Exploration of the Quality of Life and the Impact of Settlement Experiences of Adult Male Syrian Refugees Living in Jordan: Focusing on the Mental Health

Mousa Haron Jawasreh

PhD 2021

Exploration of the Quality of Life and the Impact of Settlement Experiences of Adult Male Syrian Refugees Living in Jordan: Focusing on the Mental Health

Mousa Haron Jawasreh

A thesis submitted in partial fulfilment of the requirements of the Manchester Metropolitan University for the degree of Doctor of Philosophy

Faculty of Health, Psychology and Social Care

2021

Abstract

By the end of 2019 the global number of refugees reached 79.5 million; the top source country being Syria with 6.6 million in total (United Nations High Commissioner for Refugees, 2020).

This research aimed to understand the impact of displacement on the quality of life of Syrian refugees settling in Jordan, with a specific focus on mental health. The focus on mental health shed light on the impact of torture and trauma experiences and subsequent mental health conditions. The study sought to investigate the perspectives and worldviews of the adult male Syrian refugees in one specific refugee camp and employed a generic qualitative design. Qualitative data was collected from seventeen adult male participants in the form of semi-structured interviews conducted face-to-face in Jordan. The research explored the lifestyle and circumstances of adult male Syrian refugees and how this affected their quality of life and mental health. The participants reported the impact of changes in culture, education and work since they arrived in the refugee camps, and the effect on their mental health throughout the years they had spent as refugees (2011-2019).

This study reviewed the effect of the services that adult male Syrian refugees obtained via the Non-Governmental Organisations (NGOs) throughout the years of being asylum seekers and identified positive interventions for the adult male Syrian refugees. Analysis of the responses demonstrated the harsh reality of camp life and the difficulties involved in trying to meet basic daily needs. The refugees were worried about securing jobs and did not feel that they could rely on the services provided by NGOs. They were worried about the future and the ongoing uncertainty, as well as feeling a loss of control and sense of helplessness due to being unable to change their current situation. Whilst some of the interviewees reported trauma and Post-Traumatic Stress Disorder (PTSD), the majority disclosed no serious diagnosable mental illnesses.

In conclusion, this study found that the refugees want to change their current life conditions by working and having an income and to have a sense of purpose in life. The mental health problems they reported were more a reflection of their current situation, the settings and circumstances, than markers of serious mental illness.

These findings can inform our interventions with future groups of refugees and other cases of forced migration. The conclusion offers recommendations for the NGOs, hosting communities and decision makers regarding the refugees in Europe, the Middle East, and North Africa (MENA). On this basis, it is recommended that the authorities and the NGOs reform their vision of care and aid towards the refugees, focusing more on improving their sense of control and working with them to find possible solutions that would empower them and give them productive and meaningful lives.

Acknowledgements

Reaching the Doctorate level was a dream since my childhood, many obstacles throughout the whole educational life, since the first push at the kindergarten. These obstacles and challenges would never be removed without people with golden spirits especially during my PhD. Producing this thesis was not going to be accomplished without the primary supervisor Doctor Ian Warwick's help, which I believe that God put him in my path. He directed me during these years like a father to son, his responses always were very positive and encouraging even when I am down the hill. I appreciate his detailed attention to my research, coherently, consistently, English language issues and spending years teaching and directing me. I will always remember him with a smile.

Doctor Kenneth McLaughlin, my second supervisor, had great and valuable impact and directed me really well in the hard times. I cannot express how much I'm gratitude to his time during the supervision meetings and great critical feedback thought out the whole thesis which I will never forget.

My father Dr. Haron Jawasreh and my mother Tamam, I will never be able to pay back this favour, without you I would never reach this far in education and knowledge. I dedicate this achievement to both of you for believing in me. I am grateful to the loving wife for the sleepless nights and full support through the years. A big thanks for my brother, sisters, friends for encouragements and the confidence you gave me.

Contents

List of Tables

List of Abbreviations

MMU- Manchester Metropolitan University

IDPs- Internally Displaced Persons

ECHR- European Convention on Human Rights

UNESCO- United Nations Educational Scientific and Cultural Organization

NGOs- Non- Governmental Organizations

MINI- Mini- International Neuropsychiatric Interview

WHOQOL- BREF WHO quality of life

CQoL- Community Quality of Life

WHC- Women's Health Centre

PHC- Primary Health Centre

MSF- Médecins Sans Frontières

MHPSS- Mental Health and Psychological Support

SBF- Syria Bright Future

PTSD- Post Traumatic Stress Disorder

SWLS- Satisfaction with Life Scale

GHQ-12- General Health Questionnaire-12

PCL-5- PTSD Checklist

SWB- low subjective well-being

HTQ- Harvard Trauma Questionnaire

HSCL-25- Hopkins Symptoms Checklist

PCL-C PTSD- Checklist for Civilians

DSM IV-TR- Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision

CBCL- 4/18- Child Behaviour Checklist 4-18

PTRI-C- Post-traumatic Reactions Index for Children

CPTSD- Complex Post Traumatic Stress Disorder

PC- pain- catastrophizing

TRBs- Trauma-related beliefs

CAT- United Nations Convention against Torture

USA- United States of America

DSM-III- Diagnostic and Statistical Manual

HADS- Hospital Anxiety and Depression Scale

IES-R- Impact of Events Scale-Revised

DSM- Manual of Mental Disorders

GHQ-28- General Health Questionnaire 28-item version

SCL-90- 90-item- Symptom Checklist

GAF- Global Assessment of Functioning

NCTTP- National Consortium of Torture Treatment Programs

ORR- Office of Refugee Resettlement ORR

BAI- Beck Anxiety Inventory

BDI- Beck Depression Inventory

SECV- Survey of Exposure to Community Violence

CIDI- Composite International Diagnosis Interview

PTG- Post Traumatic Growth

WHO- World Health Organization

LCA- Latent Class Analysis

ITQ- International Trauma Questionnaire

JOD- Jordan Dinar

IMC- International Medical Corps

MENA- Middle East and North Africa

UNCHR- United Nations High Commissioner for Refugees

WFP- World Food Program USA

CIA- The Central Intelligence Agency

ISIS- Islamic State of Iraq and Syria

SOHR -Syrian- Observatory for Human Rights

USSR- Union of Soviet Socialist Republics

FSA- Free Syrian Army

MOC- Military Operations Centre

OPCW- Organization for the Prohibition of Chemical Weapons

SIT- Social Identity theory

PTEs- Potentially Traumatic Events

ICD-11-- International Classification of Diseases 11

PCLS- Posttraumatic Stress Disorder Scale

DESNOS- Disorder of Extreme Stress Not Otherwise Specified

MDD- Major Depressive Disorder

PI- Principal Investigator

CHAPTER ONE: INTRODUCTION

INTRODUCTION – PERSONAL MOTIVATION

Becoming a refugee is not a personal choice; it is more of an 'involuntary' choice of leaving home, area or country borders. This can happen for several reasons; for instance, warfare, political instability, natural disasters or persecution for their political or religious beliefs, ethnicity or nationality. Manmade or natural disasters can cause enormous numbers of people to flee for protection and safety. Refugees often turn to safe neighbouring areas or countries and their flight from danger can be for a short time until they go back or can result in a permanent stay if there is no prospect of safety.

Several challenges can take place when a person becomes a refugee, such as having to learn a different language, finding a shelter or a house, obtaining a job, community differences, discrimination and racism, education and schools, living apart from families, lack of communication,

mental health related issues, financial problems, loss of status and other issues depending on the resettlement causes and location.

I had worked directly (field) and indirectly (office based) with refugees for over three and half years in Jordan. This was mainly with the Syrian refugees who had emigrated to Jordan and included refugees living in the camps and refugees residing within the host community.

My primary role in my employment was to attend to the core basic needs of the refugees – largely the provision of food and shelter. Working closely with the refugees had a profound impact on me and as a result of these quite powerful experiences I have developed a deep sense of responsibility to make known the voice of the refugees, their daily life challenges and their obstacles and problems.

Over my years in the refugee camp, I have been a witness to the daily life issues of refugees and observed that being a refugee presents huge personal challenges. Whatever the NGOs and authorities provided for refugees still left the refugees feeling desperate and unhappy. I observed that the assistance delivered for the refugees was not enough to lift their mood. I observed that focusing on issues like providing food and ensuring that everyone was living in adequate shelter was only addressing part of the problem. There were other issues that seemed to trouble the refugees such as their mental health and emotional wellbeing. This seemed to be linked to the loss of status, hope for their family and a secure future, as well as the prospect of facing an unstable life with unclear goals. As I have the opportunity to undertake a PhD and publish my research findings, I therefore took a pledge to carry the message to a wider audience in the best method available hoping their voice will be heard by a wider audience.

Having read about the growing number of refugees around the world and the impact on them and their mental health status has made me want to investigate the issue in greater depth and to examine more thoroughly my observations that their mental health problems are very complex. I was concerned that a lot of emphasis was focused mostly on the various trauma and war experiences, yet many of the daily conversations I witnessed focused on current events that reflected having lived in a refugee camp for up to seven years. The mental health problems appeared to be more a reflection of the current life situation, the environment surrounding the camp, and the loss of purpose rather than a manifestation of the trauma of coming from a conflict zone. In particular, adult male refugees seemed troubled by their loss of status along with other personal losses as I have noticed and considered during my previous experiences with the refugees.

In this thesis, I extend my deliberations over the impact of trauma, loss and the stresses of confinement in refugee camps through further exploration of the existing literature concerning refugee mental health and the quality of life globally among the Syrian refugees in Jordan and other countries. I then developed an appropriate research program to extend the knowledge I have gained through my experience of working in the camp and the knowledge I have gained from the available literature in order to advance the knowledge available on refugee mental health and quality of life. The research I undertook increased the knowledge I had gained from earlier studies as I have previously completed a master’s degree in Health and Social Care.

This degree provided me with a solid foundation and made me very aware and familiar with the issues among refugees whilst working with them. The

master’s degree also gave me direction for what to focus on during collecting the data and how to direct the questions to obtain the required data for this study. Another personal motivation was to obtain a higher professional degree to inspire me on working on the refugee studies and try to better their life by showing their daily obstacles through publishing my research.

The completion of this study has given me an opportunity to read and know more about the subject which enriched my information and gave me a good background on the topic It also gave the refugees a chance to talk freely to someone who is going act as their advocate, to deliver their voice and message about their years of experience of being a refugee.

PROBLEM STATEMENT

Forced migration due to persecution has a long history. Refugees have clearly been an issue since the beginnings of civilisation, but in the past few years the number of refugees has increased significantly across the globe, especially after the events of the Arab Spring. The Arab Spring started as a reaction to oppression in Tunisia in December 2010. The Syrian uprising started in March 2011 when campaigners called for a "Day of Rage" throughout Syria. A month earlier, several youths were arrested in the Syrian town of Daraa after they had written graffiti which called for the overthrow of the regime of President Bashar Assad.

It is important to recognise that forced migration due to persecution in the Middle East has a long history that goes back to the very beginnings of historical accounts and links the accounts of suffering in this study with the

origins of two of the major religions of the world, Judaism and Islam. The displacement of 11 million Syrian refugees and IDPs is on a such a scale that it will surely be recorded in history as one of the major displacements of people in all time.

At the moment this history is still unfolding and the stories of the refugees are still being recorded, but it is important to reflect that the origins of this uprising were located in the abuse of some young boys, which at the time seemed like a minor event. Such are the origins of Judaism and Islam.

During Pharaoh time in Egypt, the king was concerned about the multiplication of Hebrews, he turned them into slaves to build and supply cities, Pithom and Ramses. Later, the Pharaoh ordered that every new-born male baby was to drown in the river (Isbouts, 2019). During this time, a couple from Levi, Amram and Jochebed's tribe had a baby. They left the baby floating on the river scared that Egyptians would kill him. The Pharaoh's daughter found the basket and kept the baby and that baby was Moses. He grew up and had a strong relationship with the Hebrew slaves. Once, he saw an Egyptian beating an Israeli worker; he killed the Egyptian and buried him (Isbouts, 2019).

Moses first talked to God when he was in Sinai, and God was in the form of a burning bush (Isbouts, 2019*). "I have observed the misery of my people who are in Egypt,*" God's voice called out to him (Exodus 3:7). Then God told Moses to lead the Israelites out of the bondage and take them to the Promised Land. God also ordered Moses to let his brother Aron speak for him, because *"he can speak fluently" (*Exodus 4:14) (Isbouts, 2019).

The Pharaoh ordered the Israelites to leave Egypt. They left with raised right hand and the left-hand carrying lumps of dough. Later on, Pharaoh changed his mind and order the army to pursue them. The Israelites felt

very scared for their lives and cried to Moses, Moses told them that God would help them, then he stretched out his staff over the sea; the sea then parted letting the Israelites to escape through the sea. The Pharaoh's army followed them, so then Moses waved his staff, so the sea goes back to normal and killed the entire army Pharaoh. This story is remembered by the Jewish people annually during a festival of Passover (British Library, no date).

Another big story of migration due to persecution was in Prophet Muhammad's life. Many Muslims left Mecca to escape death, so too the Prophet did when he comprehended that it was dangerous to stay in Mecca. His plan was to escape to Al-Medina Al-Munawwara because he had many followers there. In the night the prophet and his followers migrated to evade the search armies that might come after them (King Hussaien. Gov. Jo, No date).

The reason that I was concerned about the Syrian war's impact in particular, was because the border with Syria is only twenty kilometres, thirty minutes by car, from my hometown of Irbid. The Syrian town of Daraa where the conflict erupted is only ten kilometres further after the arrest and torture of some local boys.

As outlined in Chapter Two, this border was created in 1923 by the two imperialist powers who controlled this area of the Middle East a hundred years ago, France and Great Britain, and does not reflect any ethnic or cultural divide between the communities. The refugees from this area of Syria are ethnically and culturally the same as my hometown.

Concern for the refugees inspired me to work in the refugee camps. Due to my previous experience with the Syrian refugees and my professional background, I became familiar with their needs and what I perceived was

needed to rebuild their lives and improve their mental health. Consequently, this made me determined to pinpoint the real unspoken and unseen issues that could contribute to the future methods of mental health support for the refugees. My key interest was to provide the world with a good look at the refugees' current life conditions and their mental wellbeing, hoping to uncover the care that they need and to determine whether the current interventions and life conditions are for the refugees' benefit or not.

The global refugee crisis is massive. By the end of 2019 the number of refugees globally reached 79.5 million, according to the United Nations High Commissioner for Refugees (UNHCR) (2020a). Despite the enormity of the problem, a population much larger than the UK and about the size of Iran or Germany, the voice of refugees is hardly heard because they wield so little power. The refugees themselves have little choice but to focus on keeping themselves alive and safe. The largest refugee numbers are from Syria with 6.6 million refugees displaced externally and 6.7 more displaced internally in Syria (USA for the United Nations High Commissioner for Refugees UNHCR, No date: Online).

Many of the refugees are in camps located far away from main areas of indigenous society, where their distress is less obvious. The length of the crisis has drained the refugees in various ways, and this has led to serious mental health issues which this study investigated. The study also explored the effectiveness of current aid delivery.

In order for the experiences of the Syrian male refugees who were resettled in Jordan at the Za'atari camp to be gathered, qualitative data was collected through semi-structured in-depth voice-recorded interviews. Their accounts were transcribed and translated and then analysed.

Believing that this study will serve millions of oppressed humans I had determined to conduct and carry the refugees' suffering.

My approach to research design was strongly influenced by Hennink et al's (2011) text on interpretive qualitative research. This quote has inspired me in my research endeavours:

"Each problem that I solved became a rule which served afterwards to solve other problems." (Descartes and Gröber, 1905).

