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Syrian Refugee Women's Perspectives About Their Mental Health and Well-Being

by

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ABSTRACT

The prolonged state of civil war in Syria has caused a large influx of Syrian refugees in Canada. Refugees may face overwhelming stress in migration and resettlement that can contribute to the development of poor health and mental health outcomes. The purpose of this research was to explore Syrian refugee women's unique perspectives around their mental health and well-being in the resettlement period. In-depth interviews were used to obtain information about women's experiences with mental health services and the contextual factors that influence their health and well-being in resettlement. The study's findings will inform culturally safe mental healthcare services and healthy public policy.

Keywords: Syrian refugee women, mental health, well-being, social supports, resettlement

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DEDICATION

This thesis is dedicated to the Syrian refugee women who made this research possible.

Your voice is mighty. May your bravery shape the future for other newcomers to Canada.

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Epigraph

"[T]he more radical the person is, the more fully he or she enters into reality so that, knowing it better, he or she can transform it. This individual is not afraid to confront, to listen, to see the world unveiled. This person is not afraid to meet the people or to enter into a dialogue with them. This person does not consider himself or herself the proprietor of history or of all people, or the liberator of the oppressed; but he or she does commit himself or herself, within history, to fight at their side."

-Paulo Freire, *Pedagogy of the Oppressed*

Chapter I: Introduction

This chapter provides an introduction to the Syrian refugee crisis, the impacts of forced migration on refugee women's mental health and well-being and the importance of resettlement factors. I discuss the key terms refugee, mental health, gender and resettlement period to provide context to the research study. I begin with a personal story that touches on my motivation to complete this research. The chapter concludes with the research study purpose.

My Story

In my hometown, people belonging to visible minorities were few and far between. Those who relocated to the Northern community were, in my experience, treated with hostility and distrust. Challenging the status quo was never on my to-do list. I was focused on completing my schooling so that I could leave and never return. My reflections on racism and the treatment of minority groups are a consequence of life-events—relocating to complete a nursing degree and ultimately working as a Registered Nurse. I was raised White and have been treated accordingly throughout my life; yet, I am Métis. I have never experienced racial discrimination. Whiteness has been described as type of cushion that provides privilege and status and repels racial stress (DiAngelo, 2011). My protection from racial stress influenced my approach to caring for diverse populations as a new graduate nurse. At times, I exercised colourblindness when in contact with clients. The ideology of colourblindness ignores racial differences and embraces the idea that all people are equal, are capable of changing their life circumstances and should be given the same opportunities (Holland, 2014). In reality, it is known that systemic discrimination restricts people's access to social determinants of

health and impacts their lived experience and health trajectory (Blanchet Garneau, Browne, & Varcoe, 2017).

My journey of critical consciousness began in 2016. I was home for my annual family visit when my grandmother asked my opinion of the Liberal Government's efforts to resettle Syrian refugees in Canada. I realized that I didn't have an opinion when I struggled to find an answer that was suitably neutral. I was completely unaware of what was happening in Syria, the difficulties experienced by those who had fled the country and of the effects of resettlement. My resolve to become informed brought me back to academia. Through my graduate studies and in speaking with Syrian refugee women, I have become aware of Syrian refugee women's unique lived experience and of the challenges they face in migration and resettlement. I have also observed their strength and optimism in the face of adversity. My present experience has made me conscious of how my privilege as a visibly White, Canadian-born, educated woman has influenced my mental health trajectory. Awareness of power differentials is important for negotiating multiple identities that may be present in nurse-client interactions (Bansal, 2016; Spence, 2005). Cultural safety is a mechanism that health care providers may use to achieve openness with their clients and to promote shared health care decision making for effective, safe client care (Spence, 2005). My goal as a feminist researcher is to disseminate knowledge that will contribute to increased awareness of factors influencing Syrian refugee women's mental health outcomes and to promote culturally safe mental health care.

Background

In March 2011 a group of Syrian teenagers, inspired by the 2010-2011 wave of anti-government protests dubbed the Arab Spring, graffitied their school with revolutionary messages targeting the authoritarian regime of President Bashar al-Assad (Šterbenc, 2018). The president's violent response to the teens' actions sparked uprisings across Syria that soon escalated to all out civil war (Steenkamp, 2018). The persecution and displacement of civilians by the Syrian government and various militant groups created the largest refugee crisis of the 21st century (World Vision, 2018). Since the start of conflict in 2011, more than 5.6 million people have fled Syria to escape chemical warfare, massacre, torture and gendered violence (United Nations Refugee Agency, 2019b). Millions of people remain displaced inside Syria. Responding to the Syrian crisis, in 2015, the Canadian government partnered with the United Nations Refugee Agency and foreign governments to launch a wide scale resettlement initiative (Government of Canada, 2018c). Statistics from May 2018 indicate Canada has welcomed approximately 54,560 Syrian refugees, of whom three out of four are women and children (Guruge et al., 2018). Migration statistics from Immigrant Services Society of BC (ISSofBC, 2018) show that 4,400 Syrian refugees have resettled in communities across British Columbia (BC).

Refugees may face overwhelming stress related to the experience of becoming a refugee and of migration (Kronick, 2018). In Canada, impacts on individuals' mental and physical health are well documented (Guruge et al., 2018; Kanagaratnam, Pain, McKenzie, Ratnalingam, & Toner, 2017; Newbold & McKeary, 2018). Immigrant and refugee women in particular, experience poorer health and mental health outcomes

compared to the general population of Canadian women (Bhuyan & Schmidt, 2018). Historically, resettlement factors have been a stronger determinant of refugee health and well-being than pre-migratory experiences of trauma (Kanagaratnam et al., 2017; Newbold & McKeary, 2018). Multiple intersecting personal, social and environmental factors influence refugee women's mental health, well-being and health service utilization in the resettlement period (Clark, 2018; Guruge et al., 2018). Influencing factors include gender, socioeconomic marginalization, lack of language skills and education, discrimination and risk of violence (Clark & Vissandjée, 2019). Barriers to accessing healthcare services such as communication difficulties, cost of services, lack of awareness or information about services, distrust of health care providers, lack of transportation and lack of childcare may further shape refugee women's mental health and well-being post-migration (Bhuyan & Schmidt, 2018; Newbold & McKeary, 2018). Grasping the complexities of Syrian refugee women's mental health and well-being presents a challenge for health care providers, who may overlook a client's unique story and history in their relatively short assessments (Newbold & McKeary, 2018). A high level of unmet health care needs exists among Syrian refugees who entered Canada between July 2015 and 2016 (Tuck et al., 2019). Furthermore, psychological problems have been identified as an emerging health issue among Syrian refugee women (Guruge et al., 2018).

In this research study, I investigated Syrian refugee women's self-perspective of their mental health and well-being in the resettlement period and their experiences accessing mental health services in the Interior region of BC. I was interested in obtaining firsthand observations of the factors women perceived as influencing their

mental health and well-being, as well as information about the barriers they experienced when accessing mental health services. The following definitions of refugee, mental health, gender, resettlement period and cultural safety are presented to provide context to the research study.

Definitions

Refugee. According to The Office of the United Nations High Commissioner for Human Rights (2018), a refugee is any person who:

> Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of the country of his nationality...and is unable or, owing to such fear, is unwilling to return to it. (para.10)

Some scholars distinguish *refugees* from *migrants* on the grounds of their migration push factors (Carastathis, Kouri-Towe, Mahrouse, & Whitley, 2018). Push factors include political or economic instability (Carastathis et al., 2018). *Refugees'* migration is said to be forced due to conditions of war or political persecution in their home countries (Carastathis et al., 2018). In contrast, it is said that *migrants* immigrate voluntarily most often for economic or educational reasons (Carastathis et al., 2018). Migrants are selected for entry to Canada based on their Comprehensive Ranking System (CRS) score (Government of Canada, 2017a). The CRS is a points-based system that uses criteria such as level of education, language skills, work experience and relationship status (Government of Canada, 2017a) to determine people's ability to adapt to and contribute to the Canadian economy (Zhu, 2016). Due to the circumstances of refugees' arrival in Canada, they are not as well vetted as migrants (Beiser & Hou, 2017). Consequently,

refugees often lack human capital resources such as language skills and education (Picot, Zhang, & Hou, 2019).

Identifying a group of people as refugees is not indicative of any essential characteristics they share (Brown-Bowers, McShane, Wilson-Mitchell & Gurevich, 2015). Refugee is a label that can be understood or privileged in different ways and is shaped by broad socio-political and societal processes (Cole, 2017; Zetter, 2007); it conditions and homogenizes the identity and behaviours of different people (Cole, 2017). Being identified as a refugee simultaneously restricts people from and provides access to resources (Cole, 2017). Historically, the label has been used to restrict access to cities and nation states and regulate the rights of those given entry to them (Zetter, 2007). The meaning attached to the categorization refugee shifts with power regimes and political agendas (Brown-Bowers et al., 2015). In Canada, the label refugee has had negative connotations in the media and government rhetoric (Holtzer, Moore-Dean, Srikanthan, & Kuluski, 2017).

In 2012, the Conservative Government claimed that cutbacks to the Interim Federal Health Program (IFHP) were necessary to prevent exploitation of Canadian resources by phony or fraudulent refugees (Holtzer et al., 2017). Prior to 2012, the IFHP provided refugees and refugee claimants with temporary health coverage similar to that of Canadian citizens receiving welfare benefits (Dhand & Diab, 2015). IFHP reform is said to have significantly reduced this coverage through introduction of a complex eligibility determination system (Beatson, 2016; Harris & Zuberi, 2015). Positioning of refugees as fraudsters creates unwelcoming social environments for refugee women,

which may contribute to their marginalization and poor mental health outcomes (Brown-Bowers et al., 2015).

Mental health. In this study mental health is "shaped by various social, economic, and physical environments operating at different stages of life" (World Health Organization [WHO], 2018b, para. 1). The risk of poor mental health outcomes has been closely linked to the existence of social inequalities (WHO, 2018b). Improving the conditions of individuals' everyday lives may improve their long-term mental health trajectory (WHO, 2018b). Heterogeneous perceptions of health and well-being may exist among individuals and groups (Hynie, 2018; Newbold & McKeary, 2018). Some refugee women are reported to have a holistic view of mental health that frames the experience of well-being from "multiple dimensions, including esthetic, political, and spiritual" (Rezazadeh & Hoover, 2018, p. 81). Women's unique viewpoints on mental health and illness may influence the ways in which they respond to stressors in the resettlement period, use mental health services, and seek help (Donnelly, Hwang, Ewashen, & Adair, 2011). Sociocultural factors such as stigma and discrimination also play an important role in refugee women's mental health and well-being. Fear of being excluded by their cultural communities may lead some women to downplay or dismiss changes in their well-being (Ahmed, Bowen, & Feng, 2017). Transition to poor health among otherwise healthy immigrants is termed *the healthy immigrant effect* (HIE) (Vang, Sigouin, Flenon, & Gagnon, 2015). Literature on the HIE explains that although immigrants and refugees enter host-countries with better overall health than host-country citizens, it is eroded overtime with exposure to resettlement stressors and institutionalized forms of discrimination (Tabibi & Baker, 2017). Refugees in particular arrive with more pre-

existing vulnerabilities which may be compounded by resettlement stressors, leading to a downturn in their health post-migration (Newbold & McKeary, 2018).

Gender. According to the WHO (2018a):

> Gender refers to the socially constructed characteristics of women and men—such as norms, roles, and relationships of and between groups of women and men…While most people are born either male or female, they are taught appropriate norms and behaviours—including how they should interact with others of the same or opposite sex within households, communities, and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion— all of which aversely affect health. (para. 1)

Historically, gender has been prioritized over other determinants of health such as race, ethnicity, socioeconomic status, religion and immigration status in women's health research (Hankivsky et al., 2010). However, people are not one dimensional (Hankivsky, 2014). Consideration of single determinants of health such as gender or race is insufficient for understanding people's lived experiences and health outcomes (Hankivsky, 2014). Consequently, the issues of structurally vulnerable groups such as refugee women (Clark, 2018) have been marginalized in mainstream women's health research (Hankivsky et al., 2010). This research highlights intersections between gender, race, ethnicity, socioeconomic status, geography, religion and immigration status that may challenge or promote Syrian refugee women's health and well-being during resettlement in Canada (Clark, 2018).

Resettlement Period. What constitutes the resettlement period is not entirely clear, as a common definition does not exist. However, in this study the resettlement period is inferred as one year from the date of refugees' arrival in Canada. This is because most refugees are dependent on federal or private funding and social supports for one year after their arrival (Government of Canada, 2017d). Some scholars have more broadly defined the resettlement period as the time of necessary cultural transition that occurs after refugees' arrival in host-countries (Baird, 2012). Baird (2012) articulates cultural transition as the three-step process of separation, cultural liminality and integration into host culture. Successful adaptation is reflected in refugee women's satisfaction with their everyday lives (Baird, 2012).

Cultural Safety. Cultural safety is a concept derived from concerns of recruitment and retention of Maori nurses and the relationship to nursing education in New Zealand (The Nursing Council of New Zealand, 2011). The Nursing Council of New Zealand (2011) define cultural safety as:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognize the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice compromises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual," (p. 7).

I have chosen this definition of cultural safety because it comes directly from the Maori people and speaks to the historical and sociopolitical contexts of health and health care inequities. Unlike other approaches to client care, "cultural safety requires that people are cared for 'regardful of' rather than regardless of the aspects of their life which make them unique" (Jones, 2017, p. 9). Health care providers who wish to employ cultural safety in their practice may focus less on acquiring knowledge of clients' ethnocultural practices and more on acknowledging and neutralizing power differentials in the health care provider-client relationship (Jones, 2017; Spence, 2005). In this research study, I used cultural safety to help mitigate power differentials during interactions with participants. Consideration of cultural safety was also key to in-depth analysis of the data and generation of effective recommendations for mental health care practice, public policy and research.

Study Purpose

The purpose of this research was to explore Syrian refugee women's unique perspectives of their mental health and well-being in the resettlement period. There is a risk of poor mental health outcomes among Syrian refugee women (Guruge et al., 2018) and a high rate of unmet health care needs in the broader Syrian refugee population (Tuck et al., 2019). This study intends to inform healthcare service providers and policymakers of factors that support Syrian refugee women's mental health and well-being in the resettlement context. Important factors may include culturally safe health care practices which take into account the social determinants of mental health and public policies that support Syrian refugee women rather than marginalize them.

Summary

This chapter provided background information about the Syrian refugee crisis and the impact of forced migration on refugee women's mental health and well-being. I reflected on how my personal experiences have shaped my beliefs about visible minorities. My desire to be informed about the experiences of Syrian refugees was identified as the motivation for this research. The meanings of the key terms refugee, mental health, gender, resettlement period and cultural safety were outlined in detail. The chapter concluded with the study purpose. In the next chapter, a review and analysis of literature concerning refugee women's mental health and well-being is provided.

Chapter II: Literature Review

In this literature review, current research on refugee women's experience of forced migration is presented. Barriers experienced in resettlement period, impacts on mental health and well-being, and protective factors are highlighted. Electronic databases including CINAHL, Google Scholar, MEDLINE, PILOTS, PsycARTICLES and PsycINFO were searched in addition to researcher networks such as ResearchGate and Mendeley for literature published from 2000-2019. Searches were performed with the keywords Syria, refugee, migrant, asylum seeker, women, female, girl, health, well-being, and Canada. Inclusion criteria were: (a) primary sources and secondary sources i.e. peer-reviewed and grey literature; (b) qualitative, quantitative and mixed methods studies that included refugee women in the sample; and, (c) seminal works of refugees and resettlement. Exclusion criteria were: (a) studies published in non-English languages; and, (b) studies that do not mention psychological aspects of health or well-being. Screening of titles and abstracts resulted in 61 manuscripts for review. The knowledge presented in this literature review is important for contextualizing the experiences of Syrian refugee women in Canada. Gaps in the existing literature are identified and build a case for the significance of this study.

Pre-migration Experience

Many factors may impact women's mental health and wellbeing before they flee their countries of origin and are labelled refugees (Cantekin, 2019). Specifically, their mental health may be affected by war, imprisonment and torture, destruction of infrastructure, poor access to healthcare services, death or displacement of family members, culturally prescribed gender roles and economic insecurity (Cantekin, 2019;

Newbold & McKeary, 2018). Women often suffer the greatest harm in situations of war despite the relatively few who engage in active combat (Asaf, 2017). Some researchers associate gender role ideologies that legitimate social inequality with the type of rhetoric and methods used by authoritarian regimes and militant groups (Asaf, 2017; Pittaway & Bartolomei, 2001). As a consequence of such ideologies, gender-based violence is often perpetrated against women during conflict (Asaf, 2017; Jesuthasan et al., 2018). Gender based violence refers to "any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships," (United Nations Refugee Agency, 2019a, para. 1). Examples of gender-based violence include: domestic violence, rape, early marriage, harassment, sex trafficking and exchange of sex for basic needs of survival (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). Gender role ideologies also limit many women's pursuit of education and employment, instead encouraging them to assume mother and caregiver roles (Clark, 2015; Clark, 2018). Dependence on men to secure income for food and shelter places women at risk of poverty, as men may become separated from their families or killed (Adanu & Johnson, 2009). Jesuthasan et al.'s (2018) study of refugee women arriving to Germany (2015-2016) reported an inability to obtain food and water. Lack of basic needs is stressful for all women, but mothers in particular have the added pressure of ensuring their children's health and safety (Cantekin, 2019). Some parents believe that early marriage will protect their daughters from gender-based violence and poverty (Bartels et al., 2018). However, early marriages may result in intimate partner violence, high-risk pregnancy and discontinuation of girls' formal education (Bartels et al., 2018).

Migration: In Flight

Women may face challenges fleeing their home country such as protracted journeys through unsafe regions and poor conditions in refugee camps (Chan, Young, & Sharif, 2016). These challenges may compound the trauma they experienced pre-migration e.g. human rights abuses, family separation and lack of basic needs (Chan et al., 2016). Overcrowding in refugee camps often leads to food shortages, poor sanitation, lack of shelter and privacy and disease transmission (Cantekin, 2019; Newbold & McKeary, 2018). Sexual abuse of women and children may occur at the hands of peacekeepers running the camps and military forces sent to protect them (Chan et al., 2016; Pittaway & Bartolomei, 2001). To protect themselves, women who lack husbands and male relatives may confine themselves to their dwelling and avoid social interaction (Cantekin, 2019). Reports indicate that living conditions outside of refugee camps are not much better (Wells, Steel, Abo-Hilal, Hassan, & Lawson, 2016). Refugees living in cities and rural areas also struggle to obtain basic needs (USA for UNHCR, 2018). In some countries, discrimination has resulted in Syrian refugee women's exploitation and limited access to employment, housing, education and healthcare (Wells et al., 2016).

Changes to refugees' health status is correlated with time spent in refugee camps and asylum countries (Newbold & McKeary, 2018). Individuals who are permitted entry to Canada must undergo a health status assessment before their departure (Newbold & McKeary, 2018). Cost of pre-departure medical assessment and treatment is covered by the IFHP (Government of Canada, 2019c). However, refugees are responsible for the cost of travel documents and airfare to Canada (Guruge et al., 2018). Federal loans of up to $10,000 may be issued to refugees who cannot afford such costs (Guruge et al., 2018).

Previously, refugees were required to start loan repayment 30 days after their arrival in Canada (Government of Canada, 2018b). Recent changes have extended the period before repayment to one year (Government of Canada, 2018b).

Post-migration Experience

Refugees' arrival in a new host-country marks the beginning of the resettlement period (Ohene-Bekoe, 2017). Resettlement is a difficult process with an indeterminate timeline (Newbold & McKeary, 2018). Refugee women must adjust to the socioeconomic and cultural norms of their settlement community while attempting to learn the official language (Guruge et al., 2018). As previously mentioned, multiple factors may influence refugee women's mental health and well-being post-migration. Resettlement factors such as immigration status, gender roles and expectations, ethno-religious identity, language and socioeconomic status may simultaneously challenge and support women's mental health outcomes (Clark, 2018; Guruge et al., 2018; O'Mahony, 2017). Evidence suggests that experiences of discrimination, poverty and social exclusion contribute to the development of mood and stress disorders among refugee women (Shishehgar, Gholizadeh, DiGiacomo, Green, & Davidson, 2017). However, other studies show that refugee women often develop strategies to manage their stress and protect their mental health and well-being during resettlement (Kingsbury & Chatfield, 2019). Such strategies include: reaching out to peers and health care providers for support, seeking comfort in spiritual beliefs and practices and pursuing employment or education (Kingsbury & Chatfield, 2019).

Immigration and sponsorship status. Resettled refugees are granted permanent residency status upon their arrival in Canada (Drolet & Moorthi, 2018). Permanent

residents receive health coverage under the IFHP, legal rights and protections and the ability to apply for Canadian citizenship after four years of residence (Government of Canada, 2019a). To gain permanent residency, a principle applicant must be found eligible and admissible to Canada by immigration officials (Canadian Council for Refugees [CCR], 2017). Country of origin became a category of assessment in 2012 with the implementation of immigration Bill C-31 (Aberman, 2014). Bill C-31 established a Designated Countries of Origin list which differentiates safe countries from those that are refugee-producing (CCR, 2013b). Refugee claimants from safe countries such as Mexico, Czech Republic, or Greece (Government of Canada, 2017b) face fast-tracked application and hearing timelines, may be denied refugee status with no right to appeal and have little access to healthcare if they are granted asylum (CCR, 2013a). These rules are racially discriminating and may affect refugee women who are fleeing gender-based violence in safe countries (CCR, 2013a). Conversely, the same women may be prioritized for permanent residency by women at risk or urgent protection programs (Government of Canada, 2017c). These types of resettlement programs recognize gender-based violence as grounds for immediate resettlement in Canada (Government of Canada, 2017c). An important condition of resettlement is sponsorship.

