilst Syrians faced diverse social challenges, native people only had to think about employment:

> *"We think of things they do not think about* [...] *I mean for us as citizens, we can worry about the financial situation, family situation, children, but as a western citizen maybe he would be worried more about his job. I do not see them worrying about the same things." (Participant 12, Man)*

Almost all participants talked about how ***community connection*** is paramount in preserving the values and cultures of Syrian people as well as a place to share worries and experiences:

> *"We started gathering with the rest of the Syrian families or individuals* [...] *our encounters begin with one guy on the road or in a certain meeting, certain dinner at a restaurant, sometimes while we are walking we hear his accent so we stop him* [...] *we are trying as much as possible to gather these people to preserve our customs, traditions, heritage and association with our country" (Participant 8, Man)*

They elaborated on the importance of establishing trusted connections in the community, either with people already in their lives or with new friends. Participants emphasized the significance of these connections in combating disturbances of emotions and stressors:

> *"Being with people with whom you feel loved from, this helps the person a lot to heal or to get out from the situation that he is in" (Participant 8, Man)*

However, some participants had different point of view and remarked that the community feels ***dysfunctional***, as it contains people from different backgrounds with diverse perspectives:

> *"Not all the people who came from Syria have similar characteristics or the same culture, no! …Today they tell you, but we are a community and we should… ok I get it, but today what is happening -no disrespect- today you are gathering the criminal and the killer, and the doctor and the engineer, and the student and so on. You are putting them in one plate, and you tell us that we are a community, but correct we are a community, but all these ideas, how will you initiate communication between them?" (Participant 2, Man)*

Health Beliefs and Practices

Refugees shared their methods of self-help, or what some described as '***becoming their own doctor'***. Many shared stories about applying that concept to try to help themselves heal and to forget:

> *"The person is his own doctor. Whatever happens to you, support or help, if you were not helping yourself from the inside, you won't be able to succeed. You must keep combating in this life, there is no other way" (Participant 1, Woman)*

Other expressed their desire to talk to trusted friends or loved ones as a form of therapy. They talked about how getting advice and input from loved ones strengthens the bonds of these relationships, and act as a source of releasing pent-up emotions:

> *"I won't let things pile up every day I mean…everyday, everyday, everyday, someone should talk to someone who they feel comfortable with…like your husband or son, daughter, anybody at home…everyday" (Participant 10, Woman)*

Appreciation of the health benefits of ***nature*** even within urban parts of the UK was conveyed through the interviews and emphasis and encouragement to use nature as a form of healing was seen:

> *"I go to the sea and sit by the sea side, and I express my concerns to the sea, I speak to it. I go to the park, I try to get away from people" (Participant 8, Man)*

Others talked about resorting to ***faith*** or faith practices, and the ways these practices can alter their mood and help them:

> *"My mental state is better when I recite the Quran, I continue to do it, it provides comfort for me... Reciting the Quran is a comfort for me… Sometimes I listen to it on the phone, and this is honestly a comfort for me" (Participant 11, Man)*

A number of participants strongly emphasized doing something you enjoy as a way to improve mental health. Examples included hobbies, such as reading, writing or a playing a musical instrument:

Barriers to healthcare access

All refugees showed good knowledge of the healthcare system in general and how to access care facilities. However, there was a general hesitance towards accessing mental health care

services. Many participants apposed this idea of consulting white British doctors for ***fear of being misunderstood***:

> "*No one would understand what we went through and the situation like you would…who did not witness it won't sympathise, yes, so it's hard for me to go and explain my mental status to a doctor, it's better to explain to God." (Participant 11, Man)*

Another participant talked about how keeping emotions hidden created a difference between internal and external appearances. This was compared to a new looking phone, but with no battery inside:

> *"I feel that a person is just like the mobile phone where you have to always charge his battery, many times they tell me, wow you look fresh and active today, so I tell them I'm just like the newest version of iPhone, just without a battery" (Participant 8, Man)*

Participants talked about how ***stigma*** affects their decision to approach mental health services, because of beliefs about mental health informed by growing up in Syria. These participants expressed their concerns of becoming a source of gossip and being labelled as "crazy":

> *"Back in Syria, people are used to or have the assumption that people who go to psychiatrists have something wrong in their brains, crazy or something* [...] *so the majority of Syrian people are coy of going to the doctor or are not used to this habit, because we don't have something like that in Syria." (Participant 9, Man)*

On the other hand, half of the participants strongly believed in the notion of breaking taboos regarding mental health. Five of them reported going to a mental health clinic previously in Syria, and four described going to a mental health clinic after moving to the UK:

> *"it is necessary to resort to psychiatric medicine… psychiatry is a normal thing and healthy* [...] *we have a misconception about it like it's for crazy people or so… no, no. On the contrary, it's something healthy and a person must resort to it whenever he feels the need to speak to someone" (Participant 7, Man)*

There was a consensus amongst all participants that learning the English ***language*** was, by far the most difficult barrier faced by the refugees, whether it was in their day-to-day life or in accessing medical health care:

> *"I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones* [...] *the language." (Participant 7, Man)*

Some commented on how the presence of translators can make the challenges of seeking health care tougher and that some information could get lost in the translation:

> *"For the translation I think it's not very helpful, sadly… I mean every expression or word I give out has a certain feeling to it, and for a translation it might not give out the proper meaning or it won't come out the intended way, I believe" (Participant 12, Man)*

> *"I told them also that the presence of a translator will not make me feel comfortable… sometimes you want to say personal things, or things straight from your heart, so to have a third person as a translator, it will be a bit difficult" (Participant 10, Woman)*

Several refugees voiced their stories of struggle in learning the English language despite strenuous efforts, especially as the majority of participants were over 45 years of age. However, they all recognized that it is a necessary component for their integration and life in the UK.

Appreciation of the care received by refugees was a major part of each interview. Participants were grateful for all the efforts given to help them settle in and for the care given to their health:

> "*What I have seen is that the health care services here are very attentive and they follow up patients* [...] *The health care system here is very nice. They follow up, since I came here, all the tests I need, the medications I require* [...]*Their health care system is excellent!" (Participant 1, Woman)*

Participants emphasised that treatment should be based on each case individually. In this way, personalised care was presented as important – and something that should be provided – to Syrian refugees.

Discussion:

This study is the first of its kind to be conducted in the UK. Our findings show that refugees face constant challenges as they try to integrate into a new society. Participants described loss of family members, separation from loved ones in Syria, nostalgia for the homeland as causes of psychological distress and an overwhelming sense of sadness. Struggle for connectedness due to cultural difference and the problematic nature of rapidly formed migrant communities were perceived to hinder effective integration. Participants believed in 'being their own doctor' and

turning to faith, ritual and nature for healing and comfort. Taboo and stigma around mental health and language barriers were cited as barriers to accessing mental healthcare services.

Participant narratives in this study reflected existing literature exploring mental health issues in Syrian refugees,(24, 29). Previous research on post immigration factors has highlighted related issues around cultural integration, loss of family and community support, discrimination and adverse political climate,(13, 30, 31). *Betancourt et al* (2015) report that many refugees perceive community support as essential to dealing with past and present difficulties,(32). Participants in the present study emphasised the importance of their community not just in coping, unity and support but also as a means to preserve traditions and common values. This finding reflects a desire for future generations to remain connected to the homeland. Many participants in *Betancourt's* study expressed concerns over division in the political, educational and personal stance of other members of their community. Some evidence of discord within the Syrian community was evident in our study. Such differences may lie in kinship groups or friendship networks within communities which exert a sense of obligation above that of national identity,(33).

Coping mechanisms affect the well-being and mental health status of individuals. Strategies reported among Syrian refugees elsewhere include active and passive ones: cigarette smoking, excessively watching the news, worrying, behavioural withdrawal and "doing nothing",(34). Participants in our study emphasised listening to their own body and trying to cope using non-clinical methods such as utilizing nature, faith practices and hobbies. Using nature for the purpose of improving mental health is a recognised coping strategy, and several studies suggest that it indeed offers benefits,(35). *Barton and Pretty* (2010) highlighted the importance of "nature doses" and "green exercise" in the improvement of mental health and concluded that this approach constituted a means of promoting mental therapy efficiently and easily,(36).In recent studies of Syrian refugees, faith was reported as a significant coping mechanism. *El-Khani et al* (2017) explored the coping mechanisms used by displaced Syrian refugee mothers in refugee camps and found that parents utilized adaptation to their circumstances, social support and maintained mental health using faith as a coping strategy,(37). Similar results were found by *Boswall & Al Akash* (2015) who conducted an ethnographic study on Syrian women in Jordan and found that reading the Quran and practising faith was among the most common coping mechanisms,(38). This is also shown by *Hirschman 2004* on his study of immigrants in the United States, which concluded that faith and religious practices provide ethnic communities

with refuge from the hostility and discrimination from the host society as well as opportunities for economic mobility and social recognition,(39)