1.1 CHALLENGES AND OPPORTUNITIES FOR THE RESEARCHER

In Jordan, Syrians and Jordanians are both Arabs and speak the same language which made the transition to Jordan slightly easier for the Syrian refugees as the language and the dialect was not a barrier or an issue for them. In addition, the Syrian refugees are Sunni Muslims which was an advantage for them in Jordan and made them more welcomed. Moreover, the Syrian refugees came from the South of Syria, close to the border with Jordan. People of Dara'a, in the south of Syria, are close culturally to Jordanians from the North of Jordan.

Before the Syrian Civil War Jordanians and Syrians used to marry each other, which made the relationship on the borders very close. The first city from the Jordanian side towards Syria is Al-Ramtha. People from there used to bring Syrian-made goods and food and sell them in Jordan's markets. When the war first started, the people in Al-Ramtha hosted many Syrian families due to close links between families which had origins in

historical marriage relationships. For example, one of the Jordanians in Al-Ramtha donated a multi-storey building for free for the refugees to stay in until the end of the war.

In 2011, when war started, Syrians were initially welcomed very well in the community and were supported financially and emotionally. Then in 2012 the number of refugees increased rapidly such that no one could manage the huge influx. The Jordanian government alongside the UNHCR launched Za'atari Camp in the East of Jordan.

Syrians were moved to the camp and some others managed to live with relatives in Jordan or rented homes, stayed in the community and expanded to different cities and towns all over Jordan. The Syrian crisis lasted longer than anyone expected, so the Syrians became vulnerable and used their savings and wanted to settle until the situation was resolved back in Syria.

Syrian refugees started to work in Jordan usually with low wages and in the handiest jobs that they were skilled in in Syria. Most of them were not educated as they were Sunni Muslims, who were denied a proper education by the Assad regime. The Syrian government worked in the past to keep them uneducated as much as they could and that made them become unskilled workers and they had to become farmers to survive. This was however an advantage for them when they migrated as they could use their manual skills in Jordan and could work in almost any handy job.

I did not come to this study as someone who was completely new to the area. I am myself Jordanian, and the Syrian refugees lived in the same community where I am from. I have lived most of my life in northern Jordan, a short distance from Syria; from the same area and with the same

historical community links I have described in the previous paragraphs. I had previously worked for several years in a refugee camp and I therefore had considerable experience of the challenges facing refugees. I had witnessed the various levels of distress experienced by the men in the camp, from the time when they first arrived, still traumatised by the proximity to military conflict, some having lost or become separated from relatives, some had been captured and tortured and others had physical as well as mental injuries. After a time, the refugees had other challenges that came from living long-term in a temporary camp.

It was therefore very important that I undertook the collection and analysis of the data without being influenced by my prior knowledge and experience and that I focused on exploring my core questions. In order to achieve this, it was essential that I was prepared to consider alternative interpretations and ensure that I accurately report the thoughts and feelings of the refugee participants.

Prior to undertaking my doctoral study and prior to working in the refugee camp, I had completed a masters' degree in Health and Social Care at a university in the United Kingdom. I have also worked in care settings in the UK which gave me valuable experience of working with vulnerable people as well as insight into alternative ways of caring compared to Jordanian approaches to care. In my academic and professional career, I have had a commitment to enhancing my knowledge and skills in caring for those people who have been impacted by trauma. I have a commitment to finding the best way to help improve the mental wellbeing of the millions of refugees in the Middle East. This project has therefore presented me with an opportunity to explore the mental health needs of refugees in considerable depth.

LOCATION OF THE STUDY

This study data was collected in Jordan from adult Syrian refugee males in December 2018 from Za'atari camp in the East of Mafraq governate and it is the largest Syrian refugees camp in the world. The camp population reached 76,143 Syrian refugees by January 2020 (UNHCR, 2020).

According to World Food Program USA (WFP) (2020) there are around 650,000 Syrian refugees in Jordan who are registered with the UNHCR. The majority are living within the host communities in cities and towns, that means they must pay for their own life expenditure such as rent, food or transportation. Mostly they still depend on the Non-Governmental Organizations' (NGOs) help to secure the basic needs because the work permits are limited (WFP, 2020).

It is important to consider the enormity of Syrian refugee problems in Jordan and other neighbouring countries. In terms of the registered Syrian refugees in the Middle East and North Africa (MENA), Amnesty International Organization (2016) has reported the number as follows:

- Jordan has about 635,324 Syrian refugees, which equates to one in five people in the whole country.

- Iraq hosts 245,022 refugees from Syria.

- Lebanon hosts approximately 1.1 million Syrian refugees, which equates to one in five

people in the whole country.

- Turkey has the most Syrian refugees' number in the world; about 1.1 million, about one in eighty of the Turkish population

- Egypt has the least among the neighbouring countries. It hosts 117,658 refugees escaping from Syria (Amnesty International, 2016).

The published numbers are just the Syrian refugees who are registered with the UNHCR. These figures give reliable evidence of the size of the crisis in the neighbouring countries. At the end of 2015, King Abdullah II of Jordan declared that the Syrian refugees constitute 20% of Jordan's population (Murshidi, 2016), which is a significant number of refugees in one country. One concern is that this can quickly affect the Jordanian community in numerous different ways.

In recent years, the biggest refugee number worldwide was Syrian, and the conflict is still ongoing since its onset in 2011 (Murshidi, 2016). In 2015 about one out of four of the world's refugees was of Syrian nationality, and 95% of these Syrian refugees was settled in the surrounding countries. At the end of 2014, the figure of people helped or sheltered by UNHCR worldwide had reached a record high of 46.7 million individuals (UNHCR, 2015a). This has now grown hugely because it is estimated that 13.9 million people were evacuated from Syria because of the conflict or discrimination.

In 2013, the Syrian conflict and harassment led to about 42,500 people leaving their homes every day to pursue protection and help somewhere else, either inside the borders of their country or in other countries such as Jordan, Lebanon, and Turkey. By December 2015, the registered number of the Syrian refugees was 633,466 in Jordan, 1,070,189 in Lebanon,

244,527 in Iraq, 123,585 in Egypt and 2,291,900 in Turkey as published in the (UNHCR, 2015a).

THE PSYCHOLOGICAL IMPACT OF POLITICAL CONFLICT IN THE MIDDLE EAST

In the past few years, people of many Arab countries have protested against their governments, in what has been known as the ‘Arabic Spring'. During the event, many serious conflicts occurred in the area which has resulted in many people becoming internally displaced or refugees. The Arab Spring event has led to many changes in the area. Several Middle Eastern regimes have seen their power completely disappear with the Arab uprisings that began in 2010.

Kawakibi summarises the origins of the Arab Spring very clearly:

“Civil society was corrupted, becoming simply a means of perpetuating power. Furthermore, the public expression itself became treasonable. The media was, it goes without saying, silenced and became enablers of these at-risk regimes. The nature of the legitimacy of power in Syria did not seem so very different to that of other regimes." (Kawakibi, 2013:1).

When the disobedience movements began in Tunisia, the Syrian government did not at first feel any threat. It did not expect that the inexistent political liberties protest was growing because of the weakening economy and systematic corruption. The protest led to a serious issue in the country that grew very quickly from 2011 to have two different sides

fighting which are now the Assad regime and the Free Army in Syria (Kawakibi, 2013).

Additionally, in terms of the overall situation in Syria, the humanitarian situation progressively deteriorated with clashes, violence, and disagreement between different parties, which caused human rights violation by all sides.

The on-going disagreement and conflict were a block against delivering any humanitarian aid, particularly in Northern Syria. Roads and routes to give different types of support were closed in front of the humanitarian organizations or made the level of help available reduced to a small scale due to insecurity (European Commission, 2016). The population who were considered at a high vulnerability in the country was 13.5 million people. Of those who needed humanitarian assistance, 6.5 million were forcibly displaced and 4.6 million individuals were living in hard-to-reach areas including areas that contained 480,000 besieged individuals.

The people mainly affected by this conflict are the civilians who have experienced displacement by force, the children forcibly enrolled in the army, the women and girls subjected to rape and sexual violence, and the people who are victims of compulsory disappearance and summary executions (European Commission, 2016).

The amount of humanitarian aid that is needed is overwhelming all over the country. The primary needs have been to evacuate and treat wounded people, and to provide food, safe drinking water, sanitation, health services and shelter. Since the beginning of the war, merchandise and food stock prices have kept on rising continuously.

With the significant number of refugees internally and externally displaced, shelter is a high need (European Commission, 2016). It is evident that there is a high demand for resources to address all kinds of different humanitarian needs, and the need is getting bigger whilst the general situation is getting worse, which basically affects all aspects of the quality of life for the refugees and is found to be the origin for many and various mental health problems. A report from the United Nations High Commission for Refugees (UNHCR), conducted by Hassan et al., (2015) has provided details about the mental health issues among Syrian refugees. The conflict in Syria has affected the Syrian refugees and the Internally Displaced Persons (IDPs) in Syria.

This has led to mental health disorders and psychosocial distress which can be seen in a wide-ranging variety of emotional, cognitive, physical, behavioural and social problems. For example, Hassan et al., (2015) stated that: the emotional issues are: ‘sadness, grief, fear, frustration, anxiety, anger, and despair’ (Hassan et al., 2015, p14).

This study shows that mental health problems are found to cause a range of symptoms among the refugees, which need reviewing further and investigating in depth. Thus, this study can give data and evaluation about the refugees’ current mental condition, to inform treatment strategies that could reduce the consequences and to prevent the mishandling of mental health issues during a crisis.

Regarding the cognitive problems, it has been reported that refugees suffer from a loss of control, helplessness, worry, ruminations, boredom, and a loss of hope. It has been noted that the Syrian refugees and IDPs are suffering from physical indicators for instance: sleeping problems, fatigue, and appetite loss (Hassan et al., 2015). This gives a good indicator that the

refugee status, even if it is within the same country, is a good reason for a mental disorder and psychosocial distress to appear and occur.

Taking social and behavioural issues in hand, Hassan et al., (2015) found that the social and behavioural manners are affected by leaving home and becoming refugees whether it is inside the same country or outside the country borders; some of the issues that were reported for example include withdrawal, violence, and aggression.

It is also common to find interpersonal difficulties. For the majority of Syrian refugees and IDPs, most of the reported problems are a result of continued violence, displacement, and the hard-living environment that they are living in. The challenging life environment frequently is a risk factor for demoralization and a loss of hope.

Persistent existential worry about safety, belief, the coherence of identity, social role, and society are not easily treated by western medical methods of psychiatric diagnosis and psychotropic medication and need culturally appropriate solutions.

Similarly, the experience of the various trauma has some related symptoms, for example, nightmares, intrusive memories, flashbacks, avoidance behaviours, and hyper arousal. The war experience can transfer into the daily life of the refugees and cause emotional abnormality and mental health problems (Hassan et al., 2015). These symptoms can be collated under a single psychiatric diagnosis, such as Post-Traumatic Stress Disorder, but this study sought to explore the utility of western diagnoses and treatments in the context of adult male Syrian refugees.

RESEARCH AIMS

This study was carried out in Jordan to explore the Syrian refugees' mental health and quality of life to give the world a good look at their current status, hoping to inform the best methods to provide the care that they need. The research utilised the methodology of establishing key themes and entering them into a thematic table to analyse the findings to provide analytical data based on the information that was gathered from the field in Jordan (Braun and Clarke, 2006; King, 2004).

This research study provides a description of the political context in the Middle East which is included to give the reader an overview of the general situation in the region. A descriptive summary of the scale of the Syrian refugees' mental health is attached to global and local figures of the extent of the refugee crisis and to investigate the impact of settlement experience on mental health.

I worked with the Syrian refugees for more than three years, in the camps and in the host communities, and I am motivated to help them by showing their case to the world through this research. I have taken my direction from David Turton who stated that there is no justification for research into another person's burden unless alleviating that pain is an explicit objective (Allen, 1996).

The purpose of the research is to understand the impact of displacement on Syrian refugees settling in Jordan on their quality of life and their mental health. The focus on mental health sheds light on the torture, trauma experience and common mental health conditions, but it also

illuminates the impact of living in a refugee camp for many years and the mental health problems that are generated by persistent stress.

The literature I had previously read did not show a complete picture (from my experiences as a worker in the refugee camp) of daily challenges that can impact on the refugees' mental health. There were no studies available that have included the refugees' narratives in the same way as this study set out to do. The intention of this study was unique and unparalleled, basically because it had at its heart a desire to reflect the Syrian refugees' suffering exactly as they said it.

The significance of this study emerges by examining the Syrian refugees' resettlement experience, their quality of life and their mental health and the prospects for recovering good mental health in Jordan. By employing a refugee camp worker who was immersed in the language and culture of the region, the study adopts an innovative approach to generating valuable knowledge. The intention was to generate information that can be utilized by stakeholders and decision makers such as local, national and international non-governmental organizations (NGOs) and others which could benefit from the findings to aid raising the profile of the concerns of the refugees.

With such a massive displacement of refugees in Jordan and other countries, this lends an opportunity to gain a direct account of the physiological and mental health issues confronting the lives of the individuals that have been affected most, the refugees. This research will contribute to understanding all aspects of life and address their effect on the mental health of the refugees to give a clear image for mental health providers and the humanitarian aid.

RESEARCH OBJECTIVES

- **To explore the lifestyle and circumstances of adult male Syrian refugees and how this relates to their quality of life and mental health living in Jordan.**

- **To look at the background of adult male Syrian refugees and report the changes such as, culture, education, and work they have engaged in since 2011 until the data collection date in 2018 to evaluate the effect on their mental health state throughout the years.**

- **To overview the effect of the services that adult male Syrian refugees obtained via the NGOs throughout the years of being asylum seekers.**

- **To identify positive interventions for the adult male Syrian refugees, which could be applied to world refugees, and to any cases of forcible migration that can happen in the future.**

- **To provide recommendations for the non-governmental organizations (NGOs), hosting communities and decision makers regarding the refugees in the Middle East and North Africa (MENA) and Europe.**

In developing the aims and objectives for the study I was strongly influenced by Hennink et al., (2011) who suggest that aims should explore new topics and understand complex issues. Such as, people's believes, and behaviour. They also stated that aims and objectives should recognise the communal and cultural standards of a culture or society. Thus, makes the qualitative research the best method for addressing 'why' questions Hennink et al., (2011).

STRUCTURE OF THE THESIS

Chapter 1 summarises the experiences as a worker in a refugee camp that provided the motivations for undertaking this study. The chapter depicts the historical and political background to the Syrian refugee crisis and the psychological impact political conflict in the middle east has had on the refugees. It outlines the aims and objectives of the study and the methodology of the study and the challenges I faced as a researcher.

Chapter Two provides the political and historical context in the Middle East and the location of the Syrian conflict within this context. This chapter outlines the significant level of global involvement in the war, the magnitude of the military power invested by the world superpowers and the low level of significance the fate of twelve million poor people has within this conflict. The global political and military context helps explain a significant element of the powerlessness and hopelessness of the refugees.

There are two chapters in this study that explore the literature on the quality of life and the impact of conflict trauma on the mental health of refugees.

In **Chapter Three**, the search criteria are defined, and key terminology is explained before the body of existing research on the quality of life and mental health of refugees is explored. The main body of this chapter focuses on the literature relating to the experiences of the refugees and the relationship between key socio-economic factors such as employment, housing, access to health and welfare services, the refugee journey, the role of support services and the quality of life of the refugees.

Chapter Four explores the literature that relates more specifically to individual mental ill health and looks more closely at the impact of the refugee journey on the mental health of individuals, with a specific focus on depression and Post-Traumatic Stress Disorder. In particular, the chapter focuses on the contrast between western psychiatric medicine and the cultural norms within Arabic society.

In **Chapter Five**, the research method approach that was used to complete this study is addressed and explained to give a clear idea of how

the researcher carried out the research. This chapter includes a section on research design and the approach that was employed. The rationale for methods, sampling, negotiating access, generalizability, research neutrality, ethical consideration, confidentiality, risk to participants, risk to the researcher, benefits for the participants, gaining ethical approval, recording, transcribing process, translating, analysis method, trustworthiness, study limitations, collecting the data, the interview questions, methodology evaluation, and the emerged themes.