Sponsorship was established to minimize the economic dependency of newly arrived refugees (CCR, 2015). Refugees generally leave their belongings and funds behind or lose them in flight from their home-country (Newbold & McKeary, 2018). Three types of sponsorship provide refugees with different access to social supports and health care services during their first year in Canada (Agrawal & Zeitouny, 2017). Government-assisted refugees (GARs) receive access to the Resettlement Assistance

Program (RAP) which provides income assistance, temporary housing, settlement information and an array of support services (Government of Canada, 2017d). Privately sponsored refugees (PSRs) receive similar provisions from private citizens and sponsor groups and may access support services through community or settlement agencies (Drolet & Moorthi, 2018). The burden of responsibility placed on private sponsors can be financially and mentally draining (Drolet & Moorthi, 2018). This stress may be compounded by religious and ethnocultural tensions between private sponsors and refugees (Drolet & Moorthi, 2018). Financial responsibility for blended visa office-referral refugees' (BVORs) is shared by the RAP and private sponsors (Government of Canada, 2017d). Like PSRs, BVORs may access support services through organizations in their community (Drolet & Moorthi, 2018).

Labels such as GAR, PSR, and BVOR stratify refugee women into distinct socioeconomic classes and restrict their access to supports and integration services (CCR, 2015). Evidence suggests that PSRs experience a higher degree of socioeconomic integration and are exposed to a broader range of supports and services than other refugee groups (Drolet & Moorthi, 2018). However, the generosity and commitment of private sponsors varies (Agrawal & Zeitouny, 2017). GARs have the benefit of a fixed program of supports and services (Drolet & Moorthi, 2018), but their access to them is limited to one year (Government of Canada, 2017d). BVORs are noted to enjoy the most financial stability due to their federal and private sources of income assistance (Agrawal & Zeitouny, 2017).

Gender roles and expectations. Resettlement often impacts gendered roles and expectations within families and ethno-cultural communities (Bhuyan & Schmidt, 2018).

Increased autonomy and opportunities for education and employment may benefit refugee women who come from countries where traditional gender roles are entrenched (Bhuyan & Schmidt, 2018). Traditional gender roles often confine women to the home as wives and mothers and put pressure on men to become sole-providers for their families (Rezazadeh & Hoover, 2018). While traditional marriage arrangements may continue post-migration (Clark, 2018), they are often unsustainable and constitute a barrier to women's socio-economic and cultural integration (Browne et al., 2017). Refugee women generally experience an increase in educational, household and financial responsibilities during resettlement (Sabir, Sevenhuysen, Fieldhouse, & Stieber Roger, 2017). Increased demand for women's time and energy is associated with high levels of stress and may impact their ability to access health care services (Bhuyan & Schmidt, 2018). To find balance, refugee women may be forced to work out new arrangements for themselves and their families (Sabir et al., 2017).

Altered gender roles facilitate refugee women's agency but can create tension with their intimate partners (O'Mahony & Donnelly, 2013) and larger ethno-cultural communities (Rezazadeh & Hoover, 2018). Refugees may adhere to traditional gender roles to maintain control while they adjust to the socio-economic and cultural realities of resettlement (Rezazadeh & Hoover, 2018). Individuals who feel disempowered may stigmatize refugee women who embrace altered gender roles (Rezazadeh & Hoover, 2018). Consequently, refugee women may become isolated from their ethno-cultural communities (Rezazadeh & Hoover, 2018). Men who feel threatened by their wives' newfound independence may assert their dominance through violence and abuse (O'Mahony & Donnelly, 2013). It is important to distinguish that this abuse is not

cultural but is structurally created due to gendered attitudes, behaviours and othering that occur in society (Tabibi, Ahmad, Baker, & Lalonde, 2018). Gender inequality perpetuates the message that men have more social power than women (Canadian Women's Foundation, 2019), while racism and classism may limit the access men have to employment and education post-migration (Tabibi et al., 2018).

Ethno-religious identity. Most refugee women lack social ties or connections upon their arrival in Canada (Bhuyan & Schmidt, 2018). The loss and uncertainty associated with separation from loved ones, friendships and communities is a major source of distress for refugee women (Shishehgar et al., 2017). To combat isolation, some groups of refugee women will turn towards their ethnic and religious communities for support (Holtmann, 2013). Studies show that ethno-religious communities and organizations may help refugee women access services and supports and develop a sense of pride in their religious or cultural identity (Bhuyan & Schmidt, 2018). They may also ease women's experience of acculturation by providing opportunities for women to partake in cultural and religious practices, express their values and speak in their own language (Shishehgar et al., 2017). Hanley et al. (2018) contend that shared characteristics such as ethnicity and religion do not necessarily mean that refugees are willing to connect or draw on each other for support. The social connections that newly arrived refugees form may be out of convenience more than trust (Drolet & Moorthi, 2018). Refugees may be unwilling to leverage resources or information from such fragile connections due to the risk of appearing vulnerable (Drolet & Moorthi, 2018).

Refugee women's willingness to identify with and participate in their ethno-religious community may be challenged by discrimination. Since the events of 9/11 anti-

Muslim racism has become increasingly prevalent (Clark & Saleh, 2019). While religious diversity exists among the Syrian population, the majority of Syrians identify as Muslim (Citizenship and Immigration Canada, 2015). Clark & Saleh (2019) state that Muslim women are particularly vulnerable to racism because of their increased visibility. This is due to Hijab or the modest dress code many Muslim women choose to follow (Clark & Saleh, 2019). In Canada, refugee women who identify as Muslim have described feeling de-normalized and othered for wearing hijab in leisure and public spaces (Kallas, 2017). The public othering of Muslim women presents a barrier to refugee women's integration into settlement communities and the formation of social connections outside of their ethno-religious group (Drolet & Moorthi, 2018; Holtmann, 2013). Anti-Muslim racism is reported to occur less frequently in settlement communities that are multicultural or display a level of high ethnic density (Holtmann, 2013). Despite the what is known about the risk of anti-Muslim racism among women, little is known about its effect on their mental health (Hassouneh, 2017).

Language. Refugee women have expressed a desire for proficiency in one of Canada's two official languages (Rezazadeh & Hoover, 2018). Lack of language skills limits refugee women's ability to gain employment, access healthcare services, forge social connections outside of their ethnic group and participate in their children's learning (Salami et al., 2019). In the healthcare context, lack of language proficiency may necessitate the use of a translator (Shishehgar et al., 2017). Many women who have suffered trauma and abuse may feel hesitant to disclose their thoughts and experiences through intermediaries (Ahmed et al., 2017; Shishehgar et al., 2017). Muslim women may also avoid disclosure for fear of mental illness stigma (Ahmed et al., 2017). In

opposition to these statements, some research suggests that the use of interpreters may actually increase the amount of information refugees share with health care providers (Kronick, 2018). Mutual agreement exists around the fact that family members and lay people should not serve as interpreters for refugee women (Ahmed et al., 2017; Kronick, 2018; Rezazadeh & Hoover, 2018).

Multiple barriers may prevent refugee women from gaining language proficiency. A heavy work load at home or work may limit women's ability to attend education classes (Bhuyan & Schmidt, 2018; Sabir et al., 2017). Transportation from home or work may also present an issue (Bhuyan & Schmidt, 2018). Due to a lack of social ties and anti-Muslim racism within resettlement communities (Drolet & Moorthi, 2018), many women have few chances to practice English and French with native speakers (Rezazadeh & Hoover, 2018). PSR and BVOR women are ineligible for language classes through the RAP and must search for classes offered by community groups or settlement agencies. However, GARs lack private sponsors who may direct PSRs and BVORs to different types of language classes (Agrawal & Zeitouny, 2017). Lack of adaptive teaching programs for illiterate individuals is a structural barrier to language proficiency for some refugees (Agrawal & Zeitouny, 2017).

Socioeconomic status and housing conditions. Refugee women who received limited education in their home country are at a disadvantage for gaining employment when compared to women with high levels of education and job experience (Rezazadeh & Hoover, 2018). However, both refugee women with education and experience and those without may experience difficulties securing employment due to racial discrimination in the Canadian labour market (Block & Galabuzi, 2011). The value of

individuals' training and experience is said to vary depending on their racial background (Bhuyan & Schmidt, 2018). Foreign workers face nonrecognition of credentials obtained outside of Canada (Bhuyan & Schmidt, 2018), unequal wages and exclusion from high paying jobs (Block & Galabuzi, 2011). Women who don't receive recognition of their credentials may be forced to accept low paying or unsafe jobs (Rezazadeh & Hoover, 2018). Job re-training represents a significant financial stressor for women (Rezazadeh & Hoover, 2018). However, those who accept jobs they are overqualified for may experience serious impacts to their perceived self-worth (Hynie, 2018). Other forms of discrimination that refugee women may encounter in the employment sector are gendered violence (Pittaway & Bartolomei, 2001) and exploitation of their low language proficiency (Rezazadeh & Hoover, 2018). Language barriers are noted to keep women from understanding their workplace rights and from seeking help for abusive treatment (Rezazadeh & Hoover, 2018).

Resettled refugees have reported a downturn in their standard of living associated with non-recognition of their education and work experience (Drolet & Moorthi, 2018). Women who experience a downwards shift in socioeconomic status during resettlement may struggle to recreate previous standards of living (Holtmann, 2013). This can greatly impact women's satisfaction with their resettlement experience and may cause them to yearn for their old lives (Robertson, 2015). The opposite can be said of women who experience an upwards shift in socioeconomic status in Canada (Holtmann, 2013). Regardless, refugee women often earn incomes that are lower than that of the average Canadian woman (Rezazadeh & Hoover, 2018). Financial insecurity is noted to be a strong determinant of refugee mental health (Hynie, 2018).

Financial insecurity is a major obstacle to refugee women obtaining adequate housing (Shishehgar et al., 2017). Affordable housing is in short supply in Canada (Shier, Graham, Fukuda & Turner, 2016). Large refugee families often settle for small, inexpensive dwellings despite concerns of overcrowding (Hynie, 2018). Racial discrimination excludes many families from living in safe and convenient neighbourhoods (Hynie, 2018). In addition to racial discrimination, single or widowed refugee women may experience mistrust from landlords who doubt their ability to pay rent and damage deposits (Shishehgar et al., 2017). Inadequate living situations may also arise in situations of abuse (Tabibi & Baker, 2017). Refugee women who are victims of intimate partner violence may experience homelessness (Tabibi & Baker, 2017). A lack of language skills and awareness of available services may prevent refugee women from accessing housing supports in their communities (Tabibi & Baker, 2017). Inadequate housing of any kind may result in a loss of security and poor mental health outcomes (Tabibi & Baker, 2017).

Factors influencing healthcare access. Several factors influence refugee women's access to healthcare services in Canada. A lack of language and health literacy skills such as navigating the health care system may create communication difficulties between clients and health care providers (Clark, 2018). Shortage of trained medical interpreters is another issue (Kanagaratnam et al., 2017) and presents a structural barrier to women's health care access (Clark, 2015). Open, critical dialogue between health care providers and clients is central to the provision of culturally safe care (Nursing Council of New Zealand, 2011). Unavailability of interpreters may prevent identification of power differentials in the health care provider-client relationship and keep refugee women from

defining what they need to feel safe in the health care setting (Nursing Council of New Zealand, 2011). Lack of training for health care providers regarding differences in refugee health coverage is another structural barrier (Winn, Hetherington, & Tough, 2018). Some health care providers describe feeling unprepared to answer refugee women's questions about their service eligibility (Winn et al., 2018). Gendered norms and ethno-religious expectations may also influence refugee women's healthcare access (Winn et al., 2018). In cases of child birth, refugee women often express a preference for female health care providers and may refuse medical interventions they feel are unnecessary or detract from the experience of labour (Khanlou, Haque, Skinner, Mantini, & Kurtz Landy, 2017).

Institutional racism is a challenge to health care access that may be particularly hard for refugee women to overcome (Pelaez, Hendricks, Merry, & Gagnon, 2017). Many refugees are refused care due to a lack of provider knowledge of the IFHP (Rahman, 2016). Stewart, De Souza, and Yudin (2019) report that physicians have refused refugee women prenatal appointments due to frustration with the paperwork and long reimbursement periods associated with IFHP benefits. Such discrimination is dangerous as unmet health needs may place refugee mothers at risk of pregnancy complications (Stewart et al., 2019). Other forms of discrimination such as denying women a translator (Roy, 2016), stereotyping (Higginbottom et al., 2016) and dismissal of women's concerns (Guruge et al., 2018) have also been noted. While not aggressive, these behaviours may leave women feeling devalued (Rezazadeh & Hoover, 2018). Many refugee women already lack confidence in their authority and may avoid challenging health care providers and asserting their care preferences (Kingsbury & Chatfield, 2019).

As previously mentioned, any action that disempowers clients constitutes unsafe health care practice (Nursing Council of New Zealand, 2011). Some scholars call for better cultural safety training to help address structural racism and improve health care delivery for Syrian refugees in Canada (Rahman, 2016).

Protective factors. Several protective factors may help refugee women manage stress associated challenges in resettlement context. Spiritual practices and social connections are said to be key protective factors for refugee women's mental health and well-being (Holtmann, 2013; Shishehgar et al., 2017). Women who resume religious or spiritual practices in the resettlement context may feel nurturance or a sense of equilibrium in their everyday lives (Catolico, 2013). Spirituality may also help women process and express emotions associated with experiences of trauma and loss (Donnelly et al., 2011). However, reliance on spiritual practices for mental health and well-being may prevent some refugee women from accessing healthcare services (Donnelly et al., 2011).

Social support and a sense of belonging are important protective factors for refugees (Racine & Lu, 2015). The desire to gain affirmational support from family, friends or ethno-religious peers may drive some refugees to depart from their settlement communities for areas with more supports and higher ethnic density (Simich, Beiser, & Mawani, 2003). Affirmational support involves exchange or acknowledgement of shared experience which may facilitate emotional and cultural adaptation (Simich et al., 2003). Refugees may also rely on family and ethno-religious networks for financial assistance and employment opportunities (Hanley et al., 2018). Beiser & Hou (2017) report that the protective effect of living within close distance to ethno-religious community members is

highest during early years of resettlement. This finding may relate to expansion of refugees' social networks beyond ethno-religious group members (Hanley et al., 2018). Access to non-group friends is said to increase with length of residency and language skills development (Hanley et al., 2018). Volunteer work and activism can also be a source of affirmational support for marginalized women (Rezazadeh & Hoover, 2018). Activism in particular has been found to provide refugee women with a forum to express their voice and to affirm their unique gender and ethno-religious identities (Bhuyan & Schmidt, 2018; MacDonnell, Dastjerdi, Khanlou, Bokore, & Tharao, 2017).

Impacts on Mental Health and Well-Being

A plethora of literature details the impacts of forced migration and resettlement factors on refugee women's mental health and well-being. Mental health conditions of specific concern include anxiety, depression and post-traumatic stress disorder (Kanagaratnam et al., 2017). Prevalence rates are said to vary with methodological differences between studies and refugees' experience of different resettlement factors (Kronick, 2018). Rates of anxiety, depression and post-traumatic stress disorder are particularly high among women who experience intimate partner violence (Young & Chan, 2015). New mothers and women whose children suffer from life limiting illnesses are also at high risk of developing mental health conditions (Bhuyan & Schmidt, 2018). Many studies have found high rates of maternal depression among newcomer mothers (Brown-Bowers et al., 2015; Khanlou et al., 2017; Kingsbury & Chatfield, 2019; O'Mahony & Donnelly, 2013). Focus on the prevalence of disease has allowed some researchers to underestimate refugees' resiliency (Kanagaratnam et al., 2017; Kronick, 2018). Research tends to pathologize refugees' experiences of distress instead of

highlighting their strengths in resettlement (Beiser & Hou, 2017; Chan et al., 2016; Kanagaratnam et al., 2017).

Few Canadian research studies address the mental health and well-being of Syrian refugee women. As Syrian refugees are fairly new to Canada, additional research may be forthcoming. Much of the literature that is currently available focuses on Syrian children and youth. Of the studies conducted with people over the age of 18, the majority include Syrian men in the sample (Drolet & Moorthi, 2018; Hanley et al., 2018; Hansen & Huston, 2016; Oda et al., 2017; Pottie, Greenaway, Hassan, Hui, & Kirmayer, 2016; Tuck et al., 2019). Topics covered in the literature include: migration and resettlement experiences (Ahmed et al., 2017; Drolet & Moorthi, 2018; Hanley et al., 2018; Hansen & Huston, 2016; Kallas, 2017; Pottie et al., 2016), health care utilization and needs (Guruge et al., 2018; Oda et al., 2017; Rahman, 2016; Tuck et al., 2019), existing and emergent health issues (Guruge et al., 2018; Hansen, Maidment, & Ahmad, 2016; Pottie et al., 2016) and post-traumatic growth (Badali, Grande, & Mardikian, 2017). The following findings are consistent with literature about other groups of refugee women in Canada:

- Prevalence of maternal depression may be high among Syrian refugee women (Ahmed et al., 2017).
- Multiple factors in the resettlement context contribute to the marginalization of Syrian refugee women and increase their risk of developing mood and stress disorders (Ahmed et al., 2017; Hansen & Huston, 2016; Pottie et al., 2016).
- The support of ethno-religious peers or community groups positively contribute to perceived mental health (Badali et al., 2017; Drolet & Moorthi, 2018; Hanley et al., 2018).

- Many Syrian refugees are unaware of mental health services and supports (Guruge et al., 2018).
- A high level of unmet health care needs exists among Syrian refugees (Oda et al., 2017; Tuck et al., 2019).
- Concerns about mental illness stigma and privacy may prevent disclosure of trauma and mental illness symptomology to health care providers (Ahmed et al., 2017).
- Inequalities in health care interactions suggest the need for better cultural safety training among health care providers (Rahman, 2016).

Interestingly, Ahmed et al. (2017) and Kallas (2017) report that perceived discrimination may prevent Syrian women from engaging in recreational activities. Physical activity is said to be protective of women's mental health and well-being (Ahmed et al., 2017; Kallas, 2017).

The majority of studies reviewed focused on Syrian women living in large urban centres such as the Greater Toronto Area (Guruge et al., 2018; Oda et al., 2017; Tuck et al., 2019), Metro Vancouver (Kallas, 2017), Saskatoon (Ahmed et al., 2017), Montreal (Hanley et al., 2018) and Waterloo (Badali et al., 2017). One study included refugees living smaller cities such as Red Deer, Lethbridge and Medicine Hat in their sample (Drolet & Moorthi, 2018). Very few studies explicitly mention the ethnicity of participants (Drolet & Moorthi, 2018; Hanley et al., 2018; Kallas, 2017). Instead, some studies identify participants' preferred language (Ahmed et al., 2017; Badali et al., 2017; Guruge et al., 2018; Oda et al., 2017; Tuck et al., 2019). Statistics from Citizenship and Immigration Canada (2015) indicate that Arabs are Syria's largest ethnic group. Prior to

the civil war, Kurds, Armenians and other ethnic groups accounted for ten percent of the Syrian population (Citizenship and Immigration Canada, 2015).

Summary

Throughout this literature review I have shown that refugee women's experience of forced migration is complex. I have placed emphasis on how intersections of gender, immigration status, ethno-religious identity, language and socioeconomic status are key factors related to women's mental health. Multiple and systemic forms of discrimination are also implied in relation to access to culturally safe and effective mental health and social services which may decrease mental health in the long run. Most importantly, I have found that the literature has not thoroughly examined the resettlement experiences and mental health outcomes of Syrian refugee women. Of the studies conducted with Syrian refugees in Canada, very few focus exclusively on Syrian women. Even fewer studies discuss Syrian women's mental health and well-being. Topics of limited discussion include the experiences of Syrian refugees living in small urban centers and ethnic diversity among Syrian refugees. Furthermore, additional research is needed to understand Syrian refugee women's resettlement experiences in relation to their mental health outcomes. Investigation into Syrian refugee women's perception of the factors which support their mental health and well-being may reveal important information about their health care utilization and mental health needs. Such information will inform health care providers regarding the provision of culturally safe mental health care services and support the development of public policies that are supportive of women's mental health and well-being.

Research Questions

To meet the purpose of this study, I will answer the following questions:

1. What are the experiences of Syrian refugee women with accessing mental health services in the Interior region of BC?
2. How do contextual factors impact Syrian refugee women's mental health and well-being in the resettlement period?

Chapter III: Methodology

A theoretical framework and qualitative methodology used to conduct this study are presented and discussion of an ethnographic approach. A overview of the research sites, recruitment strategies of Syrian refugee women as potential study participants, and some of the challenges are provided. Explanation of specific qualitative steps used to collect and analyze data are reviewed before moving on to ethical considerations.

Theoretical Framework

In feminist theory, attention has shifted away from traditional single-factor (e.g. sex or gender) analyses of women's issues (Gordon, 2016). Many feminist scholars now consider how gender intersects with multiple factors such as race, ethnicity, religion, education, socioeconomic status and geography to shape women's lived experience (Hankivsky & Cormier, 2009). Paying attention to these intersections in women's health research may improve the quality of evidence produced and allow for more nuanced understandings of women's experiences and health outcomes (Hankivsky, Springer, & Hunting, 2018).

In this research study I used intersectionality as a lens to examine the interaction of various factors in the construction of Syrian refugee women's mental health and well-being post-migration. Although many interpretations of intersectionality exist, Hill Collins and Bilge (2016) provide the following definition:

> Intersectionality is a way of understanding and analyzing the complexity in the world, in people, and in human experience. The events and conditions of social and political life and the self can seldom be understood as shaped by one factor. They are generally shaped by many factors in diverse and mutually influencing

> ways. When it comes to social inequality, people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other. Intersectionality as an analytic tool gives people better access to the complexity of the world and of themselves. (p. 2)

It is important to note that intersectionality is not a recipe approach for analyzing people's lived experience and health outcomes (Hankivsky, 2014). Just as people's lives cannot be reduced to a priori categories of experience or identity, multiple categories cannot be added up to equal specific experiences or outcomes (Gkiouleka, Huijts, Beckfield, & Bambra, 2018). This is because social locations that exist at intersections of identity are not static (Hankivsky, 2014). Social locations shift with changes in time, place and structures of power, thus creating wide variation in people's lived experience and health outcomes (Gkiouleka et al., 2018). Moreover, people may experience privilege in one context while suffering oppression in another (Gkiouleka et al., 2018). In any situation people may hide or reveal parts of their identity "to create space for personal freedom" (Hill Collins & Bilge, 2016, p. 125).