Literature shows that one of the biggest barriers to accessing healthcare in refugee communities is the language barrier,(12, 13, 40-42) and this was also replicated in our study. Participants commented on the complications created by the presence of an interpreter, and raised concerns around poor quality translation as well as confidentiality. One study in the United States on refugees' access to healthcare found that language issues do not only affect access to care and doctor-patient relationship, but also restrict the ability to read and understand medical instructions and pharmaceutical prescriptions,(43). In order to secure the correct diagnosis as well as treatment delivery, interpreters who are familiar with the language and medical terminology need to be consulted. However, the presence of interpreters poses an ethical dilemma of confidentiality breaches and risks altering the relationship between refugee patient and attending physician,(44). *Fatahi et al 2010* in their study on Kurdish refugees in Sweden found that participants expressed fear, suspicion and lack of confidence in interpreters,(45). *Bhatia and Wallace 2007* found similar results in their study in the UK along with other barriers that refugees face accessing mental healthcare services, for example stigma and lacking support of a refugee-dedicated agency,(46). Lack of adequate interpretation complicates patient encounters and elicits fewer empathetic responses from the healthcare provider. In addition to decreasing rapport, it reduces patient satisfaction and increases unintentional medical error,(47-49). Furthermore, refugees who suffer from PTSD tend to endure greater difficulties in learning the foreign language spoken at the resettlement destination,(50) Hence, bridging cultural and linguistic differences is integral to improving health care access of refugees to eliminate disparities for immigrants and refugees,(51, 52).

A key barrier to mental healthcare access by refugees is the stigma,(13). Our study revealed conflicting views on the value of psychiatry: some participants out rightly rejected mental healthcare treatment for fear of being stigmatised whereas others viewed stigma as an out of date misconception. In Syria and neighbouring countries, it is socially acceptable to express sensitive emotions and emotional suffering. However, labelling those emotions with medical terminologies of distress or as mental health illnesses can lead to shame or embarrassment to the sufferer or their family by being referred to as "mad" or "crazy",(53). One way to address stigma within refugee populations is through the work of community groups. *Palmer and Ward* (2007) suggested that these groups can assume the role of mediators between refugee service users and the healthcare establishment in order to combat the negative implications of

stigma,(54). In addition, it has been shown that mental health awareness programmes can reduce stigma if provided outside mental health setting, such as in general medical clinics, community centres, schools and women's groups,(53).

Fear of being misunderstood by service care providers was also suggested by refugees as a barrier to accessing mental health facilities, "no one would understand" being a phrase repeated by participants. *Asgary and Segar* (2011) found similar barriers in their study on refugees and asylum seekers' healthcare access,(55). A potential solution to this problem would be the involvement of cultural consultants with backgrounds and experience in immigrant and refugee communities in order to provide accurate assessment and improved services to specific communities,(56). It is crucial for mental health professionals and healthcare service providers to understand that Syrian refugees have a concept of mental illness and psychosocial wellbeing that is rooted deeply in longstanding social, cultural and religious traditions,(57, 58). Despite the aforementioned barriers, our participants showed an overall good knowledge about the UK National Health Service and how to navigate appointments and access medications. This finding is in contrast with the results of *Renner et al (2020)* in Germany and *Saechao et al* (2011) in the United States who reported a general lack of knowledge of the new healthcare system,(13, 59).

Strengths and limitations

A major strength of this study is that it was conducted fully in the language and dialect of participants. In approaching this study, the researcher adopted the philosophy of Asselin (2003) that recommended that an insider researcher should approach a project with "eyes open" and gather data while assuming no previous knowledge of the phenomenon being studied,(28). This study, however, also has limitations. One limitation is the small number of participants (n=12). Of the twelve participants interviewed in this study, only three were women. Although this might have led to the underrepresentation of the women's experience, this proportion is broadly representative of the refugee population in the UK as the Refugee Council UK suggest that only 26% of the asylum seeking applications are made by women,(60). Recruitment was undertaken during the months of April-June which coincided with Ramadan (the month of fasting in the Muslim faith), and the Eid celebration (breaking of the fast). This might have influenced participants' decision whether to participate. Nevertheless, the main objective of qualitative research, regardless of sample size, is not to produce a generalisable or statistically significant outcome, but to elicit rich data upon which future enquiry can be undertaken,(61). Another