In **Chapter Six** the data from the transcribed interviews gathered in the study is analysed in the context of the review of previously published literature (chapters 3 and 4).

The interview data is explored in terms of the information on the mental health challenges that the adult Syrian refugee males were facing, in order to identify the gaps in the literature as well as pinpointing any similarities. There is a deep focus on the mental health issues resulting from the traumatic conflict experiences of the refugees and attention to the major consequences of their daily life experiences in the camp that are impacting on their mental wellbeing.

The interventions and methods that have been employed to help prevent or reduce the negative impact of the refugee experience is evaluated. Another goal of the analysis was to assess the efficacy of the aid provided by the organisations in the refugee camp.

Chapter Seven concludes the thesis, provides a brief summary of the findings and the research contribution of the study. Implications of the study for Policy and Practice are outlined and both the Methodological

Contribution and Theoretical Contribution are presented. Limitations of the study are summarized as are the Areas for Future Research.

CHAPTER 2: Historical and Political Background About the Syrian Conflict

2.1 Introduction

It is essential for any study of people in this area to first consider the international power struggles that are happening at a global level and their

influence on international, national and local relationships. The current quality of life of the Syrian refugees, their flight from the conflict and subsequent arrival in the refugee camp is a physical expression of the impact of global politics as well as internal Syrian conflict. The poor mental wellbeing of the Syrian refugees is also a reflection of vulnerability and powerlessness these individuals are living with, having lost their homes, their jobs, family members and their community.

The refugee experience that is explored in this study did not happen in a vacuum. There have been centuries of conflict and political turmoil in the region and this chapter summarises most of the essential information on the issues that have influenced this current conflict. This chapter provides the context within which the lives of the Syrian refugees are impacted and is illustrative rather than a central area of the research study itself. It is nevertheless very important to consider the place of the refugees within the vastness of the political and social history. The information for this chapter is drawn from the most up to date sources available online and has been drawn from ‘grey’ literature rather than peer-reviewed academic texts.

2.2 Syria

The Syrian Arab Republic is in the Middle East and the capital is Damascus. It is located on the eastern coast of the Mediterranean Sea. The country has a border with Turkey in North, Iraq in the East, Jordan to the South, and Palestine and Lebanon to the West. The country land size is

185,180km and it is part of Bilad Alshaam, an area that includes Jordan, Israel/Palestine, Lebanon, parts of Turkey and Cyprus. The total population in 2019 was 21.1 million (BBC News, 2019). Spoken languages are Arabic (official), English and French, Kurdish, Armenian and Aramaic.

The archaeologists consider Syria as one on the oldest civilizations on earth. It was the first to start on building cities, farming, taming animals for farming, etc. The first cities that were started were the Ibela Kingdom from 2500 to 2400 B.C, the Kingdom of Mar, the Kingdom of Ugarit, the Kingdom of Ramita, and many others subsequently.

Syria has been occupied over many eras and inhabited by civilizations such as Sumerians, Akkadians, Chaldeans, Canaanites, Arameans, Hittites, Babylonians, Persians, Greeks, Romans, Nabateans, Byzantines, Arabs and partially Crusaders. It then was ruled by the Turkish, and the French between 1846 and 1920 (Homosonline, no date: Online).

After the First World War, the Turkish left Syria in 1918. Straight after, the British army entered Syria and ruled for approximate one year. After that, the British and the French completed a secret treaty called the ‘Sykes-Picot Agreement’. The British suggested to have Syria under the French mandate, which the Arabs did not like. This started in 1920 and lasted until 1946; after that Syria became independent (History, 2017).

In 1958, Syria was united with Egypt. In September 1961, the unity between the two countries came to an end by military coup and Syria was announced as the Syrian Arab Republic. In 1970 Hafiz Alsaad became the prime minister of Syria. He is the father of the current leader Bashar Alasad and Hafiz became the official leader of the Syrian Arab Republic in

February 1971 and was to be the first Alawite leader in Syria (History, 2017).

Alawites are an Islamic sub-group generated from Shia'a and they revere Ali Bin Abi Talib. Eighty-seven percent of Syrians are Muslim. The Central Intelligence Agency (CIA), (No date: online) gives the population's religious group divisions as follows: Sunni Muslims (74%), 13% are Shi'a Muslims, following the Alawite (11%), Ismaili (1%) or Twelver Imami (0.5%) sects. Christians are 10% of the population with the remaining 3% being a combination of Druze, Jews and atheists (CIA, no date: online).

As stated earlier, the Alawites reflect a small population in Syria, but have the majority of the power as they are supported by Iran as it is a Shi'a country. Iran has been keen to extend its power base in the Middle East and as such supports Shi'a groups throughout the region.

Hafiz stayed as a leader for the country until June 2000 before he passed away because of cancer. In August 2000, Bashar was elected to be leader for the country after his father. Bashar followed his father's steps of dealing with the opposition parties by killing them and by the use violence (History, 2017).

In 1982, during the Hafiz ruling era, a protest happened in Aleppo and the regime reacted to this. They carried out a massacre and killed approximately 40,000 civilians who were against the leaders and were supporting the Islamic Brotherhood Organization. After the 1982 massacre, there were no further reported big issues in the country until 2011, when the recent big Syrian crisis started also called the 'Syrian Revolution' (History, 2017).

This conflict has had a huge impact on Syria and other neighbouring countries as well in terms of the huge numbers of fleeing refugees which has caused a massive burden on their infrastructure and financial state which will be discussed further in the different chapters of this thesis. Since 2011, the Syrian crisis has led to the Assad army demolishing homes, schools and hospitals and damaging infrastructure and many other facilities, which has made life in certain areas very devastating and hard to live in as the basic services are not available such as water, sanitation, electricity, food, healthcare and other needs.

The Syrian crisis started as part of what is called the Arabic Spring, where the people protested against their governments and leaders. In Syria, the story told by most of the refugees was that a group of young school children from Dara'a (mostly Sunni) protested in the streets and wrote phrases against Bashar Alasad on walls. In reaction to this, the police took the children into custody where they took their nails off and tortured them which then triggered the parents and the community to protest. This was the start of this whole issue and it grew so fast that the government had to involve the military to try to stop the protesters and in the aftermath the government used excessive force.

[Going back to life before this clash, I have interviewed and seen many Syrian refugees during my past work in the humanitarian aid section. They explained the explosion of emotion in their hearts and why it did not stop, and that they kept protesting and this made the situation worse].

Most of the people I met in my role in humanitarian aid said that they lived an unfair life under Bashar Alasad, his father and the government and that the discrimination was obvious between them and the Alawite Shia. Many of them were unable to continue to study at school as the government did

not allow them the opportunity; they also did not have equal opportunities in jobs. In addition, there was a major factor in the oppression which was the lack of freedom of speech.

The people back then could not even mention Bashar in any way other than praising him, otherwise they would be dragged to jail, given a number and their fate was hidden for months or years. The people were overwhelmed by this policy of repression and the unequal life, so they decided to carry on this revolution and mounted an armed conflict aiming to eliminate Bashar Alasad with the intention of having a different leader.

Many different groups, countries and parties got involved in Syria's conflict and many other groups were developed too. The regime was backed up by Russia, Iran and Hizbollah 'Party of Allah'. Hizbollah is an Islamic Shia political party based in Lebanon which has a military group (Council of Forgiven Relations, 2008). On the opposition side, the other groups consisted of the Free Syrian Army, Syrian Democratic Forces which includes mostly Kurds, Jihadi Salfi people, Alnusrah Front, Islamic State of Iraq and Syria (ISIS).

Other countries (United States of America, Saudi Arabia and Turkey) were involved in supporting these opposition groups by direct and indirect support internally and externally. Violation was used widely, and thousands were killed, tortured and were forced to leave their homes and their country.

In the midst of this conflict, another very serious problem emerged. A group of militant fundamentalist Muslims who named themselves the Islamic State of Iraq and Syria (ISIS) took advantage of the chaos, attacked

both Syrian regime forces and opposition forces and occupied huge areas of Iraq and Syria creating temporarily their own state. ISIS is an horrific group. They have committed and are still committing crimes in Syria and other countries around the world in the name of Islam. The reality is however different as they are not reflecting Islam in any way. Islam is a peaceful religion, accepts other religions and does not permit the taking of souls of humans without any reason. During their presence in the region they had killed Muslims more than any other people from different religions and their intention was to terrorise people and kill them in the worse method they can use. For example, killing the Jordanian pilot, they kidnapped him and burned him in a cage and it was filmed and streamed on YouTube.

ISIS's growth was quick, and their resources were massive as that showed they were supported externally to play a role in causing damage within Syria. The group kill people and rape women in the most aggressive ways, and they publish their activities in the media. In 2014, ISIS started taking over in some areas in Syria. After multiple terrorist attacks that were committed by ISIS in Europe and the United States of America, USA and the United Kingdom, with support from Turkey, Saudi Arabia and other Arabic countries carried out an air strikes campaign in Syria and Iraq to stop ISIS from killing and expanding (History, 2017).

In 2016, Turkish troops started their mission on the ground in Syria against ISIS and launched attacks against armed Kurdish groups in Syria as well. In 2015, Syria requested from Russia support to launch air strikes against targets inside Syria believed to be ISIS locations.

According to the Syrian Observatory for Human Rights (SOHR) (2018) 560,000 people have been killed in seven years of war in Syria including 104,000 tortured to death in regime jails (SOHR, 2008). Millions of Syrians have left their homes and crossed country borders and millions were internally displaced seeking safety (as reported in Chapter One). In 2017, a meeting took place in Geneva in an attempt to initiate a peace deal to end the war and killing in Syria, but the war is still going on.

The Syrian government has slowly regained control again in some areas that were taken by the opposition forces, and this has happened alongside Russian and Iranian support. The regime has used chemical weapons many times during this crisis, mainly in 2013, 2017, and 2018. The war in Syria became more than a battle between Bashar and opposite rebels. All the involved countries and groups have their own motivations and plans and that has made the situation worse and extended the war. Some countries have built hate between different Muslim groups as the opposition are Sunnis and Bashar is Alawite and this has made the situation even worse. It is believed that some countries have supported terrorism inside Syria so the country will stay in prolonged crisis and finish Bashar’s presidency and this will help them achieve their own goals in the region.

2.3 Russian Involvement

Russia and Syria have had a strong political bond since the Cold War (1947-1991). At the time, Russia was part of the Union of Soviet Socialist

Republics (USSR). The relationship was developed against the Western countries' power (Dmitri, 2012). Hafez Al-Assad went to Moscow in 1977 and signed an agreement for twenty years of treaty friendship and cooperation with the USSR which strengthened the relations between the two countries (Lea and Rowe, 2001).

Russia has supported Bashar and his government politically since 2011 and militarily since 2015. This has included both direct and indirect involvement. The Russian air strikes have been aimed at ISIS targets and rebel groups such as Nusra Front, Free Syrian Army (FSA) and Al-Qaeda's Syrian Branch. In the same line Russia has provided military equipment to Turkey and Syrian Democratic Forces during their operations against ISIS missions (Hubbard, 2015).

Russia's targets of attack have been criticized as they have destroyed hospitals and have killed thousands of civilians. This has led to Russia being thrown out of the UN Human Rights Council in October 2016 (Orozobekova, 2016). In 2018, the Russian air strikes increased by 34% compared to 2017 in terms of causing harm to civilians and that was only in the first six months on 2018 (McKernan, 2018).

2.4 United States of America

During the war in Syria, the United States of America (USA) was supporting the opposition in Northern Syria against the regime. They supported them financially and with military involvement as well. This led the USA's allies' countries to join the conflict as well as United Kingdom, Jordan, France,

Canada and Australia against ISIS and Al-Nusra Front since 2014. In 2017 the USA and other partners targeted the Syrian government and its allies via airstrikes (U.S. Department of Defence, 2018).

The U.S started supporting the Free Syrian Army, in non-military aid such as, food, trucks, intelligence and money. In September 2014, the USA started surveillance missions alongside Bahrain, Jordan, Qatar, Saudi Arabia and United Arab Emirates in Syria against ISIS. In 2019, the USA have launched an operation to kill the ISIS's leader Abu Bakr Al-Baghdadi.

After completion of the mission, the Trump administration ordered all U.S. forces to leave from the Kurdish area in Northern Syria and to stop their involvement in Syria's war. Trump termed this 'the endless war' as it constitutes a high cost for the USA to stay involved in the Middle East (U.S. Department of Defence, 2018).

2.5 United Kingdom

Britain combined with the United States and France and some Arabic countries and argued that Bashar Al-Asaad should step down to end the war in 2012 (Black, 2015). In 2012, the UK became involved in Syria's war by providing the opposition party with non-lethal aid and that included medical supplies and communication equipment. The UK also provided intelligence for the opposition party from Cyprus bases, by providing the

information to Turkish officials, to be passed to the Free Syrian Army (Follain and Leppard, 2012, The Times)

The British House of Commons held a vote on 29th of August 2013 to decide whether the United Kingdom should join the United States in taking military action against the use of chemical weapons that was carried out by the Syrian government. The vote was 285 to 272 to not take military action in Syria and the prime minister back then, David Cameron, respected the parliament decision even though the prime minister does not need parliamentary approval for military action (BBC News, 2013). The UK government had a plan to act against ISIS and Nusra Front in Syria as they are carrying out terrorist actions in and outside Syria.

On December 2015, the UK parliament agreed on this decision. After that UK had their first air strikes against ISIS in Eastern Syria. Syria stated that UK did not ask for permission to take this action and said it must follow Russia's example to coordinate the campaign alongside Syrian forces (BBC News, 2015).

2.6 Iran

Iran and Syria have a close bond and are strategic allies. Iran has a huge impact in Syria's war and was an important reason for Bashar's government to stay. Iran has supported Syria's government with technical support, combat troops, and nine billion US dollars financially. Iran's involvement aim is behind the geopolitical security (Startfor, 2017, World News). Until 2020 Iran was still providing full support to Syria.

2.7 Turkey

In 2011, Turkey began to train defectors from the Syrian army on its land. In July 2011, a group of them announced the start of the Free Syrian Army. In October 2011, Syria offered shelter for this group and a safe zone which is used to be the base of operation as well. Turkey, Qatar and Saudi Arabia provided the rebels with military equipment (Manna, 2012, The Guardian). In 2012, Syrian forces shot down a Turkish jet which created tension in the relationship between the two countries. Turkey provided refuge for Syrian rebels from the beginning of the Syrian war.

In early June 2011, Syrian opposition activists assembled in Istanbul to discuss regime modification, and Turkey hosted the head of the Free Syrian Army, Colonel Riad al-Asaad. Turkey became gradually aggressive to the Assad government's procedures and came to inspire reconciliation among dissident factions. Recep Tayyip Erdoğan, the Turkish president, has tried to encourage a favourable affiliation with whatever government would take the place of Assad (Epatko, 2012, PBS Newshour).

Then Vice President Joe Biden of the U.S. stated in 2014 that Turkey, Saudi Arabia and the United Arab Emirates had *"poured hundreds of millions of dollars and tens of thousands of tons of weapons into anyone who would fight against Al-Assad, except that the people who were being supplied were al-Nusra, and al Qaeda, and the extremist elements of jihadis coming from other parts of the world"* (Effarah, 2020:5). Since 2016, Turkish forces

have conducted many cross-border operations against Kurdish Militia forces.

2.8 Arab League

For Arabs, the whole war is about the balance of power in the region between Sunni and Shia'a Muslims. Iran is a Persian Shia's country and tries to control some Arab countries, that is why Iran is keen to keep Bashar's government in power as he is Alwaite Shia'a and well connected with Iran. The opposition are Muslim Sunni and the Syrian government forces are Shia'a, for this reason some Arab countries such as Saudi Arabia, United Arab Emirates, Qatar and Jordan stood by the opposition as they are representing the Sunni Muslims.