Some scholars attribute the start of intersectionality to African-American activist and law professor Kimberlé Crenshaw (Gordon, 2016). Crenshaw unveiled the term intersectionality in her 1989 text "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." In the article Crenshaw (1989) provides the analogy of a traffic intersection to emphasize the multidirectional nature of discrimination: as vehicles caught in traffic intersections may experience collisions, women caught in intersections of identity may

experience discrimination and impacts to their well-being. Crenshaw has made important contributions to intersectional theory; however, several scholars argue that intersectionality began long before her reign of influence (Carastathis, 2014; Hankivsky, 2014; Hill Collins & Bilge, 2016). During the 1960's and 1970's, women of colour—who were on the fringes of social and political movements—began to organize and engage in their own forms of activism and knowledge production (Hill Collins & Bilge, 2016). Women who identified as African American, Latina and Chicana, Native American and Asian-American used protest, poetry, art and essays to express their identities and attend to multiple axes of their oppression (Hill Collins & Bilge, 2016).

Scholars who choose to engage in intersectional research are committed to social justice (Hankivsky et al., 2010). In the broadest sense, social justice is about challenging the status quo and ensuring fair distribution of the "benefits and burdens of society" (Thurman & Pfitzinger-Lippe, 2017, p. 186). Within the health research context, social justice relates to decisions about who benefits from research and what questions and populations are prioritized (Rogers & Kelly, 2011). Health research orientated around social justice recognizes structural inequities such as discriminatory health care practices related to language, gender, religion as the root cause of health disparities (Rogers & Kelly, 2011). The oppressive nature of health and social policy may be revealed in the construction and retelling of individuals' stories (MacDonnell et al., 2017).

For the purpose of this research intersectionality is used as an analytic lens to inform healthy public policy for social change (Hankivsky et al., 2010). Factors in refugee women's everyday lives can both limit and enable their right to self-determination (Clark, 2018). An intersectional perspective may improve understanding of

the interplay between factors such as gender, race and socioeconomic status at the individual, community and structural level (Hankivsky et al., 2018). Knowledge of the factors which support the mental health and well-being of Syrian refugee women will assist health and social service providers and community members involved in women's resettlement. Consideration of how oppressive structures are established and maintained may improve the quality of findings used to inform stakeholders and policymakers (MacDonnell et al., 2017). Policy and practice reforms that address structural inequities and support women's self-determination may promote their mental health and well-being (Clark, 2018). Knowledge of discrimination and power imbalances that restrict women's access to social determinants of mental health may also inspire Syrian refugee women to engage in resistance (MacDonnell et al., 2017). Refugee women who are committed to social activism may recognize their own abilities and capacity to adapt to everyday stressors (MacDonnell et al., 2017).

Though intersectionality is an appropriate framework for conceptualizing health inequities, it is underutilized in health research (Hankivsky et al., 2018) due to a lack of consistency on translating theory into methodological practices (Hankivsky et al., 2010). Qualitative methodologies are useful for intersectional analysis because descriptive data accurately captures the scope, complexity, and role of power relations at work in people's lives (Hankivsky & Cormier, 2009). Regardless of the research methodology used, it is impossible to capture every nuance of people's lived experience (Hankivsky & Cormier, 2009). Researchers may offset this limitation by focusing on the quality of their analysis rather than the number of intersections identified.

Key principles of intersectionality such as recognizing multiple truths and realities, empowering marginalized groups and reflecting on personal and institutional power relationships (Hankivsky, 2014) promote cultural safety (Nursing Council of New Zealand, 2011). Use of a theoretical framework that supports cultural safety may help foster authenticity and acceptance (Jones, 2017) between researchers and participants. Both are important for generating open dialogue, as people who feel stigmatized or disempowered may hide aspects of their experience in order to be taken seriously (Jones, 2017). Failing to safeguard participants' voices perpetuates oppressive power relations and may impact the trustworthiness of research findings (Hankivsky & Cormier, 2009). This study utilized reflective journaling and interpreters to preserve Syrian refugee women's voices. Both strategies are discussed further on.

Ethnography

Ethnography is a qualitative research tradition (Polit & Beck, 2017). Qualitative health research explores emotions, perspectives and meanings people construct about their experiences of health and illness (Cypress, 2015). Rich description of people's perspectives and beliefs can be interpreted and translated for use in health policy and practice (Cypress, 2015). Several stages are often involved in critical ethnographic research (Hardcastle, Usher & Holmes, 2006). Generally, critical ethnographers start by building the etic or outsider perspective of the cultural group under study in order to promote strong reflexivity and establish their positionality in their research (Hardcastle et al., 2006). This often involves discrete observation of participants and reflection on the information gathered (Hardcastle et al., 2006). To build my etic perspective, I participated in Open Mosque Day and attended an English as a Second Language class.

Though no Syrian refugee women were present at the Mosque I visited, I was able to gather information about women's rights in Islam and observe the behaviours of several Muslim women. As many Syrians identify as Muslim (Moosa-Mitha, 2016), this was useful information to have before engaging with participants. The English as a Second Language class also gave me a general idea of Syrian refugee women's English skills. The next stage of ethnographic research involves engagement with participants to illicit the emic or insider perspective (Hardcastle et al., 2006). Interviews are common method of data collection in ethnographic research (Polit & Beck, 2017). The last few stages of the ethnographic process revolve around data analysis and linkage of findings to broader socioeconomic, political and historical contexts (Hardcastle et al., 2006).

Critical Ethnography

Thomas (1993) describes critical ethnography as "a type of reflection that examines culture, knowledge, and action" (p.2). Traditional ethnography seeks to illuminate cultures through close study with groups of people, description and analysis of specific behaviours and interpretation of meanings (Huot, 2019). Critical ethnography moves beyond interpretation of what is in culture and society by inviting researchers to consider alternative possibilities (Carspecken, 1996; Thomas, 1993). This approach requires researchers to reflect on the socio-political and historical contexts of people's lives, address processes of injustice or oppression and create knowledge that promotes social consciousness and change (Madison, 2005; Thomas, 1993). Moreover, researchers who use critical ethnography make a commitment to political thought, activism and the emancipation of marginalized groups (Madison, 2005). I used a critical ethnographic approach to critically analyze the influence of social structures and processes with Syrian

refugee women's mental health and well-being. Issues of social justice are included in my discussion of the research findings to expose and challenge power relations in women's everyday lives. Emancipatory goals of this research include the creation of knowledge to improve Syrian refugee women's life circumstances and the provision of supports for their unmet mental health needs.

A critical ethnographic approach requires researchers to acknowledge and examine their positioning in relation to research participants (Madison, 2005; Parissopoulos, 2014). Different social positioning between researchers and participants may cause researchers to essentialize participant experiences or tendencies (Hankivsky et al., 2010). In research with refugees, trauma discourses have often led researchers to pathologize otherwise normal responses to migration and resettlement in refugee research (Baird, 2012; Kanagaratnam et al., 2017; Kronick 2018). In particular, portrayal of participants as victims is a problematic issue in research with refugee women (Ozkalei, 2018). Acknowledgement of researcher's biases and differing worldviews are important to prevent perpetuation of oppressive representations in study findings (Dutta, 2014) and increases research rigour (Vandenberg & Hall, 2011). Researchers can acknowledge their biases and positions within hierarchies of power and privilege by engaging in reflexivity (Madison, 2005).

Reflexivity involves open reflection of both the researcher's beliefs and the influence of research on study participants, their connections to their communities, and decisions about data collection and analysis (Vandenberg & Hall, 2011). Reflection illuminates data construction and privileged information in participant observations (Vandenberg & Hall, 2011). Reflection allows researchers to maintain the balance

between "'researcher as analyst' and 'researcher as advocate'" roles in critical research (Reimer-Kirkham & Anderson, 2010, p. 199). Emotional attachment to research participants influences researcher's reporting of study findings just insidiously as biases (Reimer-Kirkham & Anderson, 2010).

Study Site

This research was conducted in several communities located in the Interior region of British Columbia. While the number of Syrian refugees living in the Interior region is unknown, the latest statistics show that 4,400 Syrian refugees are settled in communities across British Columbia (ISSofBC, 2018). Movement away from resettlement communities may contribute to variation in the number of Syrian refugees living in the Interior region.

Entry into Site

Gaining entry was a difficult process spanning a period of two months. Though I was able to partner with community resource agencies and sponsorship groups, the recruitment response was low in many communities. It is not uncommon for women belonging to minorities to be distrustful of the research process and therefore unwilling to participate (Ellard-Gray, Jeffrey, Choubak, & Crann, 2015). Recruitment strategies included posters, advertisement on social media and referral from key informants. Posters were the least useful recruitment strategy. With the support of my supervisory committee, I began to explore unconventional avenues of recruitment. This required a certain amount of creativity. For example, I combed news reports for mention of Syrian refugees and reached out to a business owner who was featured for her employment of several Syrian women. Networking with English as a Second Language (ESL) instructors at a variety

university and college campuses was my most successful recruitment idea. In one community, I was invited to attend an ESL class and introduce myself to the Syrian refugee women in attendance. This allowed the women to become familiar with me and gave me an opportunity to observe their interactions with each other and their peers. Two key informants were instrumental in the recruitment of participants. Both individuals were involved in the briefing and referral of potential participants and the scheduling of participant interviews. After initial referrals, I also relied on word of mouth for recruitment.

Participants

Nine participants were interviewed to gain insight about Syrian refugee women's self-perception of their mental health status and their experiences with mental health services in the resettlement period. Participants were from diverse ethno-religious backgrounds and identified as belonging to Arab or Kurdish families and Muslim or Christian faiths. Tables of participant demographics are provided in Appendix A. Some demographics have been withheld to protect participant confidentiality. The rigour of a small sample is dependent upon the quality and the amount of data that is obtained from each participant (Morse, 2000). Though some participants struggled to express themselves in English, detailed narrative responses were provided during interviews. Use of interpreters and frequent clarification of responses ensured data was rich and on target (Morse, 2000). As a result, the nine interviews that were obtained provided ample data to answer the research questions. Observation of Syrian women at study sites and participating in activities such as Open Mosque day added to the rigour of the study by

improving my understanding of women's connection to each other and their wider communities.

Inclusion and Exclusion Criteria

Criteria for selection of participants included: (1) Syrian refugee women, (2) 18-50 years of age, and (3) settled within the Interior region of BC ≤ 3 years. Individuals under the age of 18 and those with limited cognitive abilities were excluded from the study due to their increased vulnerability (Creswell & Creswell, 2018) and perceived inability to provide informed consent. English language abilities were preferred but were not pursued as a requirement for the study. Translators were provided for women with limited language skills during the consent and interview processes. Through conversations with key informants and participants a purposeful sample, supplemented by chain referral sampling was selected.

Data collection

Data collection occurred over a period of three months. Semi-structured interviews 40-60 minute in duration and a sociodemographic questionnaire were utilized in this study. Three of the nine interviews were conducted using translation services prompted by key informants prior to scheduled interview dates. When indicated, female interpreters with MOSAIC out of Vancouver, BC were accessed via phone. Budgetary constraints required most interviews to be completed without an interpreter. I experienced challenges with language barriers during initial interviews, however I refined my technique for clarifying and expanding on ideas in later interviews. I utilized opened ended questions (see Appendix B) to prompt participants to speak about their views and opinions (Creswell & Creswell, 2018). Participants spoke about their perspectives

concerning their present experiences and their hopes for the future. Shadowed data was collected in addition to narratives (Morse, 2000). Shadowed data is obtained when participants speak unprompted about how their experiences relate to those of others (Morse, 2000). The descriptive data gathered in interviews was bolstered by a socio-demographic questionnaire. Questionnaires were completed at the beginning of interviews to gain background information such as women's age, ethnicity, religion and level of education (see Appendix C). The questionnaire was translated into Arabic by an interpreter to ensure participants' understanding (see Appendix D).

Data analysis

Two months were required to complete the data analysis process. Multiple steps were involved in data analysis: (1) Interviews were audiotaped and transcribed verbatim along with field notes and questionnaires. Interview hard copies from the transcriptionist were reviewed and checked against recordings and field notes for accuracy. (2) Transcripts were read through several times and then uploaded to ATLAS.ti. (Version 8.3.1; Scientific Software Development GmbH, 2019) for preliminary coding. Preliminary coding involved applying tentative labels to each passage of text to summarize what was occurring. Initial coding was mostly done in vivo and occurred while data collection was still ongoing. Codes were categorized to help organize data as subsequent transcripts arrived. With the arrival and preliminary coding of each new transcript, code categories were refined and grouped together. This iterative process of data collection and analysis allowed for the construction of an increasingly dense code forest in ATLAS.ti (Version 8.3.1; Scientific Software Development GmbH, 2019). (3) The code forest was then exported from ATLAS.ti (Version 8.3.1; Scientific Software

Development GmbH, 2019) to an Excel spreadsheet for viewing and organizational purposes. This document became the study codebook. Relationships and repetitive patterns between and among code categories were identified and used to restructure the codes and code categories. Frequent meetings with my supervisor involved discussion of coding decisions and early impressions from the data. (4) To find core concepts or themes hidden within the code forest, transcripts were re-read in their entirety. Data within the codebook was then added to identified themes and sub-themes. In turn, themes and sub-themes were clustered around the research questions. (5) Multiple hard copies of the codebook were made and reviewed with my supervisor. Themes and sub-themes were continually refined. During this process, linkages were made between the codebook data and structural barriers, power relations and policies identified in the literature review. Hyperlinks across data were made with the networking function in ATLAS.ti (Version 8.3.1; Scientific Software Development GmbH, 2019). Construction of a mind map (see Appendix E) allowed me to visualize how power, processes and policies constrain women's everyday lives and to consider how they can be disrupted (Thomas, 1993). Colour coding helped organize the mind map: green for health determinants, red for risk factors, blue for aspects of identity, pink for indicators of enhanced well-being, purple for systemic barriers and white for links to participant quotes. Key themes that emerged from the data analysis process include: perception of mental health and well-being, determinants of health and well-being in the resettlement period, risk factors impacting health and well-being and health care provider-client relationships and engagement in decision making.

Trustworthiness

Several measures were taken to ensure the trustworthiness of the research findings. During the interview process, I ensured sure to ask for clarification when I could not understand participant responses. This involved summarization of information obtained from participants and, when necessary, rephrasing of interview questions. Data triangulation was also used to increase the credibility of the research findings (Creswell & Creswell, 2018; Streubert & Carpenter, 2011). This required collection of three sources of data (i.e., observation, interviews and questionnaires) at multiple sites. Another strategy used was persistent observation of the data. I read and re-read the data constantly while developing codes. This process is important for improving researcher's depth of insight (Korstjens & Moser, 2018).

Movement from raw data contained interview transcripts to final themes is recorded in memos and different hardcopies of the codebook. These records of the data analysis process form an audit trail that can be used to evaluate the dependability and confirmability of the research findings (Korstjens & Moser, 2018; Noble & Smith, 2014). Dependability is concerned with the consistency of research findings over time, while confirmability is concerned with other researchers' ability to confirm the research findings (Korstjens & Moser, 2018). Transferability of research findings was established through the use of thick description in constructed narratives (Lincoln & Guba, 1986) and consideration of broad historical, social and political patterns that may have shaped participant's lived experience (Korstjens & Moser, 2018).

Reflexivity is another important quality criterion. Reflexivity safeguards the integrity of research studies by maintaining researcher's awareness of their thoughts,

feelings and influence on the research process and participants (Korstjens & Moser, 2018). To maintain the integrity of the research study, I used reflective journals and field notes to clarify my thoughts and intentions with participants and to identify my personal biases. At times it felt difficult to sit down and write about my days in the field. However, the process of journaling helped me to unpack my emotions and experience. Some scholars consider journaling to be a form of catharsis (Lamb & Huttlinger, 1985). Writing in my research diary, I could release pent up thoughts and frustrations with fieldwork without fear of judgement. Honest exploration of feelings and insights can result in self-growth (Lamb & Huttlinger, 1985). Throughout the research process, journaling helped me to reveal biases related to my own ethnicity and a capacity for compassion that I had not previously identified in myself. My discovery of a religious bias with participants is revealed in the following field note:

> During the interview the participant breast-fed the youngest child. The baby was not fussy or particularly hungry and he kept falling asleep at the breast. The act of breast-feeding was noteworthy to me because the participant felt comfortable enough in my presence to do so. This was my first time seeing a non-Canadian breastfeed. The lack of modesty was surprising as no blankets were used to cover the breast. In my experience Canadian women tend to use a blanket or shawl to cover up…for their own comfort or others' I cannot say. The juxtaposition between the participants' hijab and bare breast was shocking. In reflection, I can see how my own bias (my Western discomfort with nudity) coloured my reaction to the participant's behaviour. I assumed that the modesty required by Islamic

religion extended to breastfeeding. I assumed that such an act would be cloistered and hidden as though it were dirty rather than innocent or wholesome. Awareness of this particular bias allowed me to better monitor my behaviour with subsequent participants and ensure their comfort during the research process.

Ethical considerations

Permission to conduct this study was obtained from my supervisory committee and The Research Ethics Board at Thompson Rivers University in Kamloops, BC (see Appendix F). Before the start of interviews, I took time to discuss and sign consent forms (see Appendix G) with each participant. The consent forms that were given to each participant included a letter which provided information about the study. A copy of the consent form and letter were translated into Arabic (see Appendix H) and were for participants to keep.

As this study revealed Syrian refugee women's unique stories, I have made efforts to preserve their voices and validate their experiences within this thesis. The option for women to have their first names included in the text was built into the consent process. A pseudonym has been assigned to the narratives of those who wished to maintain their anonymity. Participants were reminded at the end of interviews that they could request a pseudonym or leave the study at any time without consequence. They were also informed that the sociodemographic data collected in the study would be summarized without any identifiers to protect their privacy and confidentiality. All data published will maintain these standards of confidentiality. Data security has been ensured through encryption of data and storage on a password protected computer. All interview recordings and files will be destroyed after a period of five years.

Throughout the research process I have been attentive to the fact that refugee women face many stressful and traumatic situations in the pre and post-migration contexts (Kronick, 2018). Some of these experiences were revealed during data collection. The following measures were taken to ease participants' discomfort and fear of stigma during interviews: (1) When required, female interpreters were used during interviews to prevent re-traumatization. (2) I avoided sensitive topics such as trauma and gendered violence in interview questions. Despite this precaution, interview questions still caused one participant to become teary. This individual was overcome with emotion when describing her struggle to provide for her children. In this instance, I offered Kleenex and a comforting touch to the participant's hand while she finished her narrative. (3) After the interview I referred the participant to counselling services attached to the educational institution she was recruited from. One additional woman was referred for counselling at her settlement agency. While this participant did not exhibit signs of distress during her interview, I determined that she was at risk of emotional injury due to personal and financial pressures. (4) At the end of each interview I completed an informal debriefing to check in with participants and to communicate my gratefulness for their participation.

Summary

This chapter began with an overview of the intersectional framework that guided this research study. A critical ethnographic approach was well suited to this theoretical framework. Both are concerned with understanding the complexity of people's lives, revealing hidden oppression and social change. This chapter also provided an overview of the study site, participants and selection criteria. Next was an explanation of data

collection and analysis procedures. The chapter ended with discussion of ethical considerations made throughout the research process. The following chapters focus on the findings and discussion of themes identified during data analysis.

Chapter IV: Findings and Discussion: Perception of Mental Health and Well-Being

In this chapter I present and discuss findings about Syrian refugee women's perception of their mental health and well-being in the resettlement period. Individual interviews revealed how Syrian women constructed their understanding of what constitutes mental health and well-being. Participants voiced many beliefs and attitudes about mental health in resettlement. However, three dominant sub-themes emerged from participant interviews: mind-body connection, harnessing inner strength and hope for the future. The following is a discussion of these three sub-themes.

Mind-Body Connection

It is generally understood that poor physical health negatively impacts mental health and vice versa (Martin, 2016). According to some participants, both physical and mental health are integral for performing activities of daily living and for learning new skills in resettlement. As Najah explained:

> The health and well-being is the most important thing in life because if the person is not physically or mentally or emotionally healthy…it would be difficult to perform any of the activities in life. It would be difficult to even understand this language or find the energy to do the daily chores or daily routines or go out of the house.

Paradoxically, adjusting to the reality of daily living can be emotionally and physically exhausting. Several participants reported feeling stretched thin between personal, social and financial pressures. Lina describes how stress-related emotional injury is reflected in her physical appearance:

> For me like I said like there was everything easy to get but here its different…Like sometimes I tell my husband I cannot cook like before I feel lots of energy now I feel like I am losing like my energy, I am losing my body and my face is getting so tired. Like in Syria and Turkey too I think I just have one wrinkle and now its like we are getting older, we would like to be younger but for thirty-three years, all just sit for thirty years. Like for my mum, I talk to my mum last week and she look at me and she says, she said you look like more older than me why your face is so tired? Why, because lots of change in our life.