potential limitation is the fact that the study included both newly arrived as well as established refugees (range: 3 months- 10 years) and that integration challenges might differ significantly depending on the length of stay in the UK. However, this variation suggests that interventions towards addressing the challenges need to be aimed at an individual level rather than at a group level. The findings of this study may not be generalised to other refugee communities residing in other countries, however, many of the themes identified in this study appear to be common in other refugee studies of different backgrounds. A further limitation is presented in the fact that past mental health diagnoses among participants was not recorded. This decision was made on grounds of ethics, confidentiality and to promote recruitment. Participant recruitment from this vulnerable group was anticipated to be challenging. Therefore, only basic demographic data were collected in order to promote recruitment and anonymity. This approach inevitably risks participants appearing homogenous. Given the extent of trauma experienced by Syrians and the widespread challenges of integration, it was concluded that all participants would offer valuable narratives. We recognise that for some this could be vicarious in origin but consider it valid because of the close-knit nature of Syrian refugee families/communities and evidence that refugees frequently share experiences/perceptions, (59).

Conclusion

Findings of this study shed light on the predicament of Syrian refugees in the UK, whose wellbeing and mental healthcare experiences remain unstudied during integration into the UK society. Participants discussed about mental health distress, especially in terms of separation, loss and a struggle for connectedness. Many factors were found to be helpful or used as coping mechanisms by the refugee community, such as family, nature, faith and pursuing hobbies. However, multiple barriers to accessing healthcare system were identified, in particular stigma, fear of being misunderstood, and language competence. While some of the interviewed refugees had successfully managed to access mental health services, they reported beliefs and challenges that reduced the perceived value of such care. Syrian refugees have become an integral component within British society and it is hoped that this study can serve as a catalyst for further research on this vulnerable group to ensure their proper integration to the UK society.

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Authors Contribution: PP am MC designed and supervised the study. MT collected and analysed the data and prepared the initial draft of the paper. PP prepared the final draft with input from MT and MC.

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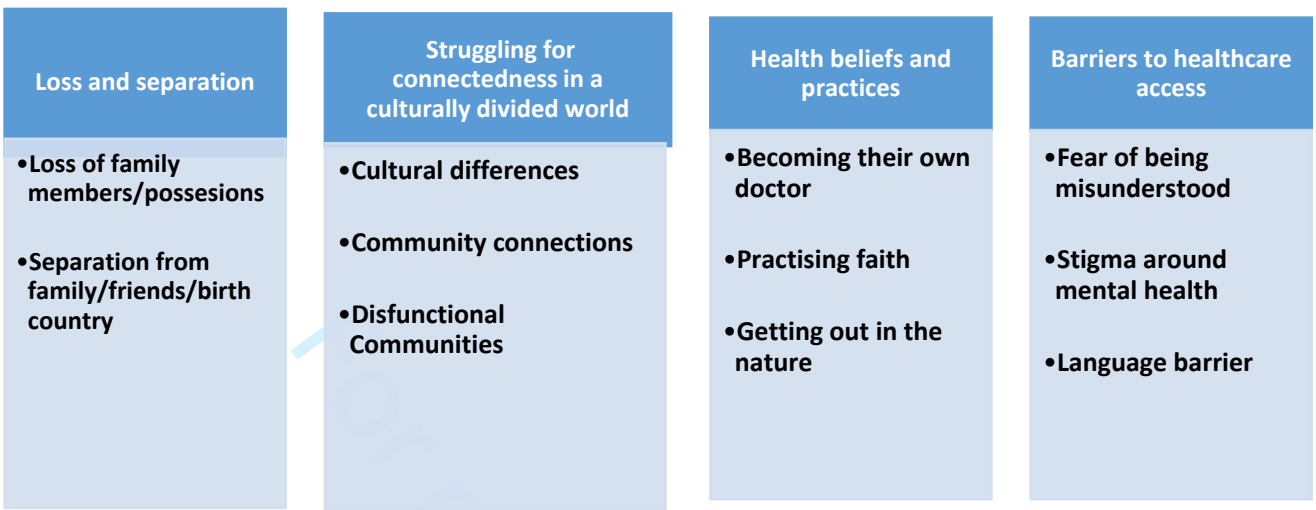
Figure 1: List of Key themes and Subthemes



Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

	Page/line no(s).
Title and abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Page 2
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Page 2
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Page 3- page 4
Purpose or research question - Purpose of the study and specific objectives or questions	Page 4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Page 4,5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Page 5
Context - Setting/site and salient contextual factors; rationale**	Pages 4
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Page 4
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Page 5
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Page 5

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Page 5
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Page 4 Page 6 Table-2 in page 6
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Page 5
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Page 5
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Page 5

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Pages 7-12
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Pages 6-12

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	Pages 12- page 14
Limitations - Trustworthiness and limitations of findings	Page14-page 15

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	Page 16
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Page 16

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014
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