2.8.1 Qatar

Qatar supported the Syrian Rebels financially by approximately three billion US dollar as the Financial Times reported. Qatar also offered refugees packages worth about 50,000 US dollars per year to defectors and families (Khalaf and Smith, 2013). The Stockholm International Peace Research Institute reported an estimation of Qatar military equipment help to rebels in Syria to be over seventy weapons cargo flights through Turkey between 2012 and 2013 (Khalaf and Smith, 2013). Moreover, Qatar hosted training bases in its lands to train about 1,200 rebel soldiers by the CIA (Youssef, 2014).

2.8.2 Jordan

The leadership of ISIS threatened to destroy and invade Jordan once they take over Baghdad. Jordanian Air Forces then Joined the U.S. bombing in Syria, which then increased the border attacks from the Syrian side by terrorist groups. Towards the end of 2014, a Jordanian fighter jet was shot down over Syrian lands and the pilot (Muath Al-Kasasbeh) survived the incident, but he was captured by ISIS. The pilot was executed by the worst methods ever. ISIS caged him and burned him alive in 2015, the video was released to the public and was a big shock for the Jordan. Jordan had two terrorists who ISIS asked to exchange, but only if they could prove that Muath was alive. Then ISIS released the video, and as a reaction Jordan executed both terrorists and took the lead into fighting against ISIS by killing thousands in one week by air strikes (Michaels and Bacon, 2015).

Jordan's involvement in Syria also took a different path. Jordan hosted foreign countries' military personnel. Many countries' missions against ISIS were flown from Jordan bases; for example, six Belgian jets conducted strikes in Syria from Jordan. Dutch, American, and Bahraini forces are based in Jordan as well (McInnis, 2016). Moreover, the bases in Jordan hosted many American drones, and French jets as well (Bellingcat Investigation team, 2016).

Jordan is also home to a command centre for coordinating Western and Arab support for Syrian rebel groups which was known as the Military Operations Centre (MOC). This provides training, tactical advice, and directions to rebels, in additional to directing material support such as, weapons, vehicles, and cash (Sands and Maayeh, 2013). Jordan has also

hosed hundreds of thousands Syrian refugees since the beginning of the war.

This research is tackling this issue in depth and investigating the situation of the refugees now in Jordan with a focus on the mental health statues and how it is affected by the war throughout those years and through conducting face to face interviews.

In Jordan the Syria refugees fitted in very well. The researcher who conducted this study is Jordanian, and the Syrian refugees lived in the same community where the researcher is from. Syrians and Jordanians are both Arabs and speak the same language which made the transition very easy to the refugees as the language and the dialect was not a barrier or an issue for them, also, they are Sunni Muslims which is was an advantage for them in Jordan and made them more welcomed.

The Syrian refugees came from the South of Syria, close to the border with Jordan. People of Dara'a are close culturally to Jordanians from North of Jordan. Before the war Jordanians and Syrians used to marry each other, which made the relationship on the borders very close. The first city from the Jordanian side towards Syria is Al-Ramtha; people from there used to bring Syrian-made goods and food and sell them in Jordan's markets. When the war first started, the people in Al-Ramtha hosted many Syrian families due to historical marriage relationships. As an example of the close ties and generosity towards the Syrian refugees, one of the Jordanians donated a multi-storey building for free for the refugees to stay in until the end of the war. Syrians were welcomed very well in the community and were supported financially and emotionally. Then the number of refugees increased rapidly such that no one could handle it.

The Jordan government alongside the UNHCR lunched Za’atari Camp in the East of Jordan. Syrians were moved to the camp and some others managed to live with relatives in Jordan or rented homes, stayed in the community and expanded to different cities and town all over Jordan. The Syrian crisis prolonged more than anyone expected, so the Syrians became weak and used their savings and wanted to settle until the situation was resolved back in Syria.

Syrian refugees started to work in Jordan usually with low wages and in the most handy jobs that they were skilled in in Syria. Most of them were not educated as they are Sunni Muslims. The Syrian government worked in the past to keep them uneducated as much as they could and that made them become unskilled workers and farmers to survive. This was an advantage for them as they used it in Jordan and worked in almost any manual jobs.

2.9 Chemical Weapons

In August 2013 rockets filled with nerve agent nerve sarin were dropped on suburbs of Damascus. The Syrian government blamed rebel forces, but the Western countries said it was only the Syrian government who did it. In reaction to this and the subsequent US military intervention, President Bashar confirmed that he would remove the chemical weapons and destroy them. The operation of chemical weapons removal was done in the following year, although on the other hand, the Organization for the Prohibition of Chemical Weapons (OPCW) has confirmed the continuity of the chemical use in the conflict. Chlorine was used repeatedly and

systematically in 2014 between April and July as investigators said. Islamic- State (ISIS) also used homemade chemical weapons and that includes Sulphur Mustard. They used this agent on the Northern town of Marea in August 2015 which caused a death of baby as OPCW reported (BBC News, 2016).

2.10 War Crimes

The UN Commission of Inquiry stated that all war parties had committed crimes such as rape, torture, killing and enforced disappearance. They also committed other humanitarian issues for example, blocking access to food, water and health services by barriers. People have been killed in their thousands by weapons and the use of barrel bombs used, dropped from the air by the government aircraft. In addition to the crimes committed by the Assad regime, ISIS has been responsible for spreading horror cross the country by killing, rape, force against religious minorities, and other types of murders (BBC News, 2016).

2.11 Chapter Summary

In this chapter, I have outlined how several major global conflicts have had an influence on the volume of weaponry and the apparent indifference to

the level of brutality the Syrian people have suffered. Some of the energy to be engaged in this conflict from the USA and Russia originates in the Cold War and the continued tensions between these historical enemies. The conflict between Iran and Saudi Arabia, between Shi'a and Sunni, which is at the root of several conflicts in the Middle East, including Syria and Yemen, is exacerbating the friction between the Shi'a and Sunni communities in Syria. Ancient conflicts between Arabs and Turks and between the Turks and Kurds are increasing the hostilities in the North of Syria. To add to this cauldron of warfare, the emergence of ISIS and their extreme behaviours has created yet more terror for the Syrian refugees.

It is within this context of extreme violence and global power battles that millions of poor and powerless Syrians have had their lives turned into turmoil. Initially, they took to the streets to protest about the arrest and mistreatment of three young boys, which was a right and justified reaction to the police brutality, but the terrifying onslaught that they have suffered and the loss of everything they held as precious has not been justified. This chapter helps illustrate the immensity of power and terror that the refugees have experienced and helps to explain the sense of hopelessness that was apparent in the refugee camp where I worked.

CHAPTER 3: THE IMPACT OF SOCIO-ECONOMIC FACTORS AND THE REFUGEE JOURNEY ON QUALITY OF LIFE FOR REFUGEES

3.1 Introduction

There are two chapters in this thesis that explore the literature on the quality of life and the impact of conflict trauma on the mental health of refugees. In this chapter, the search criteria are defined, and key terminology is explained before the body of existing research on the quality of life and mental health of refugees is explored. The main body of this chapter focuses on the literature relating to the experiences of the refugees and the relationship between key socio-economic factors such as employment, housing, access to health and welfare services, the refugee journey, the role of support services and the quality of life of the refugees.

The following chapter looks more closely at the impact of the refugee journey on the mental health of individuals, with particular focus on depression and Post-Traumatic Stress Disorder. A lot of the literature reflects the inter-relationship between socio-economic issues, the refugee experience and mental ill health. In the same way that frustration can lead to anger, anxiety and depression and trauma can lead to PTSD, anxiety and depression, there is not a defined line between the impact on the individual of poverty and unemployment and the impact of war trauma.

The two literature review chapters reflect the interaction between all the variables affecting refugee wellbeing, but in order to facilitate the development of the interview questions and the analysis of the data post-

interview an attempt has been made to purposefully separate social issues from personal issues as far as possible.

3.2 Method

The purpose of this literature review is to identify studies found in the literature that are related to the refugees' mental health and their quality of life. Library resources and online search engines which were available through the Manchester Metropolitan University (MMU). Summon and Google Scholar search engines were queried using predetermined inclusion and exclusion criteria to locate relevant articles, reports, and research. When the search was carried out on the Syrian refugees, the inclusion period was between 2011 and 2019 because the crisis had started in 2011 and was still ongoing at this moment in time. Summon is a search engine that identifies books, e-books, journal articles, source items and UniTube recordings. Summon is a comprehensive search tool, which has an option that allows researchers to expand the search result and include results from outside the library's collection. Other related search strategies were determined to enhance the literature review search.

There were 849 titles identified in the search; 50 articles met the inclusion criteria. I did not limit my research to a particular population when I was looking for data on the refugee mental health and quality of life in general, because I wanted a broad representation of the targeted topic. Searching for refugee terms separately such as the 'quality of life' or either 'mental

health’ showed more results than searching for both domains together at one study. The search included title key words, all text and topics for chapter two and three.

3.2.1 Inclusion Criteria:

1. Studies with title and abstract of relevant to the study research
2. Research published in any date
3. Reports and books, journals and articles
4. Studies only related to the refugees’ population
5. Crisis phase when searched for Syrian refugees (2011-2019)
6. Any population
7. Research published in English language only

3.2.2 Exclusion Criteria:

1. Newspaper articles
2. Irrelevant titles, or abstracts

3. Opinion, or predictions
4. Research not written in English
5. Unrelated topics

Search Keywords:

1. Refugees
2. Quality of life
3. Mental health
4. Syrian refugees
5. Syrian refugees in Jordan
6. Refugees Statistics
7. Syrian refugees’ mental health
8. Refugees mental health
9. Refugees mental health Issues
10. Syrian refugees’ quality of life
11. Refugees quality of life
12. Syrian refugees’ services
13. Internally Displaced People (IDPs)

3.2.3 Used combinations terms:

1. Syrian refugees mental health and quality of life
2. Syrian refugees mental health and quality of life in Jordan
3. Refugees mental health and quality of life
4. Syria refugees and NGOs services
5. Syrian refugees mental health and stigma
6. Internally Displaced People in Syria

7. Syrian refugees’ statistics in Middle east and globally
8. Syrian refugees in Jordan
9. Syrian refugees worldwide.

It was important to establish the terminology applied to Syrian victims of the conflict throughout this study. This study focused on the Syrian refugees who had crossed the border into a neighbouring country, Jordan. It is estimated that there are in total 5.6 million Syrian refugees and 6.2 million internally displaced people (Reid, 2020). For personal safety reasons, IDPs were excluded from being interviewed for this study. They do however remain a significant number of the human casualties of the Syrian conflict and warrant equal concern as those Syrians who have found relative safety outside of Syria. An additional vulnerability for refugees who have left Syria is the risk of becoming ‘stateless’ as this can complicate and sometimes prevent resettlement in another country.

Internally Displaced Persons (IDPs)

When people escape and stay within the same country borders, they are called an ‘Internally Displaced Person’ (IDP) which are people displaced inside their countries when they move from a conflict zone to a safer area or are displaced because of their religion, ethnicity or political views. There were 50.8 million IDPs worldwide at the end of 2019, (45.7m.) a result of conflict and violence, (5.1m.) a result of disaster as stated by (Internal Displacement Monitoring Centre, 2020).

The continuity of fighting in the Syrian Arab Republic caused the IDP number in August 2019 to increase to 6.2 million inside Syria in addition to eleven million individuals in need for humanitarian assistance, according to The United Nation High Commissioner for Refugees (UNHCR, 2019). That is the highest number in any country in the world. Further details regarding the issue of Syria is discussed in the previous chapter which describes the political context.

Nine years have passed since the Syrian crisis has started and the humanitarian needs in the country have continued to be overwhelming in aspects of severity, scale, and difficulty, with risks continuing in several areas. The United Nations estimated that there are 4.65 million individuals in serious need due to a convergence of vulnerabilities subsequent to dislocation, experience to conflicts and restricted access to basic goods and services (UNCHR, 2020).

Asylum Seeker

When a person flees to another country seeking safety and protection, they are called an ‘asylum seeker’. An asylum seeker is a term that means that a person has completed a UNHCR application for protection by the Refugees Convention or Article 3 of the European Convention on Human Rights (ECHR), which is a legal international tool approved under the sponsorship of the Council of Europe. Its requirements are compulsory in UK law courts according to the Refugee Council (2013). Globally there were 4.2 million asylum seekers in 2019 (UNHCR, 2020). In 2018, 1.7 million new application were submitted for asylum seeking, United States of America had the largest accepted applications number with 254,300 (UNHCR, 2019).

Refugee

The United Nations addressed the refugee issue in 1951 and established regulations and policies and named them the ‘Convention Relating to the Status of Refugee’, which defined the term ‘refugee.'

The term ‘refugee' was introduced by the United Nations Educational Scientific and Cultural Organization (UNESCO) as, *‘A well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and*

being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. In the case of a person who has more than one nationality, the term 'the country of his nationality', shall mean each of the countries of which he is a national, and a person shall not be deemed to be lacking the protection of the country of his nationality if, without any valid reason based on well-founded fear, he has not availed himself of the protection of one of the countries of which he is a national' (Geneva Convention, 1951, Article 1A (2), (UNESCO, N.D:Online). This definition was applied to the targeted population in this research.

In 1967 the United Nations updated the refugee convention, due to the new refugee situation that required the change. The new convention only removed the geographic and temporal limits of the 1951 convention, so it is valid to be used worldwide (Text of the 1967 protocol, UNHCR, 2010J).

This study focuses on the refugees living in one refugee camp within Jordan. (UNICEF, 2019) published a report about the Syrian crisis in April 2019. The reports states that Jordan still hosts and protects 1.3 million Syrian refugees. Presently, 121,280 Syrian refugees live in camps (75,285 refugees in Za'atari camp; 39,407 in Azraq camp; 6,588 in the Emirati Jordanian camp) and the rest are spread within the Jordan communities.

Statelessness

'Statelessness' is a term used to define the condition of a person who is not holding any nationality. While refugees may sometimes easily be

stateless, both categories are separated, and the two groups are the UNHCR's concern. Article 1 of the 1954 Convention regards the situation of Stateless Persons and defines a stateless person as *"an individual who is not considered as a national by any state under the operation of its law*" (UNHCR, 2010).

The definition made it clear to understand what a stateless person means and that can happen due to being a refugee in another country and ending up stateless. Some people are born without nationality and that means they are stateless, but for some people life forces them to be stateless due to other reasons. Each country has its own law for people to acquire their nationality or to withdraw it under certain circumstances. The nationality laws are written very carefully and applied correctly. Otherwise, some people can quickly become stateless. For instance, if a child was born or brought up in a country and did not have an identified family, this child can easily become stateless if the nationality can only be obtained based on national parents. Luckily, in general, nationality laws do not do this, so they identify them as citizens of the state in which they are born.

In 2013, the global number rose to 51.2 million displaced refugees, which was a 13.2% increase from the previous year. In one year, there was a rising number of six million refugees which shows a dangerous sign and a critical situation. Another important fact is that every day 42,500 persons are displaced by force due to a conflict or persecution in their area (UNHCR, 2015). Going back to the year 2012, the total number of refugees was 45.2 million. In 2015 the number rose to 59.5 million (about 15 million refugees more in three years), which was a global risk for the refugees themselves and for the surrounding communities (UNHCR, 2015).

Furthermore, regarding statistics about the refugee number globally, the (UNHCR) reported that the number has substantially increased from 43.3 million in 2009 to 70.8 million in 2018 and mostly the number was from Syria in the years between 2012 and 2015 (UNHCR, 2019).