How people communicate emotional distress may be influenced by cultural beliefs, mental illness stigma and experiences of trauma (Lin, Carter, & Kleinman, 1985; Rohlof, Knipscheer, & Kleber, 2014). While some participants openly described their mental health status and needs, other women were more guarded. Ebtisam commented: "Okay, so normally I don't say anything I just lock it inside my chest and I don't tell anybody about it and sometimes I tell my mum." Another participant, Sara stated: "So I really don't know whose doing what and whose accessing what because it's a private matter so every family has their own issues." People who have learned, via socio-cultural conditioning, stigma or experiences of trauma, to hide their emotions may communicate distress through somatization (Lin et al., 1985). Kirmayer, Dao, and Smith (1998) discuss somatization as a set of clinical processes often "transforming or transducing psychological conflict into bodily symptoms (often including medically unexplained and functional somatic symptoms)" (p.233). These authors recognize that somatization is often viewed as characteristic of non-Western ethnocultural groups but argue that it is a universal phenomenon (Kirmayer et al., 1998). Several participants described somatic

symptoms when asked about their mental health and well-being. Symptoms described included fatigue, trouble sleeping, pain and elevated heart rate. Anna provided the following somatic idiom when asked about her emotional state:

> I am relieved now from the nightmares. When I wasn't, when I didn't sleep and go to work I, I always like try to do my best in the work but honestly I was exhausted, I as exhausted like I, I was exhausted and at the same time I could, I can't sleep so you can just like imagine. Like you are sleepy, you are so that you are sleepy but your eyes just open.

In addition to loss off sleep, physical pain is an ailment that has been reported among Syrian refugee women living in Lebanon (Ghumman, McCord, & Chang, 2016). While pain can be a somatic symptom associated with post-traumatic stress disorder (Rohlof et al. 2014), it is important to note that such labelling may be inaccurate and stigmatizing for survivors of violence and torture (Hassan et al., 2016). One participant described experiencing intractable pain since arriving in Canada:

> Najah: Okay so I'm happy that the children are able to continue their education – this is the most important thing for me. However, I'm very exhausted and tired especially, you know, I have to carry groceries from the store to the house and all the house chores. Recently I have a pain in the neck for the past four months and I don't know what to do about it because I've been to several doctors and I really, it did not become any better and I feel it all the time when I'm sleeping, while I'm, you know, walking, sitting, this pain is continuous.

Elevated heart rate is a hyperarousal response that can be indicative of changes in a person's mental health (Nakeyar & Frewen, 2016). Among individuals with post-

traumatic stress disorder, a hyperarousal response may be triggered by situations, people or emotions associated with an original trauma experience (Rohlof et al., 2014). A situational trigger is clearly identified by Lina:

> First eight months when I heard my sister will be out here from here and when I heard like house will sell. And I feel like my heart beating so fast and what I realized I just told my husband and stay awake if something happen to me you will call 911. And he says what, 119, I said, no, 911 don't forget. And like he came to me and he rub my back and he say take a breath like life still continue on and you have children don't be like this. But you have, your heart is hurt . . .

Somatization due to cultural beliefs, stigma or experiences of trauma presents a barrier to mental health services for Syrian refugee women. Health care providers may fail to recognize physical ailments as manifestations of emotional distress (Lin et al., 1985). Delay in the diagnosis and treatment of psychological problems could lead to deterioration of women's mental and physical health.

Harnessing Inner Strength

When discussing their mental health and well-being, some women described looking inwards for strength and healing. Ebtisam commented: "Okay so generally I like to, to zero with this stuff between me and myself. And I don't think there is anything that will make me comfortable to speak to a formal entity like a doctor or a counselor." Another participant, Lina stated:

> In this four months I felt like I have to see like mental health for someone to help me but sometimes like what they can help? I don't think they can help like if you don't help yourself no-one can help is what I believe. Like if something I said oh I

> don't want to do this but I say, no, I have to do this for myself, I do it, I feel okay. But if the doctor I will give you medicine I know it will help a little bit but still like you feel something in your heart missing.

Wariness of healthcare providers and of psychotropic medications may be a gendered barrier to help-seeking. Medications are a visible sign of treatment and may alert women's spouses to changes in their mental health status. Some men may leverage information about women's well-being to assert control in intimate relationships (Donnelly et al., 2011). Women who are given information about their symptoms and alternative treatment options may be receptive to professional help. One participant, Gulistan, described how a Community Health Nurse convinced her to speak with a psychiatrist post-pregnancy. She recounted:

> The first one talk to me maybe her name [name] from Interior Health when I went to have immunization for my baby…She asked me some questions, I thought it was just normal questions, I tell her and she said, oh, you have, your number is higher to have, oh I forgot the word…Depression, yeah…She said not too much but you have a number, you can see the doctor, a special doctor, psychiatric doctor and she said if you, she said if you want, I told her, yes please, I want, sometimes I feel I need to talk to somebody.

Of the study participants, only three women had accessed mental health services. The majority denied needing mental health services. These individuals were asked what Syrian women could do to improve their own mental health and well-being. Najah commented: "I think they should study the language and just depend on themselves." Another participant, Chadea, shared the same advice with her daughters:

> I hope every, everyone in our house speak English, speak in English way, maybe someday I don't want…anyone just for their sake, yes. So I'm going to restaurant English, yes, I always say to them if you want my help I'm ready to help you but I want you help yourself because we are here in…Canada we have to do anything by myself, by herself.

Furthermore, women perceived self-reliance, cultivated through skills mastery, as an indicator of enhanced mental health and well-being. This perception may stem from neoliberal ideology which is prevalent in Canada and communicates messages about the importance of self-sufficiency (Zhu, 2016). Zhu (2016) notes that Canada's policy of multiculturalism is shifting away from meeting newcomers where they are. Now, the prevailing message is that newcomers must learn to adapt if they want to succeed in the resettlement context (Zhu, 2016).

In addition to language skills, participants described how driving improved their mental health and well-being. Gulistan stated:

> When I say my dream was driving [laughing] I just came here I tell my husband oh, I have, I would like to drive and he said oh you're free, you can make the test and if you pass I will let you drive…And just, the first lady to take the driver lessons here…Yeah I feel like stronger women.

Ebtisam emphasized how driving gave her the freedom to leave the house. Lack of a vehicle and her family's conservative values kept Ebtisam from driving in Lebanon. She commented: "Okay so in Lebanon our situation was really bad and we didn't have a car, here we have a car and we can go out and go to places. In Lebanon I hardly went outside of the house so I feel much better after coming here."

Self-care practices were another indicator of enhanced mental health and well-being. Behaviours such as watching TV, engaging in physical activity, socializing, engaging in hobbies and taking time away helped Syrian refugee women change their emotional status and confront stressful situations. Sara stated: “Sometimes when I feel like I’m stressed or a lot of pressure I just go out for a walk to kind of, you know, sort of a stress relief for myself.” Chadea, who also enjoys walking, shared this example of emotional de-escalation:

> One day before I don’t know what happen for my heart so I said to my husband please, I want to go for a few minutes out and I came back and my husband said what happen, what you want? I said I don’t want anything just I want to go for myself for a few minutes out. And I went to a few minutes out just walking and then everything is okay.

Gulistan described using a variety of self-care activities:

> I do what the nurse advise me, I give myself a rest or I give time for myself not all the time, my time for the kids, for cooking, for cleaning, she said don’t worry about cleaning, don’t worry about kids, you have husband just leave the kids with husband and go walk a little bit, go with a friend, go have coffee somewhere, yes, I like this advice, I take the time to walk by myself I feel better.

Some women struggled to separate themselves from gendered responsibilities such as childcare. Lina collaborated with other Syrian mothers to work around this difficulty. She stated:

> We go to other’s house with like five families and with twenty children, crazy but like we want to like help ourselves. Like we don’t do like this our husbands going

to work or doing their activities but for us we want to help ourselves with like we meet together once a week just like to relieve on ourselves and have fun and if we have something new we discuss about it.

Together Syrian women were able to negotiate time for themselves without involving their husbands or compromising their responsibilities.

Hope for the Future

During interviews, some participants avoided speaking about the past. These women expressed strong determination to stay focused on their future. Alaa commented: "The past going I forgot all the past…Yeah I prepare for the future and now the present." Rather than dwell on the circumstances of her family's arrival in Canada, Alaa maintained an optimistic attitude about resettlement. She explained: "The best thing is save, save my life and save the life for my daughters and there's a future for my daughters can study. My husband's work, he's working comfortable not, not like, like before he was always worried, yeah."

Chan, Young, and Sharif (2016) state that a relationship exists between optimism, hope and post-traumatic growth. Post-traumatic growth is positive psychological development that results from individuals' "struggle with highly challenging life circumstances" (Chan et al., 2016, p.292). It is believed that an optimistic attitude may help individuals work through challenging experiences and generate hope for the future, thus demonstrating psychological growth (Chan et al., 2016).

In addition to optimistic attitudes, many participants expressed a sense of hope for their futures in Canada. Hope was communicated through short and long-term goals. Common goals included obtaining employment, education and Canadian citizenship.

With regard to employment and education, Gorgiy shared aspirations for her entire family: “I hope for my family, I hope for my husband to be like a boss in his job…And for my daughter for the school will be a first one for school…I hope to find job now and after one year maybe we can buy a home for us.”

One participant, Anna, spoke about family planning with her husband. As a part of this process, Anna decided to pursue a career conducive to job-family balance. As she stated: “Because my husband and I we are planning to have family so I found that the most, the best program that I can enroll on – the one that I can work while I’m raising my own children so I choose early childhood education.” Initially, Anna felt conflicted about compromising in her education and career, as in Syria she enjoyed a position working in nuclear medicine. She commented:

> At the beginning I wasn’t sure but like my first term was really difficult for me. And I say, no, I don’t want to continue, I don’t like it. But when we, when we, when I went through the practicum and I went to the fields there was a problem, uh, I thought like I’d actually like to, to like it more. Yeah, because like its also like something, its related to my scientific program because it is like something you’re goanna like you have these things and you’re going to practice it and you’re going to have results. Something, you know, when you, when you try to cope with something so you kind of like strategies to, to match it, you know.”

Finding similarities between her old and new professions allowed Anna to grow more enthusiastic about the curriculum and her future endeavors. She commented: “Yeah so and maybe one day I can get my own–I try to get facility…I can like also using my, my certificate in some way.”

Applying for Canadian citizenship was a long-term goal that many Syrian refugee women shared. They explained that Canadian citizenship is required for them to travel out of the country. The ability to leave Canada was associated with family reunification. As Gulistan stated: "I didn't have chance to travel from Syria to Turkey but now I have chance if I get the citizenship I can go to visit my family in Turkey, yeah, because I didn't see them for six years." The following statements by Lina described her struggle with family separation:

> And everything now I think every time when you get longer here you miss somebody and it can make like sick. Like first year I cried a little bit because it was new to arrive here but next year it was okay, it was fine but this third year I feel like I really want to see my family.

Language intersected with gendered responsibilities to challenge Syrian refugee women's access to Canadian citizenship. Individuals have to meet specific speaking and listening benchmarks before applying for citizenship (Government of Canada, 2019b). A lack of child care kept some women from attending necessary English classes. Alaa commented:

> In all of this, yes, its child care just in the Link, no. But first when we're coming my husband go afternoon, I'm going in the morning, he watch the kids in the morning, I watch the kids afternoon we switch that was for the three months, four months I study, yes. After that they close the classroom afternoon, yeah, I, my husband just study in the morning because his English not very well, my English better than him. He's going in the morning and I stay with the kids all the time… Without the study its hard because we need the language and we need it for citizenship too.

Despite her struggle, Alaa remained optimistic: “If I don’t get level four, yes, maybe I help my mother-in-law get level four this year, maybe next year I can, I can leave my babies with her and I can go to class.”

Summary

This chapter discussed findings about Syrian refugee women’s perception of their mental health and well-being. The sub-themes mind-body connection, harnessing inner strength and hope for the future reflected women’s beliefs and attitudes about mental health. Narratives revealed how mental illness stigma and cultural beliefs influenced women’s expression of emotional distress and their use of mental health services. Despite their distress, women were very keen to preserve their independence. Factors such as gender roles and language barriers intersected to challenge women’s access to education, employment and Canadian citizenship. Syrian refugee women’s belief that they could overcome barriers was a positive indicator of post-traumatic growth. The next chapter focuses on determinants of mental health and well-being in the resettlement period.

Chapter V: Findings and Discussion: Determinants of Mental Health and Well-Being in the Resettlement Period

In this chapter I discuss determinants that were important for women's mental health and well-being in the resettlement period. Participant narratives reveal how different resettlement factors interacted with each other to influence women's mental health status. Factors that were commonly mentioned included formal and informal social support, inclusion in the wider community, altered gender roles and language skills and education.

Formal Social Support

Sponsorship. All nine of the study participants indicated that they were privately sponsored. Sponsors were women's first point of contact with settlement communities and were key figures in their integration. Alaa commented: "She help us with find house, with the furniture, with the money, yes, with the grocery shopping drive us, yes, with everything, with English too like to talk with us to improve our language." In the last chapter it was revealed that skills mastery was an indicator of enhanced mental health and well-being. Several participants described learning new skills from their sponsors. Gorgiy stated: "Our sponsor and he teach us about three months every day about two or three hours. It was very good, very benefit for us. I didn't go to the school never just I, I learn from the teacher and from the conversation." Another participant, Gulistan, commented: "Yeah, that's right. And my sponsor helpful, they teach me how to drive."

In addition to providing financial aid and skills instruction, some sponsors attended to women's emotional needs. One participant, Sara, described how her sponsor worked to bring some of her family members to Canada: "Okay so, yeah, the sponsor, my

sponsor he's the one who arranged this to get, you know, to bring my children with me because the separation thing had a really bad impact on my, you know, on my emotional state." Chadea also struggled with family separation, particularly during her pregnancy. She described how one of her sponsors, now a close friend, comforted her during her time of need: "When I first pregnant I cried, I cried all the time, yes my friend said what's the pain…please, I am you family."

While some participants described seeing less of their sponsors over time, others maintained a close connection. Gulistan commented:

> I, I just know when I came I don't like anybody from my sponsor but after that they are help like my kids and help us for everything. I make friends with them and I invite them for the Syrian dinner and we make friends. Or we just now, the sponsorship is finished…After one year but we still close and visit each other.

For Chadea, her sponsorship team has become her found family. She stated:

> They sponsor us for one year and then maybe if they don't like us or maybe they can't, don't help us but we, they love us and we love them, we make a big family, yes, happy family, I have a family here.

Chadea's "Canadian family," has helped foster a sense of belonging and connection to her settlement community that has positively impacted her mental health status.

Settlement organizations and integration services. Many women were in contact with immigrant settlement organizations in their communities. Participants described receiving assistance registering for English classes, applying for housing support and accessing healthcare services. Anna commented:

> They helped me a lot and officially with my healthcare service because for some reason I like I didn't know how – what happened but they, I didn't, I didn't, I wasn't in their system… So which actually which makes me like pay money for any prescription or any, even for the doctor's appointment…Yeah, it took me actually more than eight months to fix these problems and they would help you with that like [name] personally went with me to the B.C. Health and we fixed the thing and just in less than one month I got my health card.

In this situation, refugee status intersected with healthcare policy to impact the participant's access to healthcare services including mental health services. Refugees are only eligible for IFHP coverage until they qualify for provincial health insurance (Government of Canada, 2018a). Those living in BC can register with the Medical Services Plan immediately after arrival (Province of British Columbia, 2019). However, it can take up to three months for healthcare benefits to take effect (Province of British Columbia, 2019). This gap in services may leave refugees who cannot afford private medical insurance with significant financial burden and stress. When asked if it was a relief to have access to healthcare coverage, Anna stated: "Oh yeah, for sure, because I wasn't like – I always like feel oh I got prescription so I need to pay for this so, yeah, it's really like when you just like especially when you know that you can get the same prescription for free."

Another participant, Sara, noted that contact with the local settlement organization was beneficial for cultural integration. She stated: "So, yeah, I think its very, very helpful because on the one side we just, I learn English and on the other side also it helps me,

you know, understand the culture." Anna, who was referred to a variety of literacy programs by a settlement organization, explained this phenomenon:

> Yeah and also we have another activity related to the [program name] its like English learn as a group…we get together sharing the books that we're reading, discussing…There wasn't any Syrians except me…That's another, actually advantage about this because…you really like meet all the people which like gives you an idea about the multi culture of Canada because I, Syria its not like multi culture country.

Pre-civil war, Arabs were the dominant faction among ethnic groups living in Syria (Ozkaleli, 2018). People belonging to ethnic minorities have described being third class citizens, disenfranchised from national and Muslim identities (Ozkaleli, 2018). Canada employs a policy of multiculturalism which supports diversity among the population (Scott & Safdar, 2017). However, prevailing neoliberal attitudes have influenced multiculturalism so that it now also promotes newcomers' assimilation (Scott & Safdar, 2017; Zhu, 2016). A few participants mentioned that settlement organizations put them in contact with community run integration programs. A benefit of these programs was learning about multiculturalism and the experiences of other newcomers to Canada.

Housing support. Inadequate housing and economic insecurity are known sources of post-migration stress for refugees (Bhuyan & Schmidt, 2018; Hynie, 2018). Multiple participants described struggling to pay their rent. A few women spoke about their experiences applying for housing support. Refugee status, policy and gender roles intersected to impact some women's access to affordable housing. Najah stated:

> Okay so I asked the sponsor, the private sponsor about registering for…B.C. Housing and they said this will only happen when the private sponsorship is finished. I, I cannot imagine how can I work and learn the language and at the same time do the, do the stuff at home like cook for my children or take care of the house chores.

As a newly single-parent, Najah felt unable to assume the roles of both mother and provider. Caregiving stress and increasing financial burden left her feeling overwhelmed. Despite having a husband who is employed, Lina was also concerned about the cost of living. She applied for BC Housing after learning about this benefit from a friend. Lina commented:

> One person live in Victoria she said like she said here someone help us and you can go to immigration services and talk about like B.C. Housing and they will support you…And I went to immigration service I talk to [name]… she get the people for me and I find a lot of information…I sent my application and they accept so they are paying like one hundred.

Though Lina hoped to receive more help with monthly rent payments, this assistance has given her some leeway to meet her family's other needs. She stated: "Like taken from our children to pay for rent is difficult like for us. Like if you have children they're asking about like apples and you cannot buy it . . ."

Informal Social Support

Family. Availability of family support was a strong determinant of women's mental health and well-being. Family was associated with shared experience, language

and understanding. This was especially true for single parents and women belonging to diverse ethnic groups. Lina stated:

> My experience wasn't great first year with my sponsorship…the first eight months I was so upset because I was just alone here and the life was like new to us…After eight months my sponsor said like now your sister will come to [place] and I was thrilled like so happy…its very important to have like relatives…because for me, the first eight months, I was just looking for one person who speak Arabic or Kurdish…I just want like one person talking to me.

With no relatives in Canada, Najah used technology to seek comfort from her family. She commented:

> So I talk to my family in Jordan, we talk, we do video calling. And I explain to them my situation and also because some of the children are really putting a lot of pressure on me the way they behave sometimes. So, yeah, so they just tell me that, you know, maybe you have to be patient and maybe things will get better.

Several women noted the importance of mother-child relationships for mental health in resettlement. Sara observed:

> I am more at ease when I know that my children are like close to me and I can see them because, of course, if you are in another country especially in Syria or somewhere else where the situation is not stable its going to be –and there will be a lot of anxiety and fear involved.

Another participant, Lina, described the impact of a single phone call to her mother:

> I heard my house is for sale I, if I didn't talk to my mum for like one week I feel like all, the whole world is dark, I cannot like open my eyes. But if my mum talk

> to me and she smile everything is fine like I forgot everything happen. I feel like we are safe, we are surviving.

In addition to providing emotional support and cultural connection, family members assisted with women's socio-cultural integration. Family members helped women orientate to their surroundings and gain access to banking and healthcare services. Anna commented:

> So when I came to [place] it was like just mixed feeling… I knew that I have family waiting for me at the airport so that's helped me more to feel less like to, to reduce my fears…Right away I like, like just week after I arrived my cousin and I start like doing all the stuff that I need like the banking, my ID and my health card, all this stuff.

For women with children, gendered responsibilities, socioeconomic status and a lack of child care intersected to limit their access to English classes. Family support allowed women to navigate these intersections. Sara stated:

> So many of the Syrian women here that cannot go and study because of the problem of the daycare…Like my daughter, my daughter-in-law they all want to study and they want to go to school but they can't…So I am actually I want to finish I'm now at the level five because I want to also babysit my, my grandkids so their mums can go and study.

Friends. Outside of family, Syrian refugee women sought support and comfort from friends. Lina described her experience socializing with women from her college campus:

> Like we have a meeting with the Canadian and with immigrant and with Syrian people and we get together and we enjoy, we dance, we talk, we share activities and we're talking about like challenge in our life…Everyone is like very honest to say what its hard…we share together and this I thought is very helpful to us. Like when I go and I see another person is like managing and like I heard a few stories, a lot of stories like their experience. And I feel like oh I am fine.

Some women were eager to make friends but struggled with the language barrier. Anna commented:

> Even if I want to like to hang out with my friends they, they are really nice, honestly they will find my English a little bit boring, you know, I will not like…be able to follow their, their jobs, their so its going to be hard for me. Maybe I need time, you know, maybe I need time.

Women might avoid language barriers by networking with other Syrians. However, concerns about gossip made some participants hesitant to engage with their peers in person and on social media. Chadea commented:

> If I sit beside some Syrian woman next time, for example, tomorrow or two days I hear some, some more not good for me…for example I, I told you something for myself so please don't say that to another woman… I make you friend, my friend why you tell this one or this woman.

Participants mentioned that some Syrians had started WhatsApp and Facebook chat groups. Najah and Chadea chose to avoid this type of social interaction. Najah stated:

> There is a group but I'm not a part of it because in my opinion the topics they discuss are not that important or not that interesting for me. And also they always

> have problems behind this group so they always have some kind of tension or something going on.

Different access to formal social support, as determined by refugee status, was perceived to be a source of tension between Syrian refugee women. Chadea commented: "Women here…they have so many problems, in my opinion I don't have problem, never." Later in the interview she also stated: "In my opinion I have [sponsor]…some women maybe they didn't have much, I don't know for anything."

Ethno-religious community members. As with family support, contact with ethno-religious community members was associated with shared experience and understanding. Cultural traditions influenced how some Syrian women processed their experiences and managed distress. Ebtisam observed:

> Okay so generally we have some kind of a tradition that we make a certain kind of food and we make a big sort of something like banquet or we invite a lot of like the women, most women, relatives and we talk to each other about whatever is bothering us.

Many participants identified as Muslim. Altruism was central to women's worship and provided them with a sense of worth. Sara stated:

> When there are Syrian families that come like new here the mosque tells us and sometimes we go and, you know, we talk to them. I make them feel more like comfortable and I kind of explain to them that it takes a bit of a time to get adapted to the… situation and to the new environment and maybe take them to Super Store or just show them around.

The mutual aid offered by the Muslim community had one participant prepared to relocate to a larger city. Najah, stated:

> I think the job opportunities for me as a Muslim for a job will be more in Vancouver because I think it's a bigger Muslim community in Vancouver. And also the fact that we don't have our food here which is a bit of an issue for us. So I think if we move to Vancouver it would be easier.

Lack of social connections is known to place refugees at a disadvantage for employment (Vinokurov, Trickett, & Birman, 2017). However, discrimination and religious identity may also intersect to impact refugee women's job opportunities (Clark & Saleh, 2019). Unemployment and poverty are known to have many negative effects on the mental health of newcomer women (Bhuyan & Schmidt, 2018).

Inclusion in the Wider Community

Inclusion in the extended community is a resettlement factor that is very important for the health of newcomer mothers (Bhuyan & Schmidt, 2018). Women who are isolated during pregnancy may experience loneliness, difficulties eating and a lack of motivation to exercise (Bhuyan & Schmidt, 2018). For Chadea, inclusion in her sponsor's church provided her with an extended social network during her pregnancy. She commented:

> I have some friends from the church, yeah…They are so kind with me too and helpful…And when I, when I bring my baby, yes, the church make a big baby shower for me…Yes, there was surprise for me, sixty people, yes, so help for me, so many gifts for me, yes, that was big surprise for me…It felt good because if I

were in Syria like this so when I show this time I'm feeling I am not in Canada I'm in Syria now with my family.

Gulistan also experienced pregnancy during resettlement. As a busy mother of several young children, she engages with her community through her love of cooking. She explained that she has plans to distribute a cookbook of traditional Syrian recipes to the wider community. These plans took shape with the help of a local church. Gulistan explained:

> Okay, I will tell you about everything, sometimes we make this special dessert, a traditional dessert or cookies and we don't have chance to go to mosque we try to do it here. We do several time in the United Church and they give us room for the mosque there…Yeah, they are nice people because its downtown its near for everybody.

While Chadea and Gulistan's experiences with faith-based organizations were positive, Mulholland (2017) points out that newcomers may feel pressure to convert their religion after receiving support from faith-based organizations. This may add religious tension to women's burden of stress in resettlement. In addition to her working relationship with the church, Gulistan has an excellent rapport with her neighbours. She stated:

> Yeah they are so special here I just know about big city maybe different but here in [place] I have neighbors, they are old people, I love them. I invite them to have dinner in my house because they just visit me and give, bring toys for my kids, they are very friendly. And she was, she saw me when I'm wearing a dress and a scarf, she said, oh, you are, I am from Syria…she said oh welcome to Canada, you're in a safe country, you will have friends here, yeah, she was nice lady.

Volunteerism was another way women engaged with their communities. For Anna, volunteering has been a form of stress relief. She stated:

> Yesterday I stopped doing the assignment that is due today…they asked me to volunteer and I say you know what, I really have very big assignment so anyway. But I thought I felt that I'm really stuck I just went to this event and I spent like two or three hours over there and when I came back I start my assignment, everything was fine.

Some women were unable to form connections to the wider community because of responsibilities at home and in the classroom. Anna commented: "[Women] can't be separated from their kids, their husband will not understand that…So I think to get them to participate with the activity…show them that, yeah, your children are involved you can bring your children." Gender roles and socioeconomic status were other factors that influenced participant's community involvement. Some women described being dependent on their husbands for transportation. Other women were deterred by the distance to community events. Due to the lower cost of living, many participants lived on the outskirts of their settlement communities.

Altered Gender Roles

A shift in gender roles influenced women's mental health status and whether mental health services were accessed. Multiple participants described feeling pleased with the increased gender equality in Canada. For some women, equality meant having the freedom of choice. As Anna stated:

> I would also like to choose my husband. But here in Canada…I feel like I am able to do that, I have more freedom to do that…here nobody like will tell you what

> are you going to do. You're goanna choose, you're gonna say that's what I want…Because I got married here I can say…to my husband, okay, that's what I like, what I don't like, sharing responsibility, yeah.

Anna was comfortable setting boundaries with her husband and felt confident that he would be open to further negotiation as their circumstances changed. She commented: "In my situation for sure I will, I will try to involve my husband more in the responsibility like to handle some more responsibility at home especially for the kids, yeah."

A few participants associated gender role changes with a change in the pace of life. Gulistan commented:

> When we came here the life is so different and so hard, I should go to the class, I should clean the home, I should look after the baby, I should cook, I should wash the dishes, all the home I'm doing. But my husband now he start when I'm busy…he just start help me with the home cleaning, with the baby.

Incongruence of traditional gender roles with Canadian society reflects the collision between women's home and host culture. Women were simultaneously advantaged and disadvantaged by expanded gender roles.

While some participants felt empowered by the option to pursue employment and education, Alaa observed: **"**I can't do everything, you know, the mum's can't do everything, yes, I can watch the kids, I can go to school, I can go to the appointment, yeah." Lack of time was perceived as a barrier to mental health services. When asked how multiple responsibilities affected her use of mental health services, Najah responded:

> I feel like there is no time life in Canada, the pace is very fast and its very pragmatic…Maybe if I talked to somebody that will help maybe I would feel better or it will be some kind of venting. But the fact that also, you know, the commitment I have I cannot be away from the house for a long time. I think this is the main, the main reason that I don't seek [help].

Making time for help-seeking was a not a priority for some women. These individuals tended to focus on their children and husband's needs before their own which is fitting with the altruistic religious practice many women engaged in.

One participant, Sara, felt she was adapting well to changes in her gender role. She stated:

> I'm kind of adapting to my responsibilities here because before in Jordan my kids didn't go to school and I stayed home and I did house chores…but I am adapting to this lifestyle…it doesn't really affect me…sometimes when I feel like I'm stressed or a lot of pressure I just go out for a walk to kind of, you know, sort of a stress relief for myself.

The key to Sara's success was time management. Her experience raising multiple children was a source of strength and wisdom. She shared these suggestions for Syrian women struggling with altered gender roles:

> [Women] should plan their time and manage their time because normally we did not have, you know, kind of time management skills…Here you have to work so you should learn how to manage your time and, you know, get your kids at school and then manage whatever chore your responsibilities you have at home and your responsibility as a wife.

Language Skills and Education

Many women were interested in increasing their language skills and education. Language was perceived as an equalizer between Syrian refugee women and their Canadian counterparts. Lina commented:

> If you want to define something, it's very important to have a language…I told my sister she, she knows the level four, too because every time she call on myself…But I told her like never be like this…you do it for yourself… in our culture we say like language is weapon to define yourself…Every time protect yourself with the language. Like if you understand…everything will be obvious around you.

Furthermore, language skills were important for increasing women's agency. They also had a protective effect on their mental health and well-being. Lina explained how language skills have helped her manage resettlement stressors:

> With language you feel comfortable if you get in problem you will say come help me, I need something…But if you, if you didn't understand you will say please could you help me and they will go there, go there, go there and it will take you like months to do this. But if you have a language you will do it in one day and you will finish and you will have sleep at night.

In addition to these benefits, language skills gave women the power to access information about their mental health and well-being. Generally, women approached their partners and health care providers with questions about their well-being and health care services. Speaking with their partners was particularly problematic, as Anna observed: "They don't know, they like always get…the wrong information from the man…I always

try, no, that's not correct, that's wrong from where you got this information then I know that they got it from, mostly from their husbands or from their relative." Getting accurate information from health care providers was equally challenging for Chadea. She stated: "I don't understand what did they say, what do they mean?...I don't know what happen because I heard before so many problems, for example, you said something and I translate another thing." Access to knowledge placed men and health care providers in a position of power over Syrian refugee women. Supporting women's development of language skills may help neutralize power differentials operating in their homes and in the health care setting. Given the chance, Chadea would use her language skills to lift other women up. She commented: "Maybe when I, maybe when I learn more English if anyone needs my help I will be ready for help them."

In addition to these findings, language was perceived as a gatekeeper for education. Gorgiy stated: "If I can come back to study again I will, yeah…I don't have really any, any way, you know, I have to complete my English before I – after that I have a choice." Some women planned to obtain education for a career. Najah commented:

> There are already some [women] who have ambitions of continuing, you know, to continue education, to maybe get certified as daycare practitioners or other stuff or open their own small businesses. And I think the most important thing is to learn the language in order to be pro-active in this society.

Availability of childcare and early start times influenced women's use of language classes. Alaa stated: "When I find the classes with the childcare I went there." A lack of such classes has forced Alaa to study at home. Chadea faced a similar dilemma. To accommodate the needs of her children, she now attends night classes. Chadea remarked:

> When we came to [place] I have to learn English more because my life needs more, I need more everything, yes, so I have to study English with my kids so hard. So finally I find at [college] class from evening, yes, so that was good. My [husband] came go home and then I go to my class.

Summary

This chapter discussed determinants of mental health and well-being in resettlement. Factors that influenced women's mental health and well-being were formal and informal social support, inclusion in the wider community, altered gender roles and language skills and education. Connection to other people was important for women's ability to understand and process their resettlement experiences. Women engaged with their communities by networking with sponsor affiliated groups, cooking and volunteerism. Faith-based organizations were very supportive of women's integration but could also add religious tension to women's burden of stress in resettlement.

Gender roles and language intersected with a number of factors including health policy and refugee status to challenge women's use of mental health services and social supports. Advantages and disadvantages were associated with negotiation of altered gender roles. While some women relished the challenge of multiple responsibilities, others struggled to complete prescribed duties. Language skills mastery and education were important for increasing women's agency. In the next chapter I will present findings about risk factors impacting mental health.

Chapter VI: Findings and Discussion: Risk Factors Impacting Mental Health and Well-Being

This chapter examines risk factors that impacted Syrian refugee women's mental health and well-being in resettlement. Refugee women are known to experience poorer mental health and well-being outcomes than their Canadian counterparts (Bhuyan & Schmidt, 2018). Stress related to gender role differences, socioeconomic marginalization, discrimination and poor access to health and social services may increase women's risk of ill health and mental health (Bhuyan & Schmidt, 2018; George et al., 2015). Participants identified several risk factors that increased their stress in resettlement. Common risk factors were communication difficulties, socioeconomic insecurity, discriminatory attitudes and behaviours and family conflict.

Communication Difficulties

Despite women's desire to learn English, many struggled with communication after their arrival. Gorgiy commented: "In our country we, we learn English, you know, we have the foundation from the English, we have the grammar, we have the alphabet… but, you know, the problem is the accent." For Anna, managing expectations for communication at work and school has been challenging. She stated:

> Sometimes I feel that I don't like reach the expectation they want, sometimes you know when you are in the, in the educational institution its way different than workplace. And the college or school they will expect you, they will understand your ability, they will help you more but when you are in the real work place they will expect from you to be not like regular employee.

Difficulties communicating were exacerbated by a lack of translation services. One participant, Anna, described a situation in which a bank required her to provide her own translation services. She remarked:

> There's some services that you need to do it through the phone like kind of banking, sometimes they, when you're telling them, you know what, English is my second language, can you please speak slowly…they will speak maybe just one sentence and then they will continue speaking very quickly…I say you know what, I didn't get the information. They say, okay, next time when you connect to us make sure there is a translator beside you so I really feel bad about that.

Customer service policies that require people to supply their own translators decrease the accessibility of institutions such as banks. Unequal access to wealth management services may impact non-English speakers' ability to plan for their financial future. In conducting this research, I explored interpretation and translation services. Language specialists were found to be expensive and difficult to access on demand. The cost of hiring a translator may create unneeded financial stress for Syrian refugee women who are already struggling to afford their rent and daycare services. In addition, time commitments at home and school may prevent Syrian refugee women from pre-arranging language services for day-to-day activities such as banking.

While communicating with customer service agents can be stressful, difficulties communicating with health care providers can be dangerous. Lina shared the following in-hospital experience:

> I remember one time my tooth getting swollen and I went to hospital and they give me antibiotic by IV and I choke and like I didn't understand I didn't know and I

said like just I put my hand on my neck and like this and my sponsor like fortunately he realize that I am like choking.

Experiences like Lina's may increase women's distrust of prescription medications and discourage them from future help-seeking. A translator might have helped Lina communicate her health history and any medication allergies. In the hospital setting, health care providers generally have access to translation services (Roy, 2016). However, it has been reported that the availability of translators and motivation to provide language services are low (Roy, 2016). Gkiouleka, Huijts, Beckfield and Bambra (2018) point out that "institutions are embedded within contexts where specific power dynamics are in effect and negotiated" (p. 95). In Canada, power differentials are evident between Canadian citizens and refugees regarding health care entitlement. Representation of refugees as fake-claimants looking to exploit the health care system have influenced public attitudes toward refugees (Rousseau, Oulhote, Ruiz-Casares, Cleveland, & Greenaway, 2017). Negative attitudes may shape institutional perspectives and policies and influence the behaviours of health care providers (Rousseau et al., 2017). Lack of funding for translation services and indifference to clients' communication needs are forms of institutional discrimination that perpetuate oppression and contribute to poor health outcomes for refugees. Delivery of health care services could be improved by cultural safety training that requires health care providers to reflect on personal and institutional perspectives and power relationships (Nursing Council of New Zealand, 2011).

Socioeconomic Insecurity

Unemployment and high cost of living situated many participants and their families at risk of poverty. Lina experienced food and housing insecurity when her husband became unable to work. She commented: "Like my husband he injure his shoulder, he couldn't work and the government help…but like we still like need help to live…Like place you sleep in you don't think about like what will happen tomorrow….I rent house sixteen hundred plus utilities and where I find this money?" Uncertainty about the future forced Lina to prioritize rent over food for her family. She added:

> Sometimes when we go to grocery I tell my husband we don't want to buy this thing, we don't want to buy apples, he said why like children need them. I said no, no, we want to save the money for a house like for me I don't want our life to be like this.

Anna spoke about her experiences in unsafe living conditions. She stated: "We have drug dealers in the building…We're just like scared that they're going to maybe hurt us, you know…One of their customers came and knocked on the door…And he kept knocking and then he tried to break down the door and that was terrifying." Additionally, gun violence in Anna's building caused her to experience a relapse of night terrors. When asked if she has tried to find alternate housing, Anna commented: "Yeah, we tried to find a place, another place. The only thing…we can't afford it for rent."

In addition to food and housing, one participant expressed concerns about loan repayment. Najah stated:

> I am a widow and I have six children and we have this loan from the Canadian government that is like ten thousand dollars which is the flight that we came like

> the tickets that we came to Canada with and at the same time medical, some medical exams for us before we come…And we also have to buy a car…there's just so many things so I'm a bit concerned and overwhelmed.

Accoridng to Browne et al. (2017), lone parents are at a higher risk of developing emotional problems in resettlement than other parent and non-parent newcomers. Financial stress may be compounded by caregiving stress, increasing lone-parents' risk of depression and other emotional problems (Browne et al., 2017).

Prolonged family separation was another concern associated with low socioeconomic status. Immigration policy intersected with financial insecurity to prevent participants from sponsoring their family members as refugees to Canada. The application process requires sponsors to provide proof of their financial stability (Government of Canada, 2017c). Cost of airfare was another barrier to reunification. Lina observed:

> My sister is living in Germany, I don't know if I will see them like in the future because for me I never think like to go back to Syria to see them. Because we, until three years we couldn't save any money to travel there. Syria is very far away and you need lots of money to go and visit the family, I don't know.

To improve their socioeconomic status, many Syrian refugee women sought work for the first time in their lives during resettlement. Chadea stated: **"**I not work before, not in Syria and in Jordan but here I should be helping my husband because we don't have enough money, you know, we've got family, we need lots of things." Though some women embraced the opportunity for employment, gendered responsibilities prevented steady employment and significant financial earning. Gorgiy worked for a portion of her

children's school year. She stated: "We put my older daughter in [place] Christian school for kindergarten…And after that I start to work with church with daycare. I work about six, seven months." With several children still at home, Chadea worked out a different arrangement. She commented: "So, yes, on weekend I have to work just to help for, for help my husband lots of money." Managing competing responsibilities was a challenge for Chadea. She added: "Sometimes I'm feeling tired… I don't have enough time to sit down for relax, every time, busy, busy, busy, busy."

Women with work experience also experienced difficulties finding adequate employment. Despite partnering with Work BC to build a strong resume and cover letter, Anna was unable to find a job in her field. She remarked:

> My job was like working and preparing that radio treatment for cancer patients…I hope that I can find job something like that because I really have the experience but I couldn't, I couldn't. I send my resume for…chemistry or medications, drugs industry but I didn't got any, any back from them.

Lack of social networks, language barriers and discrimination may intersect to influence women's acquisition of technical and high paying jobs (Campion, 2018). For Anna, policy regarding recognition of foreign credentials was a structural barrier to employment. As she stated: "One day and I don't remember who it was but he said in Canada they don't recognize the foreign degree…They helped me a lot in Work B.C.…they sent my paper to Victoria and it was recognized my degree was recognized."

Discriminatory Attitudes and Practices

Multiple participants experienced anti-Muslim racism in their communities and in the health care setting. Wearing a hijab in public increased women's visibility and left

them vulnerable to verbal and non-verbal forms of discrimination. One participant, Anna, observed that people were more likely to avoid her if her hijab was showing. She commented:

> A couple of times I know that people in bus will not sit beside me when they see me…I do some experiment with that so the days when I don't put my hood [on]…like spot beside me, two spots in front of me and no-one will sit…When I put my hood [on] I don't have these feelings.

Avoidance was perceived as a type of non-verbal discrimination. While this type of behaviour is marginalizing, it is less frightening than other behaviours women reported experiencing. Najah experienced verbal antagonism and threats of physical violence in her settlement community. She recounted:

> We were going to, you know, to board on a bus and a guy…came close and he was just…shouting and…saying stuff that I didn't understand. And he had a cigarette in his hand and he was like very close like almost he wanted to put it out in my face…Another time it was me and my girls and a woman…wanted to take off our veils, the scarves, the head scarf and she was shouting and…she followed us to Super Store.

In the health care setting, anti-Muslim racism was embedded in hospital policies and procedures. Hospital policy became problematic Gulistan when she requested that a female health care provider be present for the birth of her child. She stated:

> I was seeing [name] you know that before and I just told her I need lady to deliver the baby she said…when I have the labor she will come but if its not her turn the

> doctor will change…I'm not understanding what they're saying, they not have difference between men and women.

Gulistan's religious preferences were overridden by physician call-out procedures. Development of appropriate cultural safety policies may assist health care providers in advocating for clients' religious preferences. Uncertainty about the gender of her health care provider was a source of stress for Gulistan. While she did eventually receive a female health care provider, Gulistan observed that other women may not be so lucky. She stated: "Because its small town we didn't have a midwife but this year they have and now its finish, they are cancelled." Unavailability of female health care providers including physicians and midwives is a structural barrier that may discourage Syrian refugee women from accessing pre and post-natal care. This is a concern as refugee women are noted to experience elevated rates of high-risk pregnancy and adverse health outcomes (Stewart et al., 2019).

Anti-Muslim racism caused not only isolation and stress but also the erosion of women's personhood. Religious intolerance made Lina feel demeaned and wary of embracing her Muslim identity. She remarked:

> Like Syria we are wearing our scarf is our religion…If you respect your religion you go to church to pray and to read the bible…and for us we are like putting this scarf and we are going to mosque…People are very kind, the country is very safe and very generous but it feel like you lost something like you are not person.

Only one participant spoke about confronting discrimination. Anna, who was fortunate to pursue post-secondary education, spoke about the importance of critical thinking and reflection. She commented:

> I just try to look at the things that happen with me from the other people's point of view… I have a neighbour…One day I was like just heading out of my apartment with my laundry…he was passing by me and it was the first time…to meet each other. So I say, hi, and he say hi and he…starring at me, my cover…My heart was beating like that, I was really scared and I didn't know what I can do in this situation if he hits me…But the thing, about reflection again, he seems afraid of me and I was afraid of him.

Consideration of other people's point of view allowed Anna to empathize with her Canadian counterparts and understand their antagonism. She stated: "If I will be in their situation and I have all the media talking about the crazy stuff what I might do, what I might react?" The realization that her neighbour's behaviours was fear driven allowed Anna to overcome her social anxiety and attempt contact a second time. She explained:

> When we meet again…I try to again using one of the strategies to not like just like to not feel this anxiety…I just like wanted to limit it. So I try to say oh hi, how are you?...This is kind of the strategy just like kind of facing your fears a little bit.

Family Conflict

Intimate partner violence. Migration to a new country may result in gender role changes and power shifts that are destabilizing to family units (Guruge, Roche, & Catallo, 2012). Such changes can place immigrant and refugee women at risk of intimate partner violence (Guruge et al., 2012). No participants reported experiencing intimate partner violence in resettlement. However, Anna commented: "I'm sorry to say that there is abusing so still abusing, its like hidden abusing, they, even they will not talk about it, you know." Perceived stigma related to intimate partner violence was a barrier to health

care access for Syrian refugee women. Anna explained that women may be hesitant to speak about issues with their health and well-being because they are afraid of consequences at home. She stated: “Oh, it, its not easy for them to trust I believe in that. They, they have their worries, have their husbands, they will not like sharing.” Intimate partner violence is known to have a variety of psychological and somatic effects (Guruge et al., 2012). To effectively address intimate partner violence, some scholars suggest that health care providers move beyond screening and offering support services toward more upstream approaches such as educating the public about healthy relationships and the impacts of abuse (Guruge, 2012). This requires health care providers to broaden their focus from identifying victims and perpetrators of abuse to deconstructing structural discrimination that creates inequalities that leave women vulnerable to abuse (Guruge, 2012). Cultural safety training may help health care providers gain an understanding of the complex social and cultural realities that impact refugee women’s mental health outcomes.