Additionally, in June 2015, in regard to the global refugee records, the (UNHCR, 2015) published some figures about the refugees globally stating that an extraordinary 59.5 million individuals worldwide were moved from home forcibly. Twenty million of the total number are refugees; more than fifty percent of them are under the age of eighteen. Another ten million are stateless people, who do not have a nationality and do not have access to the basic life needs. Considering the figures included here, they indicate clear evidence regarding the severity of this growing humanitarian crisis, which needs more attention and assessment to prevent the harmful consequences on civilians.

3.3 Literature Review Findings

This section contains a summary of previous studies that were conducted on refugees' different circumstances and in particular on their mental health and quality of life. War, conflicts, and persecution have forced millions of people to leave their homes and their native countries seeking a safe area and protection, and this can result in them being displaced inside or outside their country with the global picture well documented by the UNHCR.

The refugee number has been growing each year, particularly in the period between 2011 and 2016 due to the Syrian conflict and other conflicts in the Middle Eastern region, which is an issue that needs to be taken into account and should be looked at, not least because of its impact on surrounding countries.

It is essential that humanitarian agencies are able to minimize the consequences and side effects on the refugees and the hosting communities both together, for instance recommending change to the policies, plans and strategies. Understanding the prevalence of mental ill health, for example, can avoid overcrowded health service facilities and provide guidance to ensure enough care is made available.

The majority of people in developing countries live on less income and have access to poorer public services than the people living in high industrial countries (The World Bank, 2012), but are hosting more than 86% of the refugees globally. This compares unfavourably to the 70% before ten years ago. At the end of 2014, Syria was the highest source country of refugees around the world, taking over from Afghanistan, which was the number one country for three decades (UNHCR, 2015).

In most communities who are hosting refugees, there is a difference in the refugee's life and the original hosting people's life in most of life's aspects such as the quality of life. For the purpose of this study, as it deals with a regional issue that has global significance, the key definitions of ‘quality of life’ and ‘mental wellbeing’ are drawn from the WHO.

‘**Quality of life’** is defined as:

'*Individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*.' (WHO, 1997:1),

'**Mental health'** is defined as: '*A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*' (WHO, 2014).

One of the challenges highlighted in the research is that host communities struggle to provide the same level of healthcare as they do for their own populations. In terms of facilities for refugees, the health service facilities in the host community are fully prepared and will provide a good quality service for a certain number of beneficiaries, but the healthcare services on the refugee camp will not be sufficient to cover all the areas of health and increasing significant demands. Moreover, Saleh et al. (2018) found evidence of the difference between the experiences of the refugees and the host community and said that the arrival of Syrian refugees led to an increased burden on the main services of health, sanitation, water, shelter, jobs and education.

Research was conducted via qualitative surveys of refugee children at school who were resettling in Turkey. They found that there was a lack of Turkish language ability and absence of attending school, education, obtaining a job, housing, financial problems, accessing general services, cultural barriers and variation, social issues (Seker and Sirkeci, 2015). They also reported that the refugees struggled to make friends among their peers. Refugees were vulnerable to health problems and infectious diseases especially when living in camps (Seker and Sirkeci, 2015). For

example, the World Health Organization (WHO, 2015b) reported 37 Polio cases spread in Syria in 2014.

(Oluwaseun et al., 2012) carried out research on refugees that lived in Nigeria and compared their quality of life and mental health to the host community. They used a cross-sectional study design by using the Mini-International Neuropsychiatric Interview (MINI) (Sheehan and Lecrubier, 1997), WHO quality of life (WHOQOL-BREF) (WHO, 2004) and the Community Quality of Life (CQoL) (CQoL, no date) for data collection.

The sample size was 444 refugees and 527 non-refugees. By using MINI, some mental health symptoms were reported; the most common symptoms amongst the refugees was depression (45.3 %), then obsession (34%), followed by Post-traumatic Stress Disorder (34%), then mania (25.9%).

The lowest reported symptom was suicidal ideation (11%), although auditory hallucination (27.1%), visual hallucination (25.6%) and alcohol abuse (19%) were more common among the refugee population than the host community (Oluwaseun et al., 2012). Overall, (Oluweseun et al., 2012) found that there was a greater presence of mental health issues among the refugees that needed the intervention of local mental health services.

The study by (Oluweseun et al., 2012) shows that individuals who are living in the targeted areas were in need of urgent support and help to enjoy better long-term health and safety. The research cohort consisted mainly of IDPs who were afraid and worried for their families and did not get any social support and experienced poor mental health. Therefore, there was a need for social, general health and mental health services to

be implemented in such circumstances, although (Oluweseun et al., 2012) found that it was a challenge to apply in these situations. The challenges were compounded by problems of the equity of access, resource capacity, and competence, stigmatization and absence of awareness in service function and availability.

(Oluwaseun et al., 2012) have also reported that the refugees are three times more likely to have poor mental health compared to non-refugees. In addition, there were other factors that compounded the impact of refugee status and caused further deterioration in mental wellbeing. For instance, unemployed and unskilled workers had two or more times higher chance of poor mental health compared to professionals (Oluwaseun et al., 2012).

In a study of the refugees who resided in Nigeria, a study was carried out in 2010 concerning refugees who lived in Oru Refugee Camp, Ogun State, Nigeria (Akinyemi eta., 2014). The researchers employed a qualitative methods research design; a total of four focus group discussions, which were completed with adult refugees from both genders, a total of thirty-two participants, divided into eight individuals at each group. (Akinyemi et al., 2014) found that additional factors affecting refugees were housing, security and lack of opportunity. In respect of the refugees who resided within Nigeria, they stated that their mental health was affected by the capability and the competence to act individually. In general, the participants responding to the quality of life question, stated that it was dependent on the environment they live in, food availability, and social amenities. The refugees emphasised that housing and security were central issues to consider when examining the quality of life (Akinyemi et al., 2014).

Adding to the issues already mentioned, housing and security were important parts reported by the groups to consider regarding the impact on quality of life (Akinyemiet al., 2014). In regard to the refugees' opinion about the relationship between the quality of life and the mental health, mostly they stated that the quality of life is a central influence of mental health status (Akinyemi et al., 2014). The researchers have pointed out the principal factors which were highlighted by the refugees that affected their mental health and quality of life: poverty and unemployment, physical health, lack of family support, family problems and abuse suffered in the refugee camp, religious and spiritual factors, environment, discrimination and social vices (Akinyemi et al., 2014).

3.4 Syrian Refugees

In a recent article on the accounts of Syrian refugees, (Syam et al., 2019) conducted a study which noted the experiences of refugees living outside their home country. The study pointed out that since the onset on the civil war in Syria that occurred in 2011 and the refugee crisis that ensued right after, a large number of citizens that had previously been living in peace suddenly found their home country had become a warzone and they had become displaced to other countries. Afterwards, Syrian refugees found refuge in neighbouring countries such as Jordan, Lebanon and Turkey.

Since September in 2016, the number of Syrian refugees that were displaced externally has reached approximately 5.5 million refugees globally (UNHCR, 2020). Syria had become one of the three countries where the refugee population leaving the country was unprecedentedly high and showed no signs of stoppage. The refugee crisis can be exemplified in scale through looking at Lebanon, a country which had in 2018, an estimated population of six million inhabitants. Almost one million of this population were registered as refugees, whereas the number of unregistered refugees within Lebanon was possibly equally as high.

Since then, Syrian refugees have resettled around Lebanon in a number of places, such as in the Palestinian refugee camps that were already established, and which housed a disproportionately large number of people. Here, the living standards are harsh and inadequate, to the point that substandard housing was the norm. Lebanon has an estimated refugee population of around 450,000 Palestinians, among which 53% live throughout the country in around 12 refugee camps (UNHCR, 2020).

The Shatila refugee camp, where a study by (Syam et al., 2019) was carried out, is one of massive overcrowding, civil unrest and restricted and constricted access for its population due to the lack of proper accommodation.

There are spatial issues, a complete lack of any educational system, no electricity or power, or even drinkable water. In 2015, there used to be an open-door policy for any refugees, at least from Syria, which prompted them to not require any visa pass for entry, in addition to having free residency renewals. All these privileges, however, came to a swift end when the Lebanese government introduced revised residency renewal regulations that turned out to be far more expensive than necessary.

Syam et al. (2019) explored in their study the ramifications of that particularity, as many Syrians lost their legal status within the country of Lebanon as a direct consequence (El Arnaout et al., 2018). This, in turn, not only limited their rights and ability in travel and to access education, but even their access to some social facilities such as healthcare were limited as well.

One particular focus for Syam et al., (2019) was on the mental health of the Syrian refugees that had been displaced within Lebanon for several years. Due to losing their homes and being forced out of their own country, and then later having their new homes revoked. This caused mental health issues that were explored in greater depth by other literary works such as Abo-Hilal and Hoogstad (2013). They studied how mental health in refugee camps was being handled. It was noted in both studies mentioned above that refugee mental health was adversely affected when living in difficult living environments, and that long-term migration was a risk to good mental health across a plethora of contexts and situations.

One particularity was that women were seen as being under an enormous amount of stress due to concern for the well-being of their immediate offspring. In addition to familial worries, women had to deal with the pressures of being in debt, being poor, and unemployed, which was true for the refugees almost regardless of how their previous life had been (Abo-Hilal and Hoogstad, 2013).

In other contexts, violence was also looked at by studies such as Chu et al., (2013), as well as Farhat et al., (2018) on violence issues stemming from the mental health of refugees. Violence against and among refugees

from Syria had, in addition to stemming from the long-term displacement of the populace, been reported as a consequence of extrinsic factors and contexts as well.

Migrations – or at least, forced migrations – were described by Syam et al., (2019) as implicative of decaying familial relations, where the differences in job trends, gender roles, and the general difference between Lebanese and Syrians as a whole, all boiled together into a time when emotions and tempers were high. Farhat et al., (2018) rightly observed this phenomenon, and is also found among other Lebanon studies (Chu et al., 2013).

This led to the discussion of whether the Syrian refugees had any access to healthcare, especially since the ensuing conflict would have definitely caused severe adversity to the mental health of many refugees. Providing access to these refugees was a challenge in and of itself, especially in a part of the specialised services lacking in camps such as Shatila. In 2013, a Women's Health Centre (WHC) was established in Shatila along with a Primary Health Centre (PHC) that served as the more basic delivery system for healthcare.

After that, the Médecins Sans Frontières (MSF), an international organisation that provides humanitarian services as well as medicinal help to the refugees, did tend to some of the needs of Syrians in camps around Beirut, Lebanon, but there was a distinct lack of mental healthcare, as Abo-Hilal and Hoogstad (2013) observed in their study. The distinct lack of mental healthcare was also a result of misunderstanding what might have caused it in the first place, and it resulted in the focus being relief from the

war rather than from their current living conditions (Abo-Hilal and Hoogstad, 2013).

The Médecins Sans Frontières (MSF) workers noted that since 2015, more and more patients began reporting the distress they faced and that it did not stem as a direct consequence of the war, but instead as a result of their long-term displacement in the camps of Shatila. The MSF mental health professionals and psychologists that were able to gather data reported that domestic violence had increased significantly since the earlier refugee crisis as numbers indicated and that a further exploration had to be undertaken (Farhat et al., 2018).

Syam et al., (2019) had noted in their study that this exploration was carried out on the changes in gender roles of the Syrians, the family dynamics, their changed living experience, the violence ensuing across the camps, and other mental health concerns. All this provided limited insight into how the extended living experience in Shatila translated into detrimental mental health for Syrian refugees, as the qualitative research failed to answer the question in any meaningful way as it was perhaps over-descriptive.

To further elaborate on the subject, Syam et al., (2019) continued the studies of the MSF foundation and provided a detailed account of the sufferings of many Syrian refugees. This was reported in the study conducted on the experiences and personal accounts of refugees living in the Shatila refugee camp, which was the situation in the southern region of Beirut, Lebanon. In their study, (Syam et al., 2019) titled it "*with every passing day, I feel like a candle, melting little by little*" (p.1). It was a rather harrowing account of the hardships the people had to suffer at the

Shatila refugee camp, where the refugees had to face prolonged exposure to challenging and substandard living conditions.

The issue was exacerbated from the fact that these refugees remembered an objectively better life in Syria, which was the one they had left behind. (Syam et al., 2019) interviewed individuals who had thought that Syria was a region of peace and tranquillity before the conflict and civil strife struck the country. Many lived in open rural areas where green landscapes and fresh air were the norm. It was worth noting in the study how women were particular in their frequency of visiting their neighbours and spending time in the fresh air. The authors conducted interviews which presented life before the conflict:

"In Syria we have fresh air and sun and we can sit in front of our houses. Here we don't have any space. The door is always closed. Sometimes the children want to play outside the room, but I don't allow them to...there is air, but sunlight does not enter. (Female, aged 26)" (Syam et al., 2019: 4)

A 42-year-old male cited described Syria as essentially the ideal living arrangement for them prior to the civil strife:

"*In Syria if I broke both legs I wouldn't care because we could have anything. Here you always have to fight to live."* (Male, aged 42) (Syam et al., 2019, p.4).

A 35-year-old man expressed a similar desire to return: "*living here is worse than shelling...hunger is way worse than the shelling*." (Male, aged 35) (Syam et al., 2019, p.4).

All the participants had some level of dark, inhumane, and miserable living conditions that they had to live through in Shatila. According to the

descriptions of the refugees, the places they lived in were dark, cold, and cramped rooms where there was no electricity or running water. (Syam et al., 2019) interviewed a middle-aged woman in Shatila who described how the refugee camps made people live almost like wild animals. Several of the Syrian refugees were forced to share a single room with several members of the family, and the son of one refugee interviewed had to sleep in the kitchen as the living spaces were extremely limited.

There have been several reports of increased health problems as a result of humid houses and lack of sunlight, such as respiratory problems. This situation, in turn, meant that their financial situation would not be any better. This further meant that they were unable to afford any access to even the most basic healthcare outside of the services that organisations such as MSF provided to them.

During interviews, one common topic was the day-to-day battle for food, with several participants explaining how they consumed food from the trash bins of the site. For men, in specific, it was the problem of finding work and the demanding workplace conditions they endured if they were able to receive job opportunities. The interviewees believed that the war in Syria and the increase of incoming refugees generated increased demand for workers, which in effect reduced earnings and workers.

The uncertain and dangerous environment at Shatila was a very critical point for conducting interviews with men and women, which Murakami and Schechter (2016) pointed out to result from their displacement.

Participants were afraid of getting out into the city and often kept their children confined inside their homes. One male delegate, fifty-nine, contrasted his current living circumstances to the Syrian crisis. Almost

every interview participant was adamant about the dire financial situations they had, and the challenges they faced along the way. (Syam et al., 2019) interviewed participants who put forward just how costly living and rent was in Shatila camps, especially if the civil war prior had left them utterly penniless to continue to be able to pay or afford rent. Most of the refugees felt like they were living trapped inside the rooms they had rented, and that the situation only ever got worse. Many referred to the camp as a jail, and a 61-year-old man described it as a location where he was unable to get a breath of fresh air, and another interviewee said they thought they were in a kind of grave.

Previous research had shown that some women and their children made infrequent visits to a local park, but most people did not leave Shatila (Almoshmosh et al., 2016). Challenges in renewing their residence permits meant they feared being apprehended if they ever left the refugee camps (Almoshmosh et al., 2016).

3.5 Socioeconomic Factors Affecting Refugees After Migration

Further examination was carried out by (Betancourt et al., 2012) on the evolution and potential resolution of psychological well-being amongst the resettled refugees. The mediating factors for this were identified as socioeconomic factors, including the security provided for housing and financial stability for the refugees, in an environment where the settlement of refugees would inevitably be struck by economic and financial distress

and challenges, which can often be caused by the inability to find suitable employment or obtain proper financial security.

Moreover, there were a plethora of employment challenges that refugees experienced (Betancourt et al., 2012), among which the restrictions of their visa, differences in their languages, differences in qualifications and requirements for the country the refugees resettled in, differences or a complete lack of proper vocational skills, discrimination, physical barriers, and psychological hurdles were among the most prevalent. As such, this resulted in the refugee population of the resettled country, contributing to a much higher unemployment rate of that country, especially in comparison to the host country where the conflict ensued (Almoshmosh et al., 2019).

Data indicated that displaced people with minimal exposure to job opportunities had disadvantaged effects on their psychological health as a result of reduced career advancement prerogatives and job prospects relative to those with maximum convenience to such employment opportunities. Outside of pre-migration tension, unemployment in refugee populations was one of the most prevalent risk factors when it came to depression and anxiety among refugees. Resource constraints and financial difficulties in host countries also meant that several of the refugees only ever had limited access to stable housing in the areas where they eventually settled, which was a potentially significant source of mental stress among the refugee population.

In a study that examined the association of displacement of refugees on their mental health, Porter and Haslam (2005) conducted a meta-analysis of several dozen scholarly and academic works, looking at refugees with better housing accommodations than most, and comparing them to those

in temporary or even institutional settings. The meta-analysis revealed that mental impairments and insecure housing environments were effectively correlated, even in more extreme situations such as torture survivors who settled in the United Stated of America (USA).

On a further note, research carried out on surveys, and qualitative analyses revealed that unsafe housing had a significantly negative impact on the mental health of UK refugee survivors, so much so that cultural and social impacts contributed towards mental impairment. If it is looked at in tandem, the academic literature on socioeconomic factors well after migration, and how they had impacted the refugee population regarding their mental well-being, discerned that financial constraints and challenges in obtaining adequate accommodation posed significant obstacles to successful psychological transition after resettlement (Renner et al., 2020).

3.6 The Impact of Interpersonal and Social Factors Post-Migration

As demonstrated by Hynie (2017), forcible displacement was being experienced by an unprecedented number of people around the globe. In 2016 alone there were more than sixty-five million people who had been displaced and around twenty-two million of these were forced to leave their homes as refugees elsewhere across international borders (Hynie, 2017). That not only was that the largest number in recorded history, but

it also did not count those that had not been recorded or documented in their departure and did so in complete secrecy.

According to the 1951 Convention Related to the Status of Refugees (UN General Assembly, 1951), refugees were classified as those that had fears of persecution due to their race, religion, political stances and beliefs, sexual identity, membership in a certain social sphere, nationality, etc., and that those fears were well-founded, as they could no longer rely on their nation or their nationality to provide the backing or protection they needed. Due to this classification, these refugees were allowed to have protections and rights unique to them, signed in by the 1951 convention's signatories, though the level of their implementation was liable to shift and change over time due to political differences and conditions of providing asylum. It was found that none of those displaced across international borders was actively seeking any long-lasting solution to their issue.

In 2016, more than five hundred thousand refugees migrated from their country of birth, while more than twenty thousand were naturalised in the country in which they were granted refuge. Less than two-hundred thousand were able to receive any meaningful benefit from a resettlement programme, where refugees would essentially be selected and screened while in their asylum country and permanently resettled into a different country. Over time, with the increase in refugee populations, the issue of displacement and providing asylum remained so for more than a decade for a refugee, sometimes more (Almoshmosh et al., 2019).

However, signs of improvement were non-existent, as this number increased to over twenty years, as Hynie (2018) provided evidence of in their study. This meant that a large number of people were always trapped in a protracted issue of displacement for a large chunk of their lives, with a

majority of them being among the low-income bracket. Displacement necessitated the individual to essentially root out their old self, their identity and personality, and transition into a completely new cultural and physical environment, which often posed significant interpersonal challenges to them. Difficulties such as long-driven separation, discrimination, social isolation, loss of social identity, separation from their family in their home country, and severance of connections and linkages to their former groups and communities (Smeekes et al., 2017).

Family separation would often be the representation of most of the hurdles and issues in psychological outcomes, as it would directly act as a barrier towards a positive outcome. According to Hynie (2018), the somatisation of familial separation in refugee groups and anxiety related to it was similar to anxiety from having family overseas, and that reunification of the said family would immediately result in a mitigation of psychological distress and the effects of trauma suffered in the past (Betancourt et al., 2012).

A study of refugees from Iraq in Australia studied along similar lines, as it examined Iraqi refugees that had become separated from their immediate families. A study conducted by Miller et al., (2018) noted that those separated from their families had more disabilities relating to mental health, while Chu et al., also found that facing symptoms of depression and PTSD resulted in more severity than their non-refugee counterparts (2013).

The study by Miller et al., (2018) found a much higher probability of psychiatric disorders, irrespective of preceding exposure to trauma and present living difficulties, accounted for intrusive family fears for those that managed to remain in Iraq. This was further bolstered by research

results from qualitative interviews with Australian refugee community members.

As a whole, the results indicated that stress and concerns regarding family separation were associated with poor development of language skills, constrained jobs and employment opportunities, and a lack of adequate concentration due to the refugee status. In addition, there was social isolation, which was discovered to lead to even worse outcomes for the mental well-being of the refugee, and that the lack of social support – which is critical in such times for refugees – was part of the reason that mental health problems were exacerbated (Chung et al., 2017).

There were certain social factors that were deemed as important to the overall mental health of individuals, such as their perception of discrimination against them in society and how their social roles had changed due to their displacement. Discrimination served as not an issue resulting from other factors, but one that branched out into other avenues. For example, discrimination led to social isolation, which would have severe and adverse implications for the mental well-being of anyone, especially a refugee under distress (Chung et al., 2017).

This also affected their general quality of life, as perceived discrimination was an associative symptom for depression among refugees, regardless of whether it occurred before or after their forced displacement. In addition to this, the rapidly changing and unpredictable social roles that would result from migration were found to affect the psychological adjustment of individuals adversely (Chung et al., 2017).

As an example, regions in Africa have a certain culture regarding familial values and gender roles that would often see a dynamic shift, where the

male would lose his position as the primary earner in the family, especially in areas of financial equality between spouses (Chung et al., 2017). This led to the intensification of interpersonal issues among families, eventually leading to domestic violence among refugees.

There were other changes as well, such as the shifting socioeconomic status that would impact their mental health, their social role, and the impact that the expectation of society and societal roles had on their mental health. Refugees that had received a higher level of education and social education would fare far worse than those with relatively poorer records, and the change in social standing was the factor that led to this worsening outcome (Chung et al., 2017). In the sections below, the various factors of social and interpersonal nature and how they affected refugees are explored.

3.7 Income

Income was found to be a rather significant factor in detriment towards a refugee's health and general quality of life, at least when they were among the lower-income bracket. Income increased the common mental disorders regardless of the age group they were presented with, with (Hynie, 2018), noting that young children who were going from

adolescence into their teenage years all the way into adulthood had their mental health affected by having to survive on a low income.

For refugees specifically, the primary issue was the low income despite what they might have had as their socioeconomic background before their migration, as they had to leave everything behind forcibly. This was not limited to their nationalities and identities, but some that had local businesses within the conflict regions would have had no choice of relocation either way (Hynie, 2018). People lost their homes, their material possessions, their savings, their livelihoods, and almost all legal documents that would have proven their qualification in a given profession. It meant that securing a good income was even more difficult, with almost everyone having no documented background available, and every refugee clamouring for job opportunities (Hynie, 2018). Refugees arrived in their destination with an inherent poverty status not only would expect to remain in poverty for a long period but would suffer considerably in terms of their mental health. As a result, it was further disallowing them from securing a profession with a stable income. A correlation was found by Hynie (2018) between low socioeconomic status and mental disorders such as depression, distress, and PTSD.

3.8 Employment

There was a strong connection between financial difficulties and inadequate job opportunities. A particularly common experience for refugees was the struggle to find adequate and appropriate employment

or even any job. Refugees encountered greater difficulties in terms of jobs than voluntary migrants as they did not have power about how, where, and where to migrate (Smeekes et al., 2017). As a consequence, people would be less likely to come speaking the national language, which has been repeatedly demonstrated to be a critical employment barrier. They encountered greater difficulties in getting their qualifications recognised, as there would be a shortage of data on their vocational skills due to forced migration (Smeekes et al., 2017). While the identification of qualifications and past experiences in a foreign region is a problem faced by many, the difficulties for refugees was far greater, as they were more likely to be over-qualified for their current work, but completely unable to prove it unless provided the opportunity(Smeekes et al., 2017). Besides that, over-qualification was also often correlated with poorer self-reported mental wellness, corresponding with other studies suggesting that, for factors outside economic well-being, unemployment impacts mental health, having an effect on one’s identity and self-worth (Smeekes et al., 2017).

Unemployed refugees can be exposed to mental health risks in many diverse ways (Short and Johnston, 1997). It can lead directly to poverty which can lead to less education chances and restricted access to healthcare; an unemployed person usually feels frustrated and stressed which can lead directly to more mental health issues and it can lead to adopting the wrong coping mechanism such as drinking, smoking, gambling or drug abuse (Reitmanova & Gustafson, 2009).

3.9 Housing

Poverty would invariably lead to issues in housing, and for refugees the problems only ever got worse. Overcrowding, safety risks, lack of electricity, no running water, substandard provision of basic necessities, failing structural elements, etc., were all the norm in refugee camps such as Shatila, as demonstrated earlier (Syam et al., 2019). The linkages between poor mental health and less than substandard housing have been well-documented to affect mental health negatively. Refugees continued to be resettled into poor-quality accommodation owing to their financial limitations, unable to maintain the homes they had and faced constant overcrowding (Almoshmosh et al., 2019).

Inadequate accommodation and financial problems were the main causes of post-migration tension for refugees, in addition to family splits. Housing issues had been further compounded by housing rules and procedures that had been shown to be disproportionately prone to impact immigrants, such as demanding down payments or letters of reference, and segregation that essentially prevented them from affordable accommodation and healthier communities with improved facilities and amenities (Georgiadou et al., 2018).

3.10 Language Barriers

Language barriers have been the core of many issues, and for refugees, the problem was exacerbated beyond their control. Firstly, they had no choice in migrating to that particular country as their own home was being ravaged by civil strife. While Syrians and people in Jordan spoke the same Arabic language, differences in dialects, culture norms, etc., all contributed to issues in interpretation in such language that would often relate to unemployment (Panter-Brick et al., 2018).

Communication differences had an important impact on refugee mental well-being, which is a determining factor for mental illness. As described above, language skills critical for employment, but fluency in the settlement country's language, or access to interpreters, would have a pervasive effect (Panter-Brick et al., 2018). The lack of skilled, trained interpreters in care environments appeared as a common problem, with significant implications for health coverage.

In addition, a lack of professional interpreters had also impeded access to interpretation and traversed a variety of social rules and laws, and, therefore limited the ability of asylum seekers and refugees to advocate for their rights (Panter-Brick et al., 2018). The provision of interpretation services may be resolved by legislation, but there is a hesitation to utilise interpreters in certain settings; surveys have reported under-utilisation by health care practitioners of the accessible interpretation services, indicating a need for greater support and awareness by service providers (Panter-Brick et al., 2018).

3.11 The Asylum-Seeking Process

Asylum-seeking is essentially the very reason any refugee migrates to another locale in the first place. Asylum means to take shelter from something, and refugees often seek asylum at other locations if their home country becomes unliveable due to political strife, social hardships, economic disasters, natural disasters, etc. (Hamid, 2018). Asylum-seekers rarely have any choice in the matter, as they are more concerned with survival at first, but when they settle somewhere numerous issues pop up, which invariably lead to poor mental health and its outcomes. These problems can be exemplified by issues in housing and citizenship. For example, refugees might have to spend years without proper access to any legal employment, as they would lack the credentials and documentation to prove their vocational skills, which leaves them particularly vulnerable to poor mental health.

3.12 Social Support and Social Isolation

Isolation and loneliness are both common occurrences and concerns among refugee populations and their mental health. One of the most salient determining factors of mental health adversity in adults has been found to be social isolation, though it is far more dangerous to women and older people than male adults (Hendrickx et al., 2019). Despite that, the concern cannot be discredited, as social isolation can be contributed to by

most of the factors mentioned above, such as income, housing, employment, family separation, language barriers, etc. The lattermost is one of the major factors of social isolation, as not being able to properly speak the language can lead to feelings of isolation despite being surrounded by people. Essentially, everyone becomes a stranger, and that can lead to depressive episodes and periods of loneliness (Javanbakht et al., 2019).

3.13 Discrimination

Refugees are essentially similar to foreigners when it comes to being in another country, but they do not receive the same level of sentiment from the native population as, say, tourists might. Essentially, both sides are at a disadvantage in this situation. Refugees arrive in droves, often compromising the economic and social balance of a region and can potentially disrupt other aspects as well. While refugees have no choice in the matter, their dire situation means that they absolutely need to feel welcomed at their new homes, even if temporary, due to the trauma they might have faced (Betancourt et al., 2012).

As such, the native people are not always welcoming to the refugee population, especially in the case of long and drawn out border conflicts

that put forward a regular contingency of displaced refugees beyond their home nation’s borders (Hassan et al., 2015). Studies have put forward that the feeling of being welcome ties into the mental health of individuals and this is no different for refugees either. Acceptance can have a significant impact on mood disorders and discrimination stemming from such unwelcome behaviour can lead to further harm, such as depression and social stress. One of the main discriminations for a mixed immigration groups is the racial discrimination which is a high risk for the mental health (Rousseau, 2011). Immigration and Asylum-seeking become a major issue in nowadays, next sections explores this issue.

3.14 Immigration and Asylum-Seeking

Given the greater influx of asylum seekers in the destination countries, there is a growing movement towards increasingly stringent asylum policies, including longer minimum holding periods, prolonged screening times and conditional (rather than permanent) refugee visas. Consequently, there is often uncertainty in the process of seeking asylum, which requires the applicant to follow complicated legal procedures. Research studies have shown that the asylum seeker phase leads to

significantly increased symptoms of mental well-being (Chu et al., 2013; Laban et al., 2004).

Globally, involuntary detention is a widespread method of arrest enforced in reaction to migrants' illegal entry, including those looking for shelter outside their home countries. However, the process of seeking asylum was long and arduous, so much so that it may have adversely influenced mental well-being including the lengthy and ambiguous processing time, proximity to others with high levels of distress, lack of control over processing times for asylum claims, lack of provision or accessibility to the relevant legal representatives or similar services, lack of agency, and ongoing family separation (Li, Liddell and Nickerson, 2016).

Robjant et al., (2009) studied the impact that detention for immigrants had on their mental health outcomes and found that increased levels of PTSD, depression, and anxiety, among other mental distresses, increased with time spent in looking for shelter as refugees (Rizkalla & Segal, 2018). Findings from a detention centre put forward the notion that the prevalence of mental health disorders was increased in adults by almost three times, if they would be put in such immigration detention (Chu et al., 2013).

A research study contrasting two classes of Afghan asylum seekers in Japan with similar rates of pre-migration trauma showed that the community with previous experiences regarding detention centres for immigrants recorded substantially higher levels of depression, PTSD, and anxiety ten months after the release from detention relative to those that were not detained (Sagaltici et al., 2020). There is also evidence that extended custody of refugees may have an especially detrimental impact on refugee mental well-being (Chu et al., 2013).

Research suggests mental health outcomes will deteriorate the longer the process of seeking asylum takes (Salazar et al., 2016). A community-based analysis of Iraqi asylum seekers in the Netherlands for example, contrasted those seeking asylum for more than two years with those seeking asylum for less than six months and found that protracted asylum procedures reported higher levels of fear, stress and depression. In addition, this study found that experiencing a prolonged process of seeking asylum had a greater impact on mental disorders than the exposure to trauma from premigration. Furthermore, a follow-up analysis showed that the favourable association between a prolonged period of refugee commitment and psychopathology was partly due to the vulnerability over time to greater living difficulties (Coffey et al., 2010). These living difficulties included family conflict, unstable housing, financial difficulties, discrimination, and stressors directly related to navigating the asylum procedure, similar to the refusal to apply for asylum, immigration detention, and continued temporary protection.