Religious cultural divide between home and school. Two participants expressed concerns about the difference in cultural practices at home and in their children’s schools. Specifically, women were concerned with sex-education curriculum and dating rituals. Participants described gender and religious norms that required abstinence from substance use and sex. Lina stated:

> Family rules is different like culturally different. I am afraid of my children since they grow up for like boyfriend, girlfriend or drugs…we are scared of this. Like in our, especially in our religion like not allowed like anyone to… drink at all…I

> know in our country they become a teenager its difficult to manage them… but here its more difficult.

Gulistan worried about the practically of gender segregation in the classroom. She commented:

> I'm worried about the future for my girls…I can't let my girls communicate with boys or make boyfriends…I hope the schools with respect our religion and make my daughter free to talk and finish her education. Like sometimes we should work the boys with man, when, it's just like its work…but here some education about, uh, I just don't know the name, sex [ed]…We not and this is stage but I hope everything work well and they understand that we cannot study this thing.

The desire to maintain cultural and religious norms was a source of anxiety for these participants. Both women anticipated push back from their children and the school system but were determined to maintain traditional patterns of behaviour. Historically, Eurocentric values and Christianity have been at the centre of the public-school system in Canada (Guo, 2011). Knowledge of residential schools and how poorly Muslims are portrayed in the media (Guo, 2011) may have contributed to the women's belief that they would face push back from the schools in their settlement communities.

Summary

This chapter examined risk factors impacting mental health and well-being. Increased stress and anxiety were associated with communication difficulties, socioeconomic insecurity, discriminatory attitudes, behaviours and family conflict. Discriminatory policies and insufficient staffing made it difficult for women to access translation services in their communities and the health care setting. Unemployment and

high cost of living left Syrian women and their families vulnerable to poverty and violence. Credential recognition policies, language barriers and gendered responsibilities intersected to prevent upward mobility of women's socioeconomic status.

Women experienced overt and subtle forms of anti-Muslim racism in their communities and in hospital. Threats of physical violence, avoidance and limited access to a female health care provider marginalized Syrian refugee women and contributed to their stress in resettlement. Perceived stigma related to intimate partner violence impacted women's help-seeking and limited their disclosure of information to health care providers. Gender role changes were noted to contribute to intimate partner violence. Religious cultural divide between home and school was another source of anxiety and stress. In the next chapter I discuss health care provider-client relationships for culturally safe care and decision making.

Chapter VII: Findings and Discussion: Health Care Provider-Client Relationships for Culturally Safe Care and Decision Making

This chapter presents the final theme of health care provider-client relationships for culturally safe care and decision making. Stress and adversity in resettlement can cause refugee women to doubt their knowledge of their health status and their capacity for decision making (Robertson, 2015). Health care provider-client relationships that are culturally safe and supportive may empower refugee women to engage in health care decision making (Nursing council of New Zealand, 2011; O'Mahony, 2005). Strong health care provider-client relationships are particularly important for pregnant refugee women, as women who feel unappreciated or powerless in health care interactions may be hesitant to access prenatal care (Brown-Bowers et al., 2015; Robertson, 2015). Prenatal appointments are an important opportunity for health care providers to address refugee women's health and social support needs (Brown-Bowers et al., 2015). Key components of culturally safe and supportive health care provider-client relationships were building and maintaining trust and fostering authenticity and open communication.

Building and Maintaining Trust

Assuring confidentiality and security. Maintenance of Syrian refugee women's privacy was essential for trust in health care provider-client relationships and for women's security. One participant, Anna, asserted that privacy concerns may keep Syrian refugee women from sharing information about their health and mental health status with health care providers. She stated: "More than confidentiality, its more safety." She associated women's hesitancy to disclose health information with the threat of violence and abuse at home. Her assumption is supported by Donnelly et al. (2011) who note that

some refugee women fear the use of their health status as leverage in their marital relationships. Unemployment, social isolation and gender role changes are stressors that may destabilize men's power at home (Guruge et al., 2012). Loss of power may drive refugee men to assert control over their wives via psychological, physical and sexual abuse (Guruge et al., 2012).

Assuring the protection of women's confidentiality may encourage help-seeking and the disclosure of information needed for the diagnosis and treatment of mental health conditions. Anna believed that honesty was the best policy for health care providers. She suggested: "If they can get like a person who can like assure them that, yeah, your information will be really confidential even away from your husband, this is just about you as a woman." Alleviating the threat of interrogation may increase women's feelings of safety in the clinical setting. It may also help neutralize power dynamics related to differences in education and authority that exist between women and health care providers. Women who are at ease with health care providers may feel more comfortable partnering with them to address their mental health needs.

Another suggestion Anna had was clarification of women's rights and responsibilities in Canada. She stated: "Explain, okay, that's what you can do, that's what you have, that's your responsibility, that's your right. Unfortunately most of the Syrian women they don't know what their rights [are] here." Women who are aware of their rights in resettlement may feel empowered to speak out about abuse at home and in their communities. MacDonnell, Dastjerdi, Khanlou, Bokore, & Tharao (2017) note that storytelling is a form of resistance to oppression that may build immigrant and refugee women's individual strength and community resilience.

Continuity of care. Continuity of care is very important for the health outcomes of pregnant refugee women (Firth & Haith-Cooper, 2018). Resettlement stressors situate refugee women at a higher risk of health and mental health complications during and after pregnancy (Bhuyan & Schmidt, 2018; Firth & Haith-Cooper, 2018). Consistency in health care providers may provide needed emotional support in the place of traditional community networks (Brown-Bowers et al., 2015). It may also reduce the number of times refugee women are required to share their story and relive experiences of trauma (Firth & Haith-Cooper, 2018).

One participant, Alaa, spoke about her reluctance to revisit past experiences at prenatal appointments. She stated: "Sometimes, yeah, I think how it was back [then]…I don't talk, I don't talk with him about everything, sometimes I forget they remember me." Alaa was content to speak only about the upcoming birth of her child, she was not interested in telling her health care provider about her past. Health care providers who are familiar with circumstances in refugee women's home countries may have an idea of the kind of experiences they faced without the need for interrogation (Firth & Haith-Cooper, 2018). Cultural safety training that provides information about gender relations, politics, and ethno-religious tensions in Syria could support health care providers in their work with Syrian refugee women.

Longevity in health care provider-client relationships was associated with trust and understanding. Alaa commented:

> Its comfortable to talk with the doctor but when I'm talking with a friend she knows a lot of things about my life, about me not like the doctor that don't know me and I just go to him a few time…Maybe if I had, I know this doctor two years, three

> years, four years, yeah, maybe it would be more better…The doctors would know me more.

At the time of the interview, Alaa had been in Canada for a several years. It was surprising to hear that she had only seen her family physician a few times. It is unclear if she was seeing a new physician or if she had any medical needs prior to her pregnancy. Regardless, it is important to note that access to an obstetrician or a family physician is not guaranteed upon arrival in Canada (Redwood-Campbell et al., 2008). Physician shortages, wait lists and discrimination in the form of refusal of IFHP benefits may contribute to refugees' prolonged use of walk-in clinics (Newbold & McKeary, 2018). Fragmented care could result in misdiagnosis or nonrecognition of mental health conditions.

Fostering Authenticity and Open Communication

Offering kindness and support. Demonstrating kindness toward culturally diverse clients may be more important for the formation of therapeutic relationships than possession of discrete ethno-cultural knowledge (Brown-Bowers et al., 2015). Despite differing life experiences, perspectives and values, "respectful curiosity" can help health care providers communicate their interest in clients and develop empathic connections (Bansal, 2016, p. 43). Participants described a few techniques that health care providers used to establish rapport in the clinical setting. Gulistan commented: "Yes with the nurse…I like to talk with her…She's friendly and she, she just when she came and talk with me and love me and she give me hug, yeah." In this scenario, the Community Health Nurse used friendliness and therapeutic touch to demonstrate her interest and her desire to connect with Gulistan. Touch may not be an appropriate modality for women who

have experienced past trauma. However, it could be an important source of connection for women struggling with social isolation related to altered gender roles, family separation, language barriers and discrimination.

Another participant, Anna, noted her counselor's use of specific communication skills. She stated:

> [Language] was a barrier for me but the counselor was so supportive she was like just catching any words I'm going to say it. My English was awful at that time even though she was really supportive to try to catch a few words and, and she was like acknowledging or, or phrasing what I'm speaking and simple sentence…she was really very helpful.

Paraphrasing and reflecting on the meaning behind client's words are communication techniques that could help health care providers overcome the presence of a language barrier in provider-client interactions. As previously mentioned, language barriers can be dangerous when they prevent communication of important health information. They can also impact clients' adherence to treatment protocols (Rahman, 2016). Prioritizing health care providers' development of effective communication skills may be an important strategy for enhancing the health of Syrian refugee women.

The majority of the participants described their health care providers as helpful and kind. Chadea was the only participant to offer a suggestion for improvement. She stated: "Just smile…Yes, smile more…maybe I say what's happening…hi, how are you." Greetings and smiles were perceived as gestures of welcome and respect. Chadea stated that being offered these small kindnesses would increase her comfort and willingness to talk with health care providers.

Use of interpreters and cultural brokers. When participants were asked how their experience accessing health care services could be enhanced, nearly everyone suggested improvements in language accessibility. In particular, women suggested better provision of translation services and linguistically appropriate health information. Anna commented:

> First of all language – if we can have something like that a description of the service…Maybe have this information on Arabic…there are questions that [women] can't even, they are not able to ask it… like hidden question they always have it and I think its related directly to their well being but…they are afraid to ask it.

Clear communication is a key principle of cultural safety (Nursing Council of New Zealand, 2011). Lack of appropriate health information limits people's ability to make good health decisions (Donnelly et al., 2011). Women who are aware of mental health warning signs and services in their communities may engage in help-seeking. In this study, all participants spoke Arabic. However, for some women it was not their first language. Consideration of linguistic diversity is important for the creation and distribution of effective mental health information.

Use of interpretation and translation services was a controversial topic. Some women embraced the opportunity for clear communication with their health care providers. Other participants were more hesitant share sensitive information in front of a third-party. Gulistan supported the use of interpretation and translation services. She commented: "Oh yeah, if they are just try to understand us because our language sometimes the people not understand." Anna was careful about when she requested

translation services. She stated: “I used to see the counselor at the very beginning I prefer if I have translator but sometimes I will not have because I don’t want anybody to hear what I’m going to say.” Speaking without a translator allowed Anna to share her experiences without shame or embarrassment. Another reason for refusing a translator was perceived inaccuracy of the translations. Gorgiy commented: “Some women speak actually translate, do translate for the Syrian people and actually they can’t understand.”

One participant, Anna, spoke about the benefit of having someone from her own culture present during health care interactions. She commented: “Way better because like they, they know each other…they can predict what they might think about it or what. But like it’s the same thing when you are thinking about Canadian people and you can…like predict what…people are going to think about it, you know.” Cultural brokers are members of clients’ ethno-religious communities who can help negotiate cultural differences between clients and health care providers (Kronick, 2018). While cultural brokers may possess valuable knowledge, their presence in the clinical setting could be problematic. Women could refuse a cultural broker for the same reasons they hesitated to use a translator. That said, cultural brokers could offer needed moral support. As previously stated, differences in authority and education may deter refugee women from asserting their care preferences with health care providers (Kingsbury & Chatfield, 2019).

Gender and ethnicity of health care provider. Religion and ethnicity intersected to influence women’s preference of health care providers. Due to traditional practices of modesty and gender segregation, participants who identified as Muslim preferred to have female health care providers. Anna commented: “Yeah especially if I want to like have something like haircut or something, no, I prefer actually to have

women – special place for women and the person who is working even female, my doctor I prefer female, yeah." Female health care providers were perceived to be more understanding and compassionate of women's experiences. Alaa stated: "For the doctor the woman its more better…I don't like to see a doctor man. The woman I can explain more and she understand me more." Sara explained: "Its always better to talk to a woman doctor or a female doctor because sometimes you have some like issues and like related to, you know, female issues and maybe sometimes its embarrassing to talk to a doctor, a male doctor about them." Gender of health care providers was less of an issue for women belonging to other religious groups. Gorgiy, who is Christian, stated: "Like for me for our religion, no, it's the same thing."

As with female providers, health care providers with diverse ethno-cultural backgrounds were perceived to be more accepting. Najah commented: "Yeah, so, yeah, the family doctor is actually Japanese and I feel very comfortable with her." Another participant, Gulistan, stated: "When I give birth [name] the doctor she come here, she's from Egypt, she speak Arabic and lady I was so happy." Health care providers from diverse ethno-cultural backgrounds may be immigrants and refugees themselves or have family members who migrated to Canada. Knowledge of intersecting factors at work in migration and resettlement may increase health care providers' understanding and responsiveness to Syrian refugee women's mental health challenges. Regardless of health care providers' backgrounds, cultural safety training may increase their awareness of power relationships and assist in the negotiation of shared decision making for effective service delivery (Nursing Council of New Zealand, 2011).

Summary

This chapter examined health care provider-client relationships for culturally safe care and decision making. Protection of women's confidentiality and consistency in health care providers were important for ensuring women's safety and their trust in health care providers. Strategies for fostering authenticity and open communication in health care interactions were offering kindness and support, use of interpreters and cultural brokers and variation in health care providers' cultural backgrounds and gender.

Women were of two minds concerning interpretation and translation services. While some women felt translators improved communication, others felt uncomfortable sharing information with a third-party. Use of cultural brokers and diversity among health care providers enhanced cultural sensitivity in health care interactions. Some women perceived female and minority group health care providers as having increased understanding of their experiences and health challenges. The next chapter draws together all findings of this research study and discusses their implications for practice, policy and research.

Chapter VIII: Summary of Overall Findings, Recommendations and Conclusions

This chapter is a summary of findings from preceding chapters. I synthesize the information presented in past chapters and discuss the findings alongside existing literature. Implications and recommendations for health care practice, research and public policy are presented to improve understanding of Syrian refugee women's life circumstances and encourage the provision of supports to meet their unmet needs.

Perceptions of Mental Health and Well-Being

Women's perceptions of their mental health and well-being were influenced by cultural beliefs, fear of mental illness stigma, experiences of past trauma and resettlement stressors such as altered gender roles and financial insecurity. These factors intersected to influence women's expression of their emotional distress, their acceptance of mental health care services and their thoughts about their future in Canada. Women communicated their psychological distress as bodily ailments. Somatic symptoms included fatigue, trouble sleeping, pain and elevated hear rate. Other research with refugees identifies this transference of suffering as somatization (Lin et al., 1985). Lin et al. (1985) point out that mental health disorders may be misdiagnosed or go untreated by health care providers who are unfamiliar with the phenomenon. Prior to conducting this research, I was unaware of the phenomenon somatization. My lack of knowledge may have affected my practice as a medical nurse by preventing recognition of clients' emotional distress.

Mental illness stigma and cultural beliefs influenced women's use of mental health care services in resettlement. The majority of participants denied needing help with their mental health despite experiencing increased stress in resettlement. Only three

women accessed mental health care. Some women expressed distrust of psychotropic medications but acknowledged the benefit of talk therapy. Other participants were strongly determined to rely on themselves for strength and healing. Women perceived Self-reliance, cultivated through skills mastery, as an indicator of enhanced mental health and well-being. This perspective may relate to neoliberal ideologies in Canada that perpetuate messages about self-sufficiency (Zhu, 2016). Other indicators included self-care and a sense of hope for the future. The latter is consistent with the findings of Chan et al. (2016) who associate hope for the future with positive psychological development among refugees with past experiences of trauma. Women shared plans to obtain education, careers and Canadian citizenship. However, they acknowledged that personal and structural constraints might challenge their achievement of their goals. Gendered responsibilities and a lack of language skills were barriers to education. They also kept women from meeting language benchmarks required to apply for Canadian citizenship. I did not explore eligibility for citizenship in my review of the literature. I assumed that the only criterion of assessment was length of stay in Canada. Reflection on participant narratives has helped me recognize how native English speakers may take their skills for granted.

Determinants of Mental Health and Well-Being in the Resettlement Period

Examination of women's narratives revealed a number of contextual factors that influenced their health and well-being in resettlement. Factors that were commonly mentioned included formal and informal social support, inclusion in the wider community, altered gender roles and language skills and education. Sponsors were important sources of financial and social support in resettlement. Women were given

assistance finding housing and with language instruction. Sponsors also provided emotional support to pregnant women in the place of traditional support systems. All of the participants were privately sponsored. This prevented comparison of the levels of social support provided within the three sponsorship streams that exist in Canada. As cited in the literature review, sponsor generosity and commitment varied (Agrawal & Zeitouny, 2017). Some women remained in contact with their sponsors beyond the sponsorship period.

Settlement organizations and integration services were resources that women frequently accessed in their communities. Settlement workers assisted with women's registration for health care benefits and provided them with information about integration services. Refugee status and health care policy intersected to challenge women's access to medical coverage upon their arrival in BC. Gaps between registration and coverage availability forced some women to pay out of pocket for health care services, creating unneeded financial strain. Integration services were a welcome opportunity for women to connect with diverse groups of newcomers and learn about their resettlement experiences. Witnessing diverse groups of people come together to share experiences helped women gain an understanding of multiculturalism in Canada. Knowledge about other refugees' resettlement experiences and of multiculturalism assisted with cultural transition.

Housing support was another type of formal social support that women accessed in resettlement. High cost of living and unemployment made it difficult for some women to pay their rent. This is consistent with findings from research included in the literature review (Shier et al., 2016). As a result, women were forced to prioritize housing payments over things such as healthy food and transportation. Tuck et al. (2019) found a

higher level of unmet health care needs among refugees who were unemployed and lived in unaffordable housing. This could relate to neglect of health behaviours such as healthy eating due to housing costs. Access to housing support was complicated by refugee status. Women were required to wait until the end of their private sponsorship period before applying. This stipulation could create stress for women who are struggling with housing costs despite receiving financial assistance. Women who are afraid of appearing ungrateful may hesitate to ask their sponsors for additional help. This fear may reinforce the perspective of needing to be self-sufficient. All of the participants were very careful to express their gratitude for their private sponsors.

Sources of informal social support in resettlement were family, friends and ethno-religious communities. Friendship provided women with opportunities for relief of stress. However, the presence of a language barrier lowered the quality of communication and understanding between women and their peers. Family and ethno-religious community members were associated with shared experience, language and understanding of cultural values and perspectives. Family connections were an important source of emotional comfort for women, especially mother-child relationships. They also assisted women in balancing competing responsibilities. Family members often assumed child care duties so that women could attend language classes. Separation from family members contributed to feelings of stress and anxiety in resettlement. Citizenship was perceived as a hurdle to family reunification as women lacked the funds and clearance required for travel out of the country.

Connection to ethno-religious community members provided women with opportunities to engage in collective emotional processing. This ritual involved food

sharing and open discussion of resettlement experiences. Chung, AlQarni, Muhairi, & Mitchell (2017) explored this aspect of Arabic culture and note that Arabs' self-perceptions are often "characterized by interdependence, harmonious relationships, mutual or social obligation and social support" (p.112). Many women also demonstrated collectivism in their worship. Altruism was associated with belonging to the Muslim identity and provided many women with a sense of worth. It also provided a sense of security, as one woman felt she had a better chance of finding employment within the Muslim community.

Inclusion in the wider community was important during pregnancy. Women's connection to an extended social network reduced their feelings of isolation. Isolation has been associated with loneliness, difficulties eating and a lack of motivation to exercise during pregnancy (Bhuyan & Schmidt, 2018). Women engaged with their wider communities through activities such as cooking and volunteerism. Community involvement was influenced by gender roles and socioeconomic status. Dependence on their partners for transportation and distance from their homes to community events prevented some women's immersion in their communities. Distance was an issue because affordable housing was often located on the outskirts of settlement communities.

Altered gender roles influenced women's mental health status and their use of mental health services. Women associated expanded gender roles in Canada with the freedom of choice in their personal relationships. Freedom to choose their own husband and set boundaries within their marriage were benefits of altered gender roles. As cited in the literature review, the downside of gender role expansion was added responsibilities (Bhuyan & Schmidt, 2018; Sabir et al., 2017). Many women were unaccustomed to

balancing duties at home with work and education. Conflicts between women's home and host culture created stress and impacted their help-seeking behaviours. One woman advocated for importance of time management skills for managing the pace of life in Canada.

The ability to communicate increased women's ability to solve problems in their day-to-day lives and reduced their need for others' support. For this reason, women perceived language skills as an equalizer between themselves and their Canadian counterparts. Language skills also improved women's access to health information. Women received inaccurate health information from their partners and struggled to understand health care providers without a translator. Language skills mastery helped women seek out their own answers and neutralized power differentials operating in the clinical setting and in women's homes. Access to language classes was challenged by a lack of childcare. Childcare duties prevented some women from attending classes and restricted others to non-conventional class times.

Risk Factors Impacting Mental Health and Well-Being

Participants identified several risk factors that impacted their health in resettlement. Increased stress was associated with communication difficulties, socioeconomic insecurity, discriminatory attitudes and behaviours and family conflict. Women were keen to learn English but struggled to acquire skills fast enough. Unrealistic expectations for women's language abilities created tension in the workplace and at school. Lack of translation services was also an issue, as women may lack the time and funds required to pre-book a translator for day-to-day activities or appointments. Customer service policies that required women to provide their own translators were a structural barrier to women's

use of telephone banking services. Cultural safety training and policies may help address institutional discrimination and improve service delivery. In the hospital setting, unavailability of interpreters impacted women's ability to communicate important health information which put them at risk of adverse reactions to medical treatment. Scholars have noted poor staffing of interpreters and a lack of motivation to provide language services among health care providers (Roy, 2016). Power differentials exist between Canadian citizens and refugees regarding health care entitlement. Negative representation of refugees as undeserving of health care may influence institutional perspectives, funding decisions and policies (Rousseau et al., 2017). These in turn may influence the behaviours of health care providers towards refugees (Rousseau et al., 2017). Lack of funding for language services and refusal to provide a translator are forms of institutional discrimination that perpetuate oppression and contribute to poor health outcomes for refugees.