Upon declaration of refugee status, a temporary or permanent security visa can be given to a refugee. Temporary security visas do not grant permanent residency in the country of settlement and are only valid for a limited period of time, whereby the applicants may reapply for renewed security before the visa expires. Temporary visa requirements differ across countries and can entail restricted access to relocation facilities, minimal job and research incentives, allocated living areas, and little to no possibility of family reunification. Recent research suggests that securing provisional permits instead of permanent protection permits has a detrimental impact on mental wellbeing, including PTSD, depression and anxiety.

There is evidence that, compared to those holding permanent protection visas, refugees holding temporary protection visas face greater difficulties living (Fuhr et al., 2020). Temporary security often has long-term implications for mental health outcomes: a 2-year retrospective analysis, after adjusting for background disparities (Fuhr et al., 2020), found that refugees keeping temporary protection visas reported higher anxiety, depression and general dissatisfaction, along with a decreased desire to learn English relative to permanent protection visas. Those with such visas showing signs of mental illnesses had their English language competencies improved significantly as compared to those with less adversity to mental health.

A second longitudinal study of Iraqi refugees in Australia showed that the change in visa status from temporary to permanent was associated with decreased symptoms of PTSD and depression compared to individuals who held permanent visas (Chu et al., 2013). Over time, this improvement of conditions was accompanied by reductions in the problems of the everyday life. This research supports the negative impact experienced by stressors on mental health in relation to the refugee determination process and the insecure visa status.

The applicant result may impact mental well-being, in addition to the refugee selection phase itself. In a retrospective sample of asylum seekers in Australia, those whose refugee applications were refused retained elevated rates of depression, PTSD, anxiety, and other mental disorders relative to those whose applications were admitted while substantial differences were observed in the frequency of the symptoms (De Maio et al., 2014).

A more recent study of Australian asylum seekers found that the greater the number of rejections of asylum claims experienced, the more likely an asylum seeker would be diagnosed with PTSD, irrespective of exposure to pre-migration traumas (Canetti et al., 2016). These causes have been correlated with adverse mental well-being effects, including social and behavioural problems, as well as stressors related to the asylum seeker procedure and immigration policies. These factors should not be considered in isolation but can interact with past trauma exposure to adversely affect mental health and wellbeing (Canetti et al., 2016). For example, temporary visa status or discrimination can restrict an individual's employment opportunities and this subsequent financial burden can affect a refugee's social status.

3.15 Adult Syrian Refugees in Jordan And Mental Health Workers

As the conflict in Syria continued to rage on, the refugees that had to leave the country were left with traumatic wounds that left them mentally scarred. As such, there was a dire need for the formation of a community or group which could provide help to those traumatised by the conflict. In the ensuing conflict, not all citizens that were forced to leave were completely helpless. One particular group of citizens were actually mental health workers themselves, and they had the expertise necessary to not only provide help against mental health issues but had the first-hand experience on what the trauma largely resulted from (Kerbage et al., 2020). As such, one particular psychiatrist and a number of psychologists –

the entire group being refugees from war-torn Syria – joined together to found the Syria Bright Future volunteer organisation that would provide mental health and psychosocial services to refugees in Jordan that came from Syria. To that end, a field report was put forward by Abo-Hilal and Hoogstad (2013) which described how the Syria Bright Future organisation provides assistance to families in the kind of settings and environments where their journey will be extremely harsh. This includes adapting to completely foreign living circumstance and conditions, where they might encounter unprecedented difficulties in both the journey and well after reaching their destination.

Essentially, the organisation provided short-term counselling and support to individuals, which would strengthen their resilience against the changing backdrop of their lives, and would refer organisations and families to other organisations that would provide aid that Syria Bright Future could not. The organisations referred to were both International and local to Jordan, and the group of mental health professionals would establish further support networks for the refugees (Kheirallah et al., 2019).

In Syria, the mental health side of things in both the individual level and in its provision from the healthcare sector remained ignored to the point that it would be worse than its neighbouring countries of Iraq, Lebanon, and Jordan (Dator at al., 2018). The existing mental healthcare system for Syria was limited at the time, and it was highly oriented towards providing psycho-pharmaceutical and medicinal treatment over its therapeutic counterpart (Dator at al., 2018).

The educational graduates that work in clinical psychology would, as a result, have limited experience working with a clientele that would require

a deft and personal touch, as an industry for supporting that practice was untenable. Reflecting the status of mental health provision from a therapeutic standpoint, social workers, psychologists, counsellors, and case-managers were limited in accessibility for the general population as a result. The fact of the matter is that for most people, the preferred method of seeking mental health services was to look towards the traditional methods of providing mental health support.

In addition to this, the field of psychology was determined not to be the most respectable profession (Dator at al., 2018). Training as a psychiatric social worker, clinical psychologist, or a nurse with expertise in psychiatry was limited for Syrians. As an area of research, psychology is a member of the Syrian Faculty of Education, and studies such as the one conducted by Dator et al., (2018) examined these perspectives. This directly resulted in the only available options for a psychiatric profession being something as limiting as a school counsellor – and by extension, a piece of the Ministry of Education framework – that would not provide the expertise-level of professionalism needed. Furthermore, Non-Governmental Organisations were the next best thing, as social workers for children with difficulties in learning, physical limitation, or developmental issues, were the primary focus.

Support for a more specialised system that would provide clinical psychological care, or one that looked towards psychological healthcare as a professional field, was almost non-existent. Therefore, receiving any clinical intervention, regardless of the level of complexity and expertise required, was a difficult service to acquire. In addition, there was no framework or policy for refugee populations to become registered as nurses, psychotherapists, or professionals in clinical psychology. Any legal

procedure necessary for advanced studies, licensing, accreditation, or other avenues in clinical psychology did not exist either. The most that could be expected at the point was some informal training received from professors for all but the most passionate of students, and Abo-Hilal and Hoogstad (2013) provided that this issue did not improve with time. In Jordan, the idea of going to mental health councillor for mental issues is not acceptable and can cause stigma among the people.

3.16 Refugees Aiding Fellow Refugees

Further exploring on the topic of refugee psychiatrists providing aid in refugee camps, Abo-Hilal and Hoogstad (2013) researched a number of Syrian Psychology network members who found that fleeing to Jordan would be the best course of action along with millions of other Syrians. These psychiatrists, psychologists, and mental health professionals ended up founding their own Mental Health and Psychological Support (MHPSS) organisation that was able to assist other refugees (Abo-Hilal and Hoogstad, 2013). Despite that, this proved to be an endeavour of much larger proportions than even the most challenging set up under normal circumstances. Since 2011 at the beginning of the conflict, until 2012, no international funds had been allocated from Jordan to provide mental health services to refugees from Syria.

As refugees, it was challenging for Syrian mental health professionals to acquire work permits, acquire formal permission to operate as a qualified medical or mental health practitioner, and receive official approval for

registration as an entity (Abo-Hilal and Hoogstad, 2013). The groups of mental health professionals started without a car, funding, or an office, while being now responsible for supporting millions of Syrians. As the Syrian refugee group continued to grow in Jordan, as well as the number of people in need of support and assistance, more and more members of the Syrian psychology network began fleeing to Jordan, and more and more Syrian refugees were learning about this group and choosing to volunteer.

The founders chose Syria Bright Future (SBF) as their name. SBF was made to be a non-political and independent Syrian agency that aimed, from a multidisciplinary strategy, to provide psychological and social services in an organised manner. From this approach, the social workers, psychiatrists, and psychologists would all cooperate in providing the best level of psychosocial service they could, all the while providing a system for specialised clinical care for refugees suffering from mental health issues. Operating in regions such as Irbid and Amman, the organisation was reported by Abo-Hilal and Hoogstad (2013) to be the entry point for several mental health actors in Jordan.

3.17 Volunteers in The Crisis

Abo-Hilal and Hoogstad (2013) studied how volunteerism panned out after the Syrian crisis, and how they were helping the now-displaced refugees. First off was the fact that they were volunteers, untrained and acting due to necessity and moral obligation rather than a professional one. The second was the fact that these volunteers had little to no experience or

any formal education when it came to the kind of work the (MHPSS) did for Syrian refugees. These volunteers were, essentially, recruited by the MHPSS based on their commitment to the cause, their personality, and their motivation to carry out the cause. It was ensured, though, that these volunteers would at least have a high school diploma, which is not a high bar to set for people to provide mental health support to vulnerable refugees.

These volunteers consisted of physicians, engineers, specialised surgeons, various students, and even kindergarten teachers. This group, essentially, had a massive disparity in the overall skill level, as some professional medical workers did volunteer along with those at the most amateur level when looked from the mental health provisional perspective. Prior to becoming a civic social worker, these applicants would start receiving training for physiology and psychiatry on signs and symptoms regarding mental disorders, first aid psychology, and communication skills.

These potential helpers to the refugee communities would go through a kind of screening and preparation cycle during their first days of work. These volunteer staff would accumulate experience over time, with most of it gained through observation and visitation to the families of those afflicted, attending meetings, and discussing the emergent cases of mental issues (Yalim & Kim, 2018).

Once the necessary vocational skills would have been acquired, these individuals would formally become community volunteers for mental health support. Their daily tasks included visitation to different families, usually operating in groups of two or three, and working with colleagues, friends, family, or other people for reference. With each visit, they would follow a step-by-step process of meeting with clients and their families for

a few hours to gather some background and insight into their medical and familial history. These familial visits would include recreational activities, especially with children, to help build trust and support for the volunteers. This meeting would be crucial to point out the basic necessities that would be obvious at the surface level, though this also varied from family to family.

At times, psychological issues, mental health problems (Akgün, 2016), housing challenges, educational or medical needs, etc., or any other would-be indicated during the first visit. The volunteers of the MHPSS organisation would be well-aware of the limited resources that they had and would make referrals accordingly (Wells et al., 2016). At times, the help required would be purely psychological, so the volunteers would either point them to a psychologist or psychiatrist or contact the relevant group. Referrals would largely be reserved for specialised care, as the already inflated need was not met with an equal or even close to a fraction of the supply necessary for psychological help. As such, they were identifying the necessary course of action was a critical step in the mental health provisional process. Counselling would be offered at the home of the individual afflicted, or if not possible, at the Syria Bright Future’s office.

A large number of problems would be linked with the Syrian crisis, where individuals would find it difficult to cope with their new lives as refugees, which often had them living in less than sub-standard housing conditions. Refugees were uncertain about their future, felt like they had lost all hope, had feelings of intense anger, sadness, frustration, or fear directly as a result of the crisis, and all these often resulted in family issues as well (Yayan et al., 2019).

These specialised team of volunteers and social workers had visited over 200 families in refugee camps, which totalled for around a thousand people visited, including children and adults both. The department also treated individuals with insomnia, anxiety and Post Traumatic Stress Disorder (PTSD) (Yayan et al., 2019). The psychologists have assisted about 100 patients with mental disorders in the few months they have been working, screened about 200 afflicted people for psychological needs, and referred about 45 of those for requiring specialised psychiatric or psychological care (Wildschut et al., 2019).

3.18 Strengths of SBF And Challenges

As a final piece of their study, Abo-Hilal and Hoogstad (2013) looked at the Syria Bright Future organisation itself, noting that it had essentially become one of the most sought out community-based social care organisation for the refugees. This led to the organisation having connections where they would reach families and other people with relative ease. This was a giant leap forward for many Syrians, as decades of corruption, widespread oppression, and the policing of every little part of Syrian life, trust in organisations and their formalities was almost non-existent.

The Syrian refugees feared the infiltration of the same governmental regime that had plagued the nation previously and led to the war. Many of the refugees that continued to be forced out or escape Syria would be

unaware that Jordan was a place for providing support for these families, or that international aid and humanitarian efforts were also available. As such, people had an overwhelmingly high request of aid against psychological issues, with most SBF workers helping people from the same regions they hailed, which pointed towards the level of distress that existed in the displaced families. This was also a breakthrough in building trust for the organisation, as familiar faces working in the social help field would alleviate the fears previously held for any formal institution. Families would often confide in these social workers, and both a formal and informal level of guidance existed for both sides as a result.

This kind of community work was crucial in lowering the threshold for requiring self-help, and both SBF and MHPSS hoped to and – as evidenced by this literature – became the primary actors of providing mental health services to Syrian refugees in Jordan and other areas. Taking a community-based approach was perhaps the best decision that SBF had made, as the refugees suffered together rather than alone; it instilled a sense of belonging where there was none. Meanwhile, SBF looked to other areas in Jordan still, such as Irbid, Ramtha, and Amman, where they could continue to help the displaced refugees living in harsh conditions. Their next steps, as put forward by Abo-Hilal and Hoogstad (2013), were to provide Syrians with training for helping their own and others, as SBF cannot and could not act alone in the provision of mental health on such a large scale.

Some of the relevant literature included Internally Displaced People. IDPs are considered as refugees when they are seeking safety in their country but leaving home to another area. One such research study is about IDPs' mental health and quality of life. Getanda et al., (2015) carried out a study

in Kenya on Internally Displaced people, within Nakuru County in poor, overcrowded camps. In the Kenyan refugee camps, there was a generally limited access to basic life needs such as food, drinking water, sanitation, education, and health services (Kenya Human Rights Commission and the National Network for IDPs in Kenya, 2011). The study used mixed methods design in collecting data. Two questionnaires were applied in collecting data. First one survey was to collect socio-demographic and background data questions (Getanda, E et al., 2015). The second used the questionnaire in the study was the 6-item shortened version of the 26-item WHO Quality of Life-BREF (WHOQOL-BREF) tool (Ashutosh et al., 2014).

Reports on a similarly targeted population have stated that it was not easy for mental health support to take place due to the shortage of accessing some mental health facilities and the lack of provision (Kenya Human Rights Commission, 2011). The third part of the study used tools is a 5-item scale, the Satisfaction with Life Scale (SWLS), which is made to measure global cognitive judgment of people's life satisfaction, using a 7-point Likert Scale (Diene et al., 1985). They have also used the General Health Questionnaire-12 (GHQ-12), which is a general (non-psychotic) psychiatric morbidity screening instrument (AbuBakar and Fischer, 2011). They found that refugees were exposed to several traumas and stressful situations during their physical and psychological journey. In general, they had been found to be at high risk for mental health issues according to Keyes (2000).

Fox et al., (2001) argued that the main reported problems among the adult refugees were depression and anxiety disorder, post-traumatic stress disorders. Depression, anxiety and post-traumatic stress disorder seemed

to be the highest reported mental illness among the refugees (Fazel et al., (2005).

Porter and Haslam (2005) have conducted a meta- analysis of pre-displacement and post-displacement factors associated with mental health of refugees and IDPs. They found that there were several factors for mental health problems among refugees when conflict or disaster took place. There were pre-displacement and post-displacement causes, and that could occur among both externally and internally displaced refugees. Factors varied and could be social, financial, accommodation, education, and culture.

The results were presented distinctly for pre-displacement refugee's characteristics and post-displacement conditions. In the pre-displacement refugee's characteristics, two studies assessed population and the impact of age had a strong link; children and teenagers had better outcomes than adult refugees. The adults younger than 65 years scored higher on mental ill health than those who are aged 65 years or over (Porter & Haslam, 2005),

Moreover, the refugees who were displaced from rural areas had poorer consequences than those from urban areas*. "Region of origin was also significantly associated with mental health (Q=505.96; P.001) and was probably confounded by comparison group region of origin"* (Porter & Haslam, 2005:197). In post-displacement conditions, refugees' mental health was noted to be significantly better when relocated in permanent, and private accommodation than those resettled in less well established and impermanent private accommodation. Also, it was reported that the refugees' right to work and getting access to employment had a direct link with enhanced mental health. The researchers said that, access to the

practices of cultures was not linked to mental health (Porter & Haslam, 2005). Externally displaced persons scored higher than internally displaced persons on mental health. Refugees from resolved conflicts scored higher on mental health than who have an ongoing conflict (Porter & Haslam, 2005).