Unemployment and high cost of living placed women and their families at risk of poverty. Single parents and women whose husbands were unable or struggled to find high-paying work experienced food and housing insecurity. Many women sought work for the first time in their lives to help shoulder financial burdens in resettlement. However, gendered responsibilities restricted women to causal or part-time work which decreased their earnings. Credential recognition policies and language barriers also prevented women's obtainment of adequate employment. Women's exclusion from technical and high-paying jobs was consistent with findings about labor market discrimination included in the literature review (Bhuyan & Schmidt, 2018; Block & Galabuzi, 2011). Lack of upward mobility of women's socioeconomic status kept women

in unsafe housing situations. Unsafe housing was characterized by exposure to violence. As mentioned in the literature review, government loan repayment was a concern for women in resettlement (Guruge et al., 2018). One woman expressed uncertainty that she would be able to make payments and maintain a minimum standard of living. Women's feelings of financial stress and worry were compounded by prolonged family separation. Financial requirements for private sponsorship prevented women from applying to sponsor family members in Syria and other countries.

In parallel with arguments made by Clark and Saleh (2019), increased visibility contributed to women's experiences of anti-Muslim racism. Women who wore a hijab experienced threats of physical violence and avoidance in their settlement communities. In hospital, antiquated physician call-out procedures limited Muslim women's access to female health care providers. Experiences of anti-Muslim racism marginalized Syrian refugee women and contributed to their stress in resettlement. Interestingly, one woman reported using critical thinking and reflection to confront discrimination. This woman was partaking in post-secondary education that incorporated these concepts. Consideration of other people's point of view helped her to understand their antagonism and negotiate social interactions. Hearing about the threats that women faced in their day-to-day lives was alarming. Wilkins-Laflamme (2018) confirms that the threat of violence is all too real. In 2013, 65 hate crimes targeting Muslims were reported in Canada (Wilkins-Laflamme, 2018). This number may have expanded with the recent influx of Syrian refugees in Canada.

One woman identified that intimate partner violence could be a source of stress in resettlement. Consistent with the literature, this woman reported that abuse is often

hidden (Tabibi & Baker, 2017). She also noted that stigma related to intimate partner violence may impact women's help-seeking and limit their disclosure of information to health care providers. Some researchers have linked intimate partner violence to family destabilization in resettlement (Guruge et al., 2012). Altered gender roles may shift the distribution of power between women and their partners, creating tension and instability (Guruge et al., 2012). Avoidance of help-seeking could lead to the deterioration of women's health status and poor health outcomes.

Religious cultural divide between home and school also contributed some women's stress and anxiety in resettlement. Women were concerned about their children's exposure to sex-education curriculum and dating rituals at school. Cultural and religious norms in women's home countries require gender segregation and abstinence from substance use and sex. Women anticipated difficulty managing their children's behaviours outside of the home.

Health Care Provider-Client Relationships for Culturally Safe Care and Decision Making

Health care provider-client relationships that were culturally safe and supportive enhanced women's confidence and encouraged their engagement in health care decision making. Building and maintaining trust and fostering authenticity and open communication were essential components of positive health care provider-client relationships. Preserving women's confidentiality was important for building trust and assuring women's safety in resettlement. Concerns about their partners having access to their information kept women from disclosing details about their health status. Some

researchers suggest that men could use sensitive information as leverage to assert dominance in their marital relationships (Donnelly et al., 2011).

Continuity of care was also important for building and maintaining trust in health care provider-client relationships. Pregnant women were required to attend frequent prenatal appointments. One woman expressed distaste for reliving past experiences with multiple health care providers and desired a long-term therapeutic relationship. This finding is consistent with other research with pregnant migrant women. Firth and Haith-Cooper (2018) explain that constant dredging of the past may cause women to relive experiences of trauma. Physician shortages, waiting lists and discrimination in the form of refusal of women's IFHP coverage may contribute to fragmented care for refugee women (Newbold & McKeary, 2018).

Strategies for fostering authenticity and open communication in health care interactions were offering kindness and support, use of interpreters and cultural brokers and variation in health care providers' cultural backgrounds and gender. Gestures such a smile or touch were perceived as respectful and welcoming. Mutual respect was important for not only establishing rapport but also neutralizing power differentials between health care providers and clients. O'Mahony, Donnelly, Raffin Bouchal and Este (2012) point out that perceived disrespect or disinterest on the part of health care providers may exacerbate power differentials and discourage women's help-seeking. Negotiating the language barrier was also important for reducing power differentials in health care interactions. Health care providers who used communication techniques such as reflecting, and paraphrasing were perceived to be supportive of women's experiences.

Women's opinions varied on the use of interpretation and translation services. Consistent with the literature review, some women were hesitant to share information in front of a third party (Ahmed et al., 2017; Shishehgar et al., 2017). Women who preferred to use a translator in health care interactions cited improved communication and clarity. Other women were uncertain about the accuracy of translated information. One woman spoke about the benefit of having someone from her own culture present during health care interactions. She felt that individuals who shared her ethno-religious background might be less judgmental and better able to anticipate her needs and responses to information. Fear of being judged has been noted to discourage disclosure of information in other research with refugee women (O'Mahony & Donnelly, 2007). Cultural brokers may help clients and health care providers negotiate health care interactions (Kronick, 2018). However, their presence may also raise privacy concerns. Women's preference for female health care providers is consistent with research findings noted the literature review (Khanlou et al., 2017). Some women perceived female and minority group health care providers as having increased understanding of their experiences and health challenges. O'Mahony and Donnelly (2007) suggest that health care providers' familiarity with their clients' ethno-cultural backgrounds may facilitate the development of therapeutic relationships. Health care providers with first or secondhand knowledge of migration and resettlement may have a better idea of the challenges that women face and may be more sensitive to power differentials present in health care provider-client relationships. Cultural safety training that addresses multiple social and cultural realities may increase health care providers' awareness of power relationships and assist in the

negotiation of shared decision making for effective service delivery (Nursing Council of New Zealand, 2011).

Implications for Mental Health Care Practice

The findings of this research have several implications for mental health care practice with Syrian refugee women. In the following paragraphs, I present recommendations for health care providers who are interested in building positive therapeutic relationships and providing culturally safe mental health care. Health care providers' role in advocacy is also discussed.

When assessing Syrian refugee women's mental health status, health care providers might consider psychological sources of pain and other physical ailments. During interviews, some women denied changes in their mental health status but reported experiencing insomnia, pain, fatigue and elevated heart rate due to stress in resettlement. Clients have opportunity to negotiate culturally safe and effective health care. Women who accessed mental health services were wary of the efficacy of medications and expressed an interest in talk therapy. Accordingly, I suggest health care providers consider options other than psychotropic medications for the treatment of mental health disorders. Supporting women's use of self-care practices may also promote cultural safety. Some women felt very strongly about looking inwards for strength during resettlement. Behaviours such as engaging in physical activity and taking time away helped them manage their emotions and confront stressful situations. Health care providers need to be aware of gaps between registration for provincial health coverage and availability of benefits. Awareness of gaps in health coverage may influence health care decision making.

When initiating therapeutic relationships with Syrian refugee women, health care providers need to take time to explain confidentiality laws and establish the clinical setting as a safe space. Concerns about their information being shared with their partners may prevent Syrian women from disclosing information about their mental health status. It's important for health care providers to be vigilant for signs of hidden abuse and, when appropriate, offer information about intervention and support services. On behalf of the Canadian Psychiatric Association, Stewart, MacMillan and Wathen (2011) recommend that health care providers offer education on healthy relationships, promote public awareness of intimate partner violence and advocate for prevention policies. To help foster mutual respect and cultural safety in provider-client relationships, health care providers might consider offering gestures such as a smile or comforting touch. Development of effective verbal and non-verbal communication techniques may also be beneficial. Techniques such as reflecting and paraphrasing were helpful for overcoming the language barrier between one woman and her health care provider. Regardless, health care providers need to be aware of and consistently offer translation and interpretation services in health care interactions. Advocating for language diversity in health information available to clients and the public is also key. Women may receive inaccurate information from their partners or be unaware of available health services.

Health care providers are in an optimal position to advocate for the rights of refugees within health care institutions, health professions and society (Rousseau et al., 2008). I urge individuals working with Syrian refugee women be aware of and confront negative attitudes and perceptions about refugees. Discriminatory attitudes and behaviours marginalize women and negatively impacted their sense of self. A part of

confronting discrimination is protection of women's religious freedom. Religious practices influenced many women's preference for a female health care provider. Advocating for women's access to female health care providers is important for their safety in health care interactions and their use of health care services. Advocating for increased ethno-cultural diversity in health care education programs is also important. Health care providers who know what it is like to be a newcomer to Canada may have a better understanding of and be more responsive to women's health challenges.

Implications for Public Policy

Multilevel interventions are needed to effectively tackle differences in mental health outcomes for Syrian refugee women. While health care providers can intervene at the micro and meso levels to support women's mental health outcomes, their power to affect entire communities and social systems is limited. Healthy public policy is needed to promote mental health outcomes on a larger scale. The following are recommendations for policy makers who are interested in building healthy public policy that is culturally safe and supportive of Syrian refugee women's mental health and well-being. Policy that is culturally safe pays attention to the unequal distribution of resources such as wealth and education in society (Mackean, Fisher, Friel & Baum, 2019).

Policy makers might consider prioritizing funding for settlement organizations and integration services. Settlement organizations helped women register for health care benefits and facilitated their connection to housing support. Integration services provided opportunities for women to network with other newcomers and learn about cultural differences in Canada. Another priority might be building a universal, affordable child care system. High cost and unavailability of childcare services challenged women's

obtainment of language skills, education and adequate employment. As a result, many women struggled to pay their rent and experienced food and housing insecurity. Funding affordable housing projects and developing rent control policies may support women's financial stability. Other considerations include extending federal loan repayment or loan forgiveness programs. Women who are already struggling to pay their rent may not be able to make loan payments and maintain a minimum standard of living.

Many women were keen to continue their education in Canada but perceived language and cost as barriers. One woman with technical skills for the development of cancer treatments was unable resume work here in Canada. Funding refugee education and re-training programs may promote skilled workers' entry to the workforce. Policy makers who support refugee women's success in resettlement may also review eligibility for family reunification programs. Prolonged family separation contributed to women's stress in resettlement. Final suggestions include funding refugee sponsorship training programs and building a system for the regulation of private sponsors. Women reported receiving varying levels of emotional, financial and social support from their private sponsors. Training and support regarding determinants of mental health may decrease the burden of responsibility placed on private sponsors and improve Syrian refugee women's mental health outcomes.

Implications for Research

Researchers invested in studying the health and mental health of Syrian refugee women might consider using an intersectional lens to not only enhance their understanding of women's resettlement experiences but also promote cultural safety. Recognition of multiple social categories and power differentials is central to cultural

safety (Nursing Council of New Zealand, 2011) and may assist community members, health care providers and organizations involved in women's resettlement. Qualitative and mixed-methods studies that use intersectionality may also give voice to Syrian refugee women and allow them to engage in storytelling as a form of resistance against oppressive systems and structures (MacDonnell et al., 2017).

This study focused on the experiences of women who had been living in Canada for three years or less. Longitudinal research is needed to explore Syrian refugee women's health and well-being and their use of mental health services in the years after resettlement. Participants for this study were recruited from small communities in the Interior region of BC. The literature review revealed that research with refugees has often focused on large urban centers. Further research exploring the experiences of refugee women living in small communities may reveal differences in the level and kinds of social support available to refugees, as well as differences in their inclusion in their wider settlement communities.

Limitations

This study has certain limitations. Recruitment response was low in the communities included in the study. A small sample was selected to obtain narrative data that was information rich and thick in description. One participant identified as belonging to an ethnic group other than Arab and a religious group other than Muslim. It is known that the Syrian population is comprised of a variety of ethnic and religious groups (Citizenship & Immigration Canada, 2015). For these reasons, the generalizability of the data will be limited (Polit & Beck, 2017). The scope of the investigation could have been broadened by using a larger, more diverse sample of Syrian refugee women.

Conclusion

The prolonged state of civil war in Syria has caused a large influx of Syrian refugees in Canada. Statistics from May 2018 indicate that Canada has welcomed approximately 54,560 Syrian refugees, of whom three in four are women and children (Guruge et al., 2018). Refugees may face overwhelming stress related to experiences of migration and resettlement that may impact their health and well-being (Newbold & McKeary, 2018). Immigrant and refugee women in particular are known to experience poorer health and mental health outcomes than their Canadian counterparts (Bhuyan & Schmidt, 2018). Examination of intersecting factors of mental health such as gender, race, ethnicity, religion, language, socioeconomic status and discrimination are important for understanding Syrian refugee women's health outcomes (Clark, 2018; Guruge et al., 2018).

This research explored Syrian refugee women's self-perspective of their mental health and well-being in the resettlement period and their experiences accessing mental health services. Multiple factors including past trauma, cultural beliefs and fear of mental illness stigma influenced Syrian refugee women's perception of their mental health and well-being in resettlement. Mental health determinants such as formal and informal social support simultaneously supported and challenged women's well-being and access to health care services. Risk factors such as communication difficulties and discriminatory attitudes and behaviours increased women's stress and anxiety and negatively impacted their mental health and well-being. Culturally safe and supportive health care provider-client relationships were found to be supportive of Syrian refugee women's engagement in health care decision making.

Knowledge gained from this research may contribute to increased awareness of the challenges Syrian refugee women face in resettlement, as well as their strength and determination for a better life for themselves and their families in Canada. Recommendations for health care providers may assist in the provision of culturally safe mental health care services. Health care providers have a professional responsibility to stay informed of and incorporate research into their practice (O'Mahony, 2005). Recommendations for policy makers may support the development of healthy public policy that is grounded in women's experiences and supportive of their health and well-being.

Several knowledge translation activities will be used to disseminate findings of this research. These activities include sharing findings with Syrian refugee women, health care providers, stakeholders, and community members. Findings will be shared with Syrian refugee women directly and through key informants. A publication and conference will assist with sharing the findings to broader audiences such as stakeholders and community members. The complete publication will also be sent to the Minister of Health for the province of BC.

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Appendix A: Participant Demographics

Table 1: Participant Profiles

Participant	Age	Refugee Status	Place of Birth	Time Living in Canada	Number of Family Members in Canada	Number of Children
1	30	PSR	Homs	1 year, 8 months	0	6
2	37	PSR	Homs	9 months, 16 days	2	6
3	26	PSR	Homs	3 years, 6 days	2	3
4	33	PSR	Damascus	2 years, 9 months	6	0
5	27	PSR	Homs	2 years, 2 months	Yes; No number given	2
6	30	PSR	Aleppo	3 years	0	5
7	33	PSR	Qamishli	3 years	1	3
8	27	PSR	Homs	2 years, 2 months	8	4
9	47	PSR	Homs	3 years	7	11

*PSR = Privately Sponsored Refugee

Table 2: Education and Employment

Participant	Level of Education	Current Employment/ Hours
1	Secondary School	Yes; Part time <30h/week
2	Elementary School	No
3	University degree	No
4	University degree in progress	No
5	Secondary School	No
6	Secondary School	No
7	University degree in progress	No
8	Elementary School	No
9	Elementary School	No

Table 3: Mental Health Profile and Preferences

Participant	Mental Health Concerns	Has Seen Doctor About Mental Health	Use of Other Formal Support	Use of Traditional or Western Medicine
1	No	No	No	Western Medicine
2	Yes; Worried about finances	No	No	Western Medicine
3	No	Yes	Community Health Nurse	Both; Traditional medicine for simple illnesses like cough
4	Yes; Pressure at school, housing concerns	No	Counsellor	Western Medicine
5	No	Yes	No	Western Medicine
6	Yes; Felt lonely after arrival in Canada	No; Has an appointment	Community Health Nurse	Western Medicine
7	No	No	No	Both; Traditional medicine for something like cold or toothache
8	No	No	No	Western Medicine
9	No	No	No	Western Medicine

Appendix B: Interview Questions

Preliminary questions

1. When did you come to Canada and what were the reasons you left your home?
    a. Were you someplace else before coming to Canada?
2. Can you please describe what your typical day looks like ? What do you usually do?
3. How is this different than your lifestyle before you came to Canada?
    a. What do you like the best about living in Canada?
    b. What do you like the least?

Questions about mental health and mental health services

4. What does mental health mean to you?
    a. What are some things you do or would like to do to feel mentally healthy?
    b. Are any of these things related or affected by moving to a new community or culture?
5. How would you describe or did you perceive your mental health in Syria?
    a. How has this changed after coming to Canada?
6. What services have you used or would like to use to improve your mental health?
    a. What effects your decision to use or not use these services?

Appendix C: Sociodemographic Questionnaire (English)

TITLE: Syrian Refugee Women's Perspectives About Their Mental Health and Well-being in the Resettlement Period

PURPOSE: The purpose of this study is to explore Syrian refugee women's unique perspectives around their mental health and well-being in the resettlement period in Canada. This question- naire is designed to collect is socio-demographic information that will be used to guide interview questions. The information collected will be used in a table that does not contain identifiers and will appear in publication materials.

CONFIDENTIALITY: Do NOT put your name on this questionnaire. Identifying information will be kept confidential. Questionnaires will be scanned into the graduate student researcher's computer and stored as encrypted files. Hard copies will be kept in a locked drawer in the princi- ple investigators office.

DO I HAVE TO COMPLETE IT? Your completion of this questionnaire is voluntary. You may withdraw participation at any point without further consequences. Your collected information will be destroyed. There is no risk associated with your completion of this questionnaire. Bene- fits to your completion of this questionnaire include: anonymity, and a streamlined interview process.

If you chose to complete the questionnaire it will be assumed that consent has been given for in- formation to be used in study and publication materials.

Please check the appropriate boxes and write answers in the spaces provided. You may take as much time as you need to complete the questionnaire.

What is your Age? _____

What is your Birthplace? _____

How long have you been living in Canada? _____

What is your current city of residence? _____

What is your relationship status? Please check the option that best applies:

Single _____ Married _____ Divorced _____ Widow _____

Do you have any children? If yes, please indicate how many:

Yes _____ No _____ Amount _____

Do you have any extended family members in Canada? If yes, please indicate how many:

Yes _____ No _____ Amount _____

What language(s) do you mainly speak at home?

_____

_____

What is your highest level of educational achievement?

None ____ Elementary School ____ Secondary School ____ University Degree ____

Are you currently employed?

Yes _____ No _____

If you are employed, do you work:

Full Time _____(30 or more hours/week) Part Time _____(less than 30 hours/week) Temporary _____ (hours are dependant on need for labour)

Are you currently in a volunteer position? Yes _____ No _____

Where _____

Do you have any concerns about your mental health or well-being? If yes, please explain:

_____

_____

Do you use mainly: Traditional medicine ____ Western medicine ____

If you use Traditional medicine, please explain:

_____

_____

Have you seen a doctor about your mental health or well-being since you've come to Canada?

Yes _____ No _____

Have you used other sources of formal support:

Community Health Nurse ____ Health Link ____ Other ____

If you chose Other, please explain:

_____

_____

Do you participate in (check all that apply):

Ethnic community events _____ Religious community events _____

Other community events _____

Adapted from O'Mahony (2011).

Appendix D: Sociodemographic Questionnaire (Arabic)

العنوان : وجهات نظر اللاجئات السوريات حول صحتهن النفسيه وعافيتهن في فترة إعادة التوطين.

الهدف :
الهدف من هذه الدراسه هو استكشاف وجهات نظر النساء اللاجئات السوريات الفريدة حول صحتهن النفسيه وعافيتهن في فترة إعادة التوطين في كندا. هذا الأستبيان تم تصميمه لجمع معلومات أجتماعيه ديموغرافيه ليتم إستخدامها لتوجيه أسئلة المقابله. المعلومات التي تم جمعها سوف يتم إستخدامها في جدول لايحتوي على مُعرِفات وسوف تظهر في مواد النشر.

السريه :
لاتضعي إسمك في هذا الأستبيان. سوف يتم الأحتفاظ بمعلومات تحديد الهويه في سريه. سوف يتم المسح الضوئي للأستبيانات وتخزينها كملفات مشفره في الحاسوب الخاص بطلاب الدراسات العليا. سوف يتم حفظ النسخ الورقيه في درج محكم الأغلاق بالمكتب الأساسي للباحثين.

هل يجب علي إكماله؟
أكمالك لهذا الأستبيان تطوعي. بإمكانك سحب مشاركتك عند أي نقطه بدون المزيد من العواقب. سوف يتم إتلاف معلوماتك التي تم تجميعها. ليس هناك أي مخاطره مرتبطه لأكمالك هذا الأستبيان. فوائد إستكمال هذا االأستبيان تشمل : عدم الكشف عن الهويه ، وخطوات مقابله إنسيابيه.
إذا أخترتي أستكمال الأستبيان سوف يتم الأعتبار أنه تم الحصول على موافقه لأستخدام المعلومات في الدراسه والنشر.
يرجى التحقق من المربعات المناسبة وكتابة الإجابات في الفراغات المتوفرة. من الممكن أخذ الوقت الكافي الذي تحتاجينه لإكمال هذا الأستبيان.

ملحق د(تكمله) : أستبيان أجتماعي ديموغرافي

ماهو عُمرِك ؟ _____

ماهو مكان ولادتك ؟ _____

منذ متى وأنت تعيشين في كندا؟ _____

ما هي المدينه الحاليه المقيمه بها ؟ _____

ماهي حالتك الأجتماعيه ؟ الرجاء وضع علامه على الأختيار الذي ينطبق عليكِ :
عزباء_____ متزوجه_____ أرمله_____ مطلقه _____

هل لديك أي أطفال ؟ إذا نعم ، يرجى الإشاره إلى عددهم :
نعم _____ لا_____ عددهم _____

هل لديكِ أي أقارب في كندا؟ إذا نعم يرجى الأشاره إلى عددهم :
نعم _____ لا _____ عددهم _____

ماهي اللغه (اللغات) التي تتحدثون بها بشكل رئيسي في المنزل ؟ _____
_____

ماهو أعلى مستوى من التحصيل العلمي حصلت عليه؟
لايوجد_____ مدرسه إبتدائيه_____ مدرسه ثانويه_____ درجه جامعيه_____

هل أنتِ موظفه حالياً ؟
نعم_____ لا_____

إذا كنتِ تعملين ، هل تعملي :
دوام كامل_____ (٣٠ ساعه أو أكثر في الأسبوع). دوام جزئي_____ (أقل من ٣٠ ساعه في الأسبوع)
مؤقتاً_____(عدد الساعات يعتمد على حسب الحاجه للعماله)

هل أنتِ حالياً متطوعه في أي منصب؟
نعم _____ لا_____ أين _____

ملحق د(تكمله) : أستبيان أجتماعي ديموغرافي

هل لديك أي قلق بخصوص حالتك النفسيه أو صحتك الجسمانيه ؟ إذا نعم، الرجاء التوضيح:

_____
_____
_____

هل تستخدمين بشكل رئيسي:
الطب التقليدي_____ الطب الغربي_____
إذا كنتِ تستخدمين الطب التقليدي الرجاء التوضيح:

_____
_____
_____

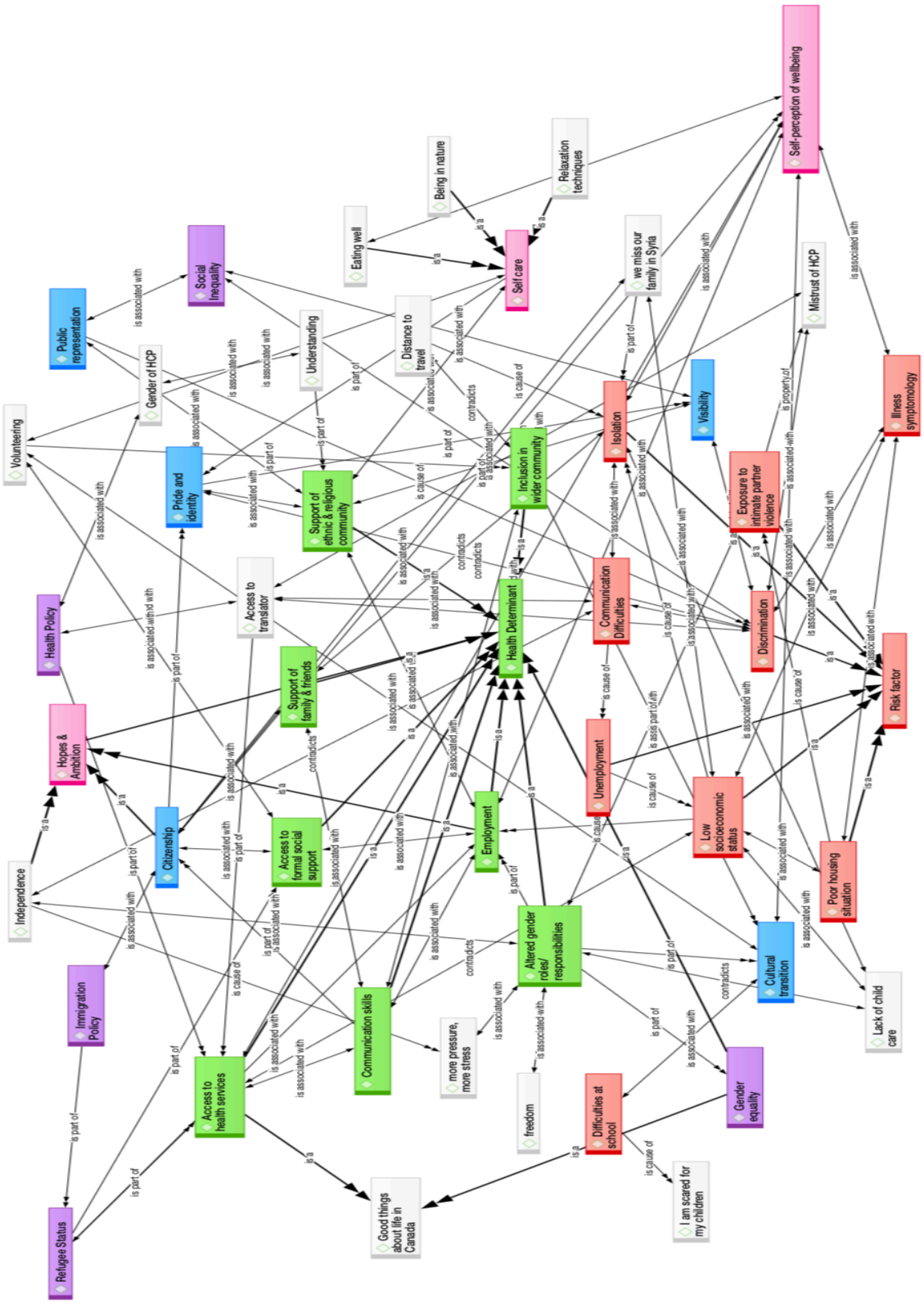
هل رأيتِ طبيبا / طبيبةً بخصوص حالتك النفسيه أوصِحتك الجسمانيه منذ حضورك إلى كندا؟
نعم_____ لا_____
هل إستخدمتِ مصادر أخرى للدعم الرسمي:
ممرض/ ممرضه صحة مجتمع_____ رابط صحي_____ أخرى_____
إذا أخترت أخرى ، الرجاء التوضيح

_____
_____
_____

هل تشاركين في (ضعي علامه على كل ماينطبق عليكي):
أنشطه إجتماعيه عرقيه_____ أنشطه إجتماعيه دينيه_____
أنشطه إجتماعيه أخرى_____

Adapted from O'Mahony (2011). معدل من

Appendix E: Mind Map



Appendix F: Ethics Approval

December 5, 2018

Ms. Jessica Bauer
School of Nursing\Nursing Thompson Rivers University

File Number: 101981
Approval Date: December 05, 2018 Expiry Date: December 04, 2019

Dear Ms. Jessica Bauer,

The Research Ethics Board has reviewed your application titled 'Syrian Refugee Women's Perspectives About Their Mental Health and Well-being in the Resettlement Period'. Your application has been approved. You may begin the proposed research. This REB approval, dated December 05, 2018, is valid for one year less a day: December 04, 2019.

Throughout the duration of this REB approval, all requests for modifications, renewals and serious adverse event reports are submitted via the Research Portal. To continue your proposed research beyond December 04, 2019, you must submit a Renewal Form before December 04, 2019. If your research ends before December 04, 2019, please submit a Final Report Form to close out REB approval monitoring efforts.

If you have any questions about the REB review & approval process, please contact the Research Ethics Office via 250.852.7122. If you encounter any issues when working in the Research Portal, please contact the Research Office at 250.371.5586.

Sincerely,
Andrew Fergus
Acting Chair, Research Ethics Board

Appendix G: Informed Consent Form (English)

INFORMED CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

TITLE: Syrian Refugee Women's Perspectives About Their Mental Health and Well-being in the Resettlement Period

WHO IS DOING THE STUDY?

This research is conducted by Jessica Bauer RN MN student and Dr. Joyce O'Mahony RN PhD in the School of Nursing at Thompson Rivers University.

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore Syrian refugee women's unique perspectives around their mental health and well-being in the resettlement period in Canada.

WHO CAN PARTICIPATE?

You are being invited to participate in this research because you are a newcomer to Canada and are settled within the Interior region of British Columbia. There are ten participants anticipated to take part in the study.

WHAT WOULD I HAVE TO DO?

If you agree to participate, ethical consent will be obtained from you with full explanation of the intent of this study. The researcher, a community/settlement agency representative, and a translator (if needed) will conduct standard intake processes and ensure you understand the confidentiality and privacy standards. Interviews approximately 60 minutes in duration will occur from November 2018 - January 2019 according to participant and researcher availability. Participants will chose the location of interviews. A short questionnaire will be administered before interview sessions to gather socio-demographic information. Informal de-briefing with the researcher will occur at the

end of interviews. Interview audio and text will also be a part of the information collected. As the purpose of the study is to reveal your individual unique stories, you may choose to have your first name included when quotes from the study are used in publication. This is NOT a requirement, and those who decline will be assigned a pseudonym. Confidentiality will be protected at all times.

WHAT ARE THE RISKS AND BENEFITS?

There are minimal risks associated with your participation in this research study. However, interview questions may trigger strong emotional responses in some participants. Sensitive topics will be avoided but may be brought up in discussion by participants. Individuals who experience distress as a result of interviews will be referred to counselling services provided by agencies that helped recruit participants for the study. Information we receive from this study may inform culturally safe mental healthcare services and healthy public policy locally, provincially for women living in the Interior region of British Columbia. Further benefits of participating include normalizing symptoms, freedom of expression, increased self-efficacy, and empowerment. A copy of the completed study and any publication materials will be sent to community/settlement agency contacts that assisted in participants' recruitment for dispersal to participants.

DO I HAVE TO PARTICIPATE?

Participation in this study is voluntary and you may withdraw from the study at any time without further consequences. If you choose to withdraw from the research study let Jessica Bauer or Dr. Joyce O'Mahony know. You are not required to provide reasons for your non-participation in the study. Your data will be removed from the study and destroyed.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

Your participation in this study is voluntary. There is no cost associated with your participation. Monetary compensation will not be provided for your time.

WILL MY RECORDS BE KEPT PRIVATE?

Confidentiality will be protected at all times. The lead researcher and supervisor will have access to data collected. All participants, unless permission has been given to use first names, will be identified by pseudonym only. All data published will maintain the confidentiality of all participants. Computer access to data will be through password only and use of encrypted electronic files. Firewall/virus protection will be utilized at all times. Data collected will be kept in a locked and secure environment in Dr. Joyce O'Mahony's office. Any paper containing data will be shredded and destroyed in a secure manner. The interview tapes will be destroyed in five years after completion of study.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your employment or any other benefit to which you are otherwise entitled. If you have further questions concerning matters related to this research, please contact:

Dr. Joyce O'Mahony (250) 377-6138 or via email jomahony@tru.ca Jessica Bauer (250) 819-8398 or via email jessie-bauer@live.ca

Or Dr. Donna Murnaghan, Dean, School of Nursing (250) 828-5401 or via email dmurnaghan@tru.ca at Thompson Rivers University.

If you have any questions concerning your rights or treatment as a possible participant in this research, please contact the Chair, of the TRU Research Ethics Board, at 250-828-5000 or TRU- REB@tru.ca.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix H: Informed Consent Form (Arabic)

THOMPSON RIVERS UNIVERSITY
School of Nursing

موافقه مسبقه للأشتراك في مشروع بحث

العنوان : وجهات نظر النساء الاجئات السوريات بخصوص صحتهن النفسيه وعافيتهن خلال فترة إعادة التوطين.

من الذي يقوم بإجراء هذه الدراسه؟

يقوم بإجراء هذا البحث جيسيكا باورممرضه مسجله و طالبه ببرنامج الماجستيرفي التمريض والدكتوره جويس اؤماهوني ممرضه مسجله حاصله على درجة الدكتوراه من مدرسة التمريض بجامعة تومبسون ريفيرز.

نموذج الموافقه هذا هو جزء من عملية موافقه مسبقه. أنه يعطيكِ فكره أساسيه عما يدور حوله البحث وعن ماذا سوف تشمل مشاركتك. من فضلك إسألي إذا اردتِ المزيد من التفاصيل عن أي شئ تم ذكره هنا، أو عن معلومات غير متضمنه هنا. خذي الوقت الكافي لقراءة هذا بعنايه ولفهم أي معلومات مرفقه. سوف تحصلين على نسخه من هذا النموذج.

ماهو الهدف من الدراسه؟

الغرض من هذه الدراسه هو أستكشاف وجهات النظر الفرديه للسيدات السوريات الاجئات حول صحتهن النفسيه وعافيتهن خلال فترة إعادة توطينهن في كندا.

من يستطيع المشاركه؟

أنتِ مدعوه للمشاركه في هذا البحث لأنكِ وافده جديده إلى كندا وتستقرين في المنطقه الداخليه لبريتيش كولومبيا. من المتوقع أن يشارك في هذه الدراسه عشر مشاركات.

ماذا يجب أن أفعل؟

إذا وافقتِ على المشاركة في هذا البحث سوف يتم الحصول منكِ على موافقه أخلاقيه مع توضيح كامل عن الهدف من هذه الدراسه. الباحث ، مندوب وكالة أستقرار/ مجتمع، ومترجم (إذا أحتاج الأمر) سيقوم بإجراء مقابله أوليه نموذجيه والتأكد من فهمِك لمعايير السريه والخصوصيه.

تستغرق المقابلات حوالي ستون دقيقه وسيتم إجرائها في يناير ٢٠١٩ على حسب توافر المشاركات والباحث. سوف تقوم المشاركات بإختيار مكان المقابلات. سيتم أعطاء المشاركات أستبيان قصير قبل جلسات المقابله للحصول على معلومات إجتماعيه ديموغرافيه. في نهاية المقابلات سوف يكون هناك أحاطه (إستخلاص معلومات) غير رسميه مع الباحث.

الصوت والنص الخاص بالمقابله سوف يكون جزء من المعلومات التي تم الحصول عليها. حيث أن الهدف من الدراسه هو إظهار قصصك الفرديه الفريده .

من الممكن أن تختاري إضافة إسمِك الأول عندما تستخدم إقتباسات من الدراسه في النشر وهذا ليس إلزامي حيث أن المشاركات الاتي يرفضن ذلك سوف يتم تعيين إسم مستعار لهن . ستكون السريه محميه في جميع الأوقات.

ماهي المخاطر والمزايا ؟

هناك حد أدنى من المخاطر المرتبطة بمشاركتك في هذه الدراسة البحثية . لكن قد تثيرأسئلة المقابله ردود فعل عاطفية قوية في بعض المشاركات. سوف يتم تجنب الموضوعات الحساسه ولكن يمكن طرحها في المناقشه من قبل المشاركات. إذا شعرن المشاركات بالحزن أوالأسى بسبب المقابلات سوف يتم تحويلهن إلى خدمات تقديم المشوره مقدمه من قبل الوكالات التي ساعدت في إنتساب المشاركات في الدراسه. المعلومات التي نحصل عليها من هذه الدراسه من الممكن أن تتطلع عليها خدمات الرعايه النفسيه الآمنه ثقافياً، وسياسة الرعايه الصحيه المحليه والأقليميه للسيدات الاتي يعشن في المنطقه الداخليه لبريتيش كولومبيا. هناك أيضاً فوائد أخرى تشملها المشاركه وهي : الحد من الأعراض ، حرية التعبير، زيادة الكفاءه الذاتيه ، والتمكين. سوف يتم إرسال نسخه من الدراسه المكتمله وأي مواد نشرإلى وكالة أستقرار/ مجتمع التي ساعدت في إنتساب المشاركات لتوزيعها على المشاركات.

هل يجب أن أشارك؟

المشاركة في هذه الدراسة اختيارية ويمكنك الانسحاب من الدراسة في أي وقت بدون عواقب إضافيه.
إذا أخترتي الأنسحاب من الدراسه البحثيه قومي بإبلاغ جيسيكا باور أوالدكتوره جويس اوْماهوني. أنتِ غير مطالبه بإبداء أسباب عدم مشاركتك في الدراسه. سيتم إزالة بياناتك من الدراسة والتخلص منها.

هل سأحصل على أجر مقابل مشاركتي أو هل علي أن أدفع مقابل أي شئ ؟

مشاركتك في هذه الدراسه تطوعي . لا توجد تكلفة مرتبطة بمشاركتك . لن يتم إعطائِك تعويض نقدي لمشاركتك. في نهاية المقابلات سوف يتم إعطاء كل مشاركه علبه من القهوة العربية (التركية) كرمز تقديري.

هل سيتم الأحتفاظ بسجلاتي في سريه؟

سيتم حماية السرية في جميع الأوقات. سيتمكن الباحث والمشرف من الوصول إلى البيانات التي تم جمعها. جميع المشاركات (إلا إذا تم إعطاء السماح بإستخدام الأسماء الأولى) سوف يتم تعريفهن بإستخدام أسماء مستعاره. ستحافظ جميع البيانات المنشوره على سرية جميع المشاركات.
سوف يكون الدخول إلى بيانات الحاسوب فقط بإستخدام كلمة سر وبإستخدام ملفات إلكترونيه مشفره. سيتم استخدام جدار الحماية / الحماية من الفيروسات في جميع الأوقات. سوف يتم الأحتفاظ بالبيانات التي تم جمعها في مكان محكم الأغلاق وآمن بمكتب الدكتوره جويس اوْماهوني. أي بيانات على الورق سيتم تمزيقها والتخلص منها بطريقه آمنه.
سوف يتم إتلاف شرائط المقابله بعد خمس سنوات من إنتهاء الدراسه.

إمضاءات

إمضائِكِ على هذا النموذج يشير إلى أنكِ فهمتِ المعلومات بخصوص مشاركتك في مشروع البحث برضاء وموافقه على الإشتراك كمشاركه. قطعاً لايقوم هذا بتنازلك عن حقوقك القانونيه أو بإعفاء الباحثين أو المؤسسات المشاركه من مسئولياتهم المهنيه أو القانونيه. لديكِ الحريه في الأنسحاب من الدراسه في أي وقت بدون المجازفه بعملِك أوأي منتفع على خلاف ذلك تستحقينه. إذا كان لديك المزيد من الأسئلة بخصوص الأمور المتعلقة بهذا البحث ، يرجى الأتصال ب:

الدكتوره جويس اوْماهوني ٢٥٠٣٧٧٦١٣٨
أو عن طريق البريد الألكتروني jomahony@tru.ca

جيسيكا باور ٢٥٠٨١٩٨٣٩٨
أو عن طريق البريد الألكتروني jessie-bauer@live.ca

أو الدكتوره دونا مرناجهان، عميدة ، مدرسة التمريض ٢٥٠٨٢٨٥٤٠١
أو عن طريق البريد الألكتروني dmurnaghan@tru.ca بجامعة تومبسون ريفيرز.

إذا كان لديك أي أسئلة بخصوص حقوقك أوطريقة معاملتك كمشاركه محتمله في هذا البحث ، يرجى الاتصال برئيس مجلس أخلاقيات البحث لجامعة تومبسون ريفيرزعلى الرقم ٢٥٠٨٢٨٥٠٠٠
أوالبريد الألكتروني TRU-REB@tru.ca

أسم المشاركه الأمضاء والتاريخ

أسم الباحث/ المندوب الأمضاء والتاريخ

أسم الشاهد الأمضاء والتاريخ

لقد تم إعطائِك نسخة موقعة من نموذج الموافقة هذا للاحتفاظ بها بسجلاتك ومراجعك.

Appendix I: Information Letter for Key Informants

[Contact Name]
Immigrant Services Team Lead & Refugee Resettlement Coordinator
[Agency Name]
December 11, 2018

This letter is to provide you with some information on the forthcoming research study "Syrian Refugee Women's Perspectives About Their Mental Health and Well-being in the Resettlement Period." I am hopeful you will be able to help with recruitment of some research participants. Firstly, my name is Jessica Bauer and I am a Master of Nursing (MN) student at Thompson Rivers University in Kamloops, British Columbia. This research is part of my MN degree. My supervisor is Dr. Joyce O'Mahony RN PhD, Associate Professor in the Faculty of Nursing at Thompson Rivers University.

The purpose of this research project is to explore with Syrian refugee women their unique perspectives around their mental health and well-being in the resettlement period in Canada. I am interested in learning about Syrian refugee women's experiences with accessing mental health services in the Interior region of BC, and how contextual factors impact their mental health and well-being in the resettlement period. An essential goal of this study is to increase the understanding of what would be most helpful in meeting Syrian refugee women's mental health needs. Syrian refugee women's perspectives will inform culturally safe mental healthcare services and healthy public policy.

I am seeking ten Syrian refugee women to participate in the study. Inclusion criteria: i) Syrian refugee women, ii) 18-35 years, iii) English speaking (preferred), iv)

settled within the Interior region of BC ≤ 3 years. Women identifying with a variety of Syrian ethnic groups (i.e., Arabs, Armenians, and Kurds) and religious faiths (i.e., Muslim, Christian, and Jewish) are of interest. Participants will be invited to an interview that will go on for a duration of approximately 60 minutes. Interviews will occur in January 2019. Participants will determine the location of interviews. Possible interview settings are the participant's residence or community/settlement agency. A questionnaire consisting of short-answer questions and checkboxes will also be utilized for collection of socio-demographic information.

If requested by the participant, representatives who are familiar to participants (such as a counsellor, caseworker, or settlement worker) can be present during interviews. The researcher will notify [Agency name] of any participants who experience emotional distress during interviews. [Agency name] will have counselling service contacts available if any level of distress is experienced. There are no anticipated risks associated with participation in this research study, however, interview questions may trigger strong emotional responses in some participants. Last, if participants do not speak English, assistance from [Agency Name] or recommendation for low cost translation services would be greatly appreciated. In return for your invaluable assistance, [Agency Name] will be recognized by name and or logo in any publications or presentations that result from the study. [Agency Name] staff will be invited to attend any public presentations.

If you know of any individual(s) who fit the inclusion criteria and who are interested in participating in the study please contact me at jessie-bauer@live.ca or by

phone at (250) 819-8398. I am also very happy to meet with you in person to discuss or answer any further questions you might have.

Sincerely,

Jessica Bauer RN MN student