George et al., (2015) have published an article in International Journal of Environmental Research and Public Health which presents findings of the relationship between settlement experiences and mental health and wellbeing of immigrants in Canada. The researchers identified acculturative stress among the immigrants in relation to adapting the host community; for example, adapting to the western food, which showed negative health side effects which eventually led to depressive symptoms. The lack of culture orientation is related to more depressive symptoms (George et al., 2015). The researchers identified that the low income and social exclusion in the post-migration circumstance, which led to high health disparities (George et al., 2015).

3.19 Chapter Summary

In this chapter, different terms that are related to refugees were identified, figures were included refugees globally from 2009 to 2020 with focus on the Syrian refugees inside and outside Syria from 2011 to 2020. This chapter explored the literature on refugees in terms of quality of life and mental health and with deeper focus on the Syrian refugees. The literature was related to the refugees' experiences in terms of language barrier,

employment, housing, access to health and welfare services, asylum seeking process, social support and social isolation, adult Syrian refugees in Jordan and mental health workers, discrimination and financial issues, refugees aiding fellow refugees, volunteers in crisis, strength of SBF and challenges.

CHAPTER 4: THE MENTAL HEALTH ISSUES THAT CONFRONT REFUGEES

4.1 Introduction

In this chapter the mental health issues that affect adult male Syrian refugees are summarised. The chapter starts by outlining the cultural context within which the Syrian men experience mental health problems and includes critiques of the Western approach to mental health and mental illness. The chapter reviews the literature that explores the experiences of mental distress amongst refugees and specifically covers the research into the mental ill health of Syrian refugees. This chapter provides initially some cultural explanations of mental ill health within Arabic Muslim society and discusses these ideas and influences that generate the challenges for research in this aspect of refugee health. The chapter covers some of the literature on western psychiatric methods of diagnosis and treatment and the critiques of western psychiatric approaches.

4.2 Refugees and Mental Health

Compared to people who emigrate to another country to work or start a family, refugees do not have the same positive motivations as they have the goal of escaping from war and persecution or from natural disasters such as earthquakes, volcanic eruptions or floods. People fleeing from local conflict often experience severe stress (Haagen et al., 2017). Shortages of food and shelter and threats of violence often accompany departures and activities, and many families become isolated and helpless. When they appear in a new country, there is often a period of fragility in the shelter process before they can start a new life.

Refugees are limited in their mobility as they are often controlled by the country they flee to, and many people go hungry, die, suffer torture, fall ill, get injured, and unfortunately, are killed before they are reunited with their family and comrades. This delays their recovery and revives the history of their traumatic experiences, making it difficult to apply the usual speaking procedures that focus on recent traumatic experiences.

In addition to trauma and rehabilitation, the treatment of injured refugees faces various difficulties (Yaser et al., 2016). The poor economic situation of refugees and the immediate language and social barriers add a new measure of psychosocial difficulties. Leaving formerly safe environments that they know well and appearing in countries little-known to themselves, they face difficulties like unhappiness and cultural assimilation, which are associated with social problems such as unemployment and social exclusion. Fullilove (1996) depicted the psychological procedures influenced by being uprooted and invited people to connect with their environment through affection, community, and personal procedures. The creators found that due to the war and the expulsion of people around

them, symptoms of longing, sadness, delayed confusion, and exclusion were manifested (in Soykoek et al., 2017).

Various investigations emphasised the importance of the factors confronting refugees after resettlement, which is evident from the experiences of refugees, and they arose during the events taking place in establishing the support for the refugees with PTSD. People have migrated around the world for centuries; a large number of migrations have happened in advance of the Syrian crisis. The purpose of the human movement is still complex: droughts and other changes in the environment; interest and motivation to study the world; plague development of the population; financial difficulties and trust in a superior life; the struggle for power and superiority, etc. (Soykoek et al., 2017).

In any case, avoiding war, abuse, and hiding has for centuries been serious and especially terrible for people under attack: many people leave their home environment and move out of their country or region to avoid danger, pain, or in many cases, an unbearable situation. The ever-growing number of transient people comprehensively tests humanity. It is estimated since the war started in Syria in 2011 that 4.8 million people are currently resettling, of which about 65-70 million people who have been forced to leave their homes globally (Soykoek et al., 2017).

Traumatic behaviour in the country of origin encourages people to flee. During the flight, when refugees try to coordinate their activities with the public of the host country, they often encounter various difficulties. A result of some investigations reported in the literature, it was revealed that refugees with temporary protected status after fruitful placement in the target country experienced pressure after claiming asylum and were at risk of repatriation. Various research studies have shown that PTSD and

other mental disorders are becoming more common among tortured refugees. Besides, other mental health risks for refugees include uncertainty about legal status during resettlement, lack of social assistance, financial situation, and separation factors (Ugurlu et al., 2016).

Over the past decades, thanks to studies of the impact of refugees on the psychological state, enthusiasm for research on this subject has continued to grow, with an increased understanding of the impact of Potentially Traumatic Events (PTEs) that led them to leave their country. Major clashes with refugees include torture, war or internal problems, loss of loved ones due to malice, and delayed suffering. Allegations of these unfriendly events can seriously affect mental health and prosperity.

The most common manifestations are Post-Traumatic Stress Disorder (PTSD) and the mental state of depression (Sifaki et al., 2017). As a refugee, there is no pre-determined causal relationship with the development of PTSD. Refugees are involved in various traumatic events and pressures during the migration process. Studies show that these psychological injuries are risk factors associated with an increased risk of PTSD.

In most epidemiological reviews and psychopathological studies of war victims, post-traumatic stress disorder and depression are the most common mental health problems. A general survey by Turrini (2017) and his partners summarized thirteen surveys on the prevalence of common mental disorders among asylum seekers, and refugees found that PTSD and depression were accounting for in up to forty percent of refugees and asylum seekers. The comparative data were obtained using a meta-survey

(Nygaard et al., 2017). One positive note from the literature was found that even though there were difficulties in life after the war and relocation, the mental health of refugees gradually improved (Kulwicki & Ballout 2015).

The negative effects of war-related traumatic events on mental health have been well documented in modern psychology books. In the post-war environment and people affected by the war, most studies have shown that there is a positive correlation between the trauma of war and the proximity of various mental health conditions. Ibrahim and Hassan (2017) studied mental disorders after the war in five countries. They found that the trauma that can occur during and after the war is associated with the occurrence of mental conditions and anxiety disorders.

Ibrahim and Hassan (2017) examined nine tests that were defined as the effects of wars and battles on the mental health of Arabs. Sandahl et al., (2017) found that military trauma has a significant impact on mental health. Besides, they found that post-traumatic stress disorder (PTSD) is one of the most widely recognised psychological complications among war victims.

4.3 Refugee Trauma and Mental Health

Over the years, research has indicated that the rate of psychological disorders continues to rise for refugees much faster than among the general population. These mental disorders include depression, anxiety, and Post-Traumatic Stress Disorder, which are often reported in higher

numbers among refugee populations. A study conducted by Li et al., (2016) performed a meta-analysis of nearly two hundred studies that examined communities that had recently been affected by conflict. These populations included refugees and other populace that had been displaced due to conflict, with an estimated prevalence of both depression and PTSD at around 30% for both psychological disorders (Chu et al., 2013). More importantly however, Li, Liddell and Nickerson (2016) conducted a systematic literature review of the chronic effects on the mental health of refugees which determined that the problem of increased mental health risks persists well after the population has resettled in another location.

Chu et al., (2013) investigated the various predictabilities of mental health issues in refugees with a more critical eye on their negative aspects. Some of these aspects include trauma due to conflict or other mental health outcomes, such as depression. This level of focus showed that several studies reached similar conclusions regarding mental health and trauma, such as refugee experiences. They concluded that even after they safely return to their home countries or just after migration, refugees tend to suffer from their various stressful encounters and that these were exacerbated due to their cumulative mental health impact.

These stressful interactions were found to be protracted as well as frequent, with the research suggesting that refugee trauma resulted in increased exposure to longer-term psychiatric disorders such as PTSD (Chu et al., 2013).

Despite anxiety before migration being present within the population as a clear indication of psychological ill health, research in this area was criticised as biased in its emphasis on such incidents, rather than taking into account the psychological effects and causes of post-migration

developments (Li et al., 2016). In more recent times, the research has focused on comprehending how mental health issues such as traumatic stress, anxiety and symptoms of depression have affected refugees well after migration, especially with the added impact of new stressors experienced in the area they were trying to settle in.

Research findings that have connected directly the adverse effect on refugee psychological wellbeing since before migration all the way to after migration have factored in and found that issues relating to after the migration of refugees was significantly linked to mental health adversity beyond the effect that trauma or any other disorder had, when occurring during the conflict itself (Li et al., 2016). This meant that refugees were far more likely to experience detrimental mental health if they had been forced to live in worsened conditions for a long time. To that end, Li et al., (2016) discussed the relationship between these mental health aspects after migration and categorised the issues in various groups, such as social and interpersonal stressors, immigration policies and asylum-related stressors, as well as post-migration difficulties.

One study's investigation into trauma history, especially how it was associated as a functional indication for psychopathological issues in children specifically, was explored in the research. Data was collected from the National Child Traumatic Stress Network's Core Data Set, with around 60 children affected by war identified and analysed. Around half of the children were male, with an average age of 13 years (Chung et al., 2018). Results indicated that there were high levels of PTSD, anxiety, trauma and grief, somatisation, and general behavioural problems stemming from detrimental mental health (Chu et a., 2013).

Exposure to conflict or violent conflict was often found to be correlated with bereavement or separation, forced displacement, exposure to violence, traumatic loss, and domestic violence in their homes. Criminal activities among such individuals were rare, with the only problems being behavioural difficulties due to their trauma (Farhat et al., 2018). These results demonstrate the diverse trauma histories, comorbid disorders and behavioural problems that seem to be critical for refugee children and adolescents need to be addressed in delivering mental health services. Provided the challenges related to access to displaced people and their mental health service requirements, family, school, and peer-based interventions both preventive and community-based are recommended as the ideal way to go (Betancourt et al., 2012). As put forward by Betancourt et al., (2012), effective mental health services are increasingly needed for refugee children and adolescents across areas where the refugee populations are high. However, the evidence base required to enable the setup and delivery of public services is still lacking.

4.4 Mental Ill-Health

There is a great correlation between war affected refugees and mental ill health. It was reported by Bogic et al., (2015) that the prevalence rates in war of affected refugees with mental health issues ranged from 4.4% to 86% for PTSD, from 20.3% and 88% for anxiety and from 2.3% to 80% for depression. Fazal et al., (2015) noted this type of heterogeneity in a systematic review of studies that had used psychiatric interviews that

were conducted in western countries to assess the mental health issues among refugees who were resettled there.

They found that there was a strong association between mental illness and war-related refugees. Potentially Traumatic Events (PTEs) are a pre-migratory reason and had a lot of attention in the literature (Mollica et al., 1997). This type of relationship between trauma and a range of mental disorders has been noted among many refugee populations in a different resettlement location and that includes Europe (Miller and Rasmussen, 2010; Steel et al., 2009). Throughout the post-migration period, refugees and non-refugees (migrants) are impacted by many aspects that may increase mental ill health or be material for mental ill health to develop and these can happen due to difficulties that can occur in the new host country or area as well as originating in the conflict zone (Miller & Rasmussen, 2017).

Post-migration has several types of stressful social experiences that have been identified which are common among refugees and they are linked to mental health issues which are: intergenerational and spousal conflicts, ethnic discrimination, harsh socioeconomical living conditions, loss of status, institutional accommodation, poor language skills and poor social support (Carta et al., 2005; Tinghög, 2010).

A group of researchers (Tinghög et al., 2017) conducted a study on Syrian refugees resettled in Sweden aiming to evaluate the prevalence of anxiety, depression, PTSD, low subjective well-being (SWB), different refugee-related PTEs and different postmigration stressful experiences and to explore their mental health comorbidity. They interviewed 1215 Syrian refugees. The results showed that depression was the most common mental health problem with 40.2%, then low SWB was 37.7%, 31.8% for

anxiety and PTSD recorded with 29.9%. The PTEs experienced before or during the migration process was common and there was a considerable level of postmigration stress. The risk for anxiety, depression, low SWB and PTSD increasing was linked with being exposed to interpersonal violence, and post-migration stress among most types of refugees-related PTEs (Tinghög et al., 2017). In Steel et al., (2009) depression and PTSD were two very common diagnoses amongst refugees. Following a meta-analysis of 81,866 refugees in forty different countries, stated that depression and PTSD are correspondingly widespread (30% and 31%) in the displaced populations. The next section will focus on the literature relating to PTSD.

4.5 Theoretical Foundation

The DSM-5 (AMA, 2013) provides specific symptomology and behaviours that can be identified in order to diagnose disorders such as PTSD. However, some of these symptoms and behaviours can be associated with other disorders. Recognising potential organic changes to a brain as an identifier, and unbiased specifier is a benefit of the Carlson and Dalenberg (2000) framework. Additionally, this theoretical framework is one of the few that highlights interrelationships between brain function and trauma-related brain modifications. Addressing and identifying symptoms and linking them to organic changes to a person's brain produced by traumatic experiences is one alternative to traditional neuropsychological assessment (Haagen et al., 2017).

The framework supports the hypothesis that PTSD causes psychological and natural changes in the human brain. These successes can cause debilitating symptoms. There is no doubt that unless psychotherapy, psychopharmacological mediation, or both of these are applied symptoms are unlikely to disappear and will continue to appear. Research indicates that between 40 and 60% of military veterans will be diagnosed with PTSD. This represents a significant number of people being diagnosed using traditional assessment instruments (Haagen et al., 2017). The presence of only one of the four potential biomarkers associated with PTSD could be an indicator of a single disorder such as major depressive disorder or a generalized anxiety disorder.

The authors highlight that approximately 9% of the greater population can be expected to develop PTSD after a traumatic event. This is far lower than the PTSD rates detected by the combat veterans using traditional psychological assessment instruments. It is even lower than the number of people in the general population that typically develop PTSD following a traumatic experience. However, these numbers can be skewed based on trauma and other factors. An example is survivors of rape and sexual assault. Thompson et al., (2018) found in a study analysing statistic related to women and sexual assault found that 53% of the subjects reported symptoms associated with PTSD and depression.

Slewa et al., (2015) provide the theoretical foundation. The authors have developed this theory based on previous research supporting the effects of traumatic experiences on a person. Factors related to trauma can result in cognitive, affective, behavioural, and physiological changes in a person. Additional factors, such as the stage of development and biological effects, can exacerbate the impact of the trauma on the person's brain form and

function. In other words, traumatic events can result in observable changes to a person's brain. A qEEG can detect these types of changes to the brain and produce identifiable biomarkers.

Tay et al., (2015) further explain that these identifiable changes can potentially be the source of (or the effects of) depression, aggression, and behavioural changes, just to name a few. The area of the brain affected can indicate the level of dysfunction related to PTSD and other trauma-related disorders. For instance, depression can be identified by qEEG through the detection of an imbalance (asymmetry) between the brain wave activity in the right and left frontal lobes of the brain. This asymmetry would be a potential biomarker that could be detected and combined with other biomarkers to diagnose PTSD based on an observable change to a person's brain function. The traumatic framework identified by Nosè et al., (2017) is based on a fight or flight or freeze limbic system response. The model recognises that these responses can then be reignited (triggered) at a later time in which the victim encounters a similar threat. The rush of adrenaline, dopamine, and other chemicals in the body through activation of the sympathetic nervous system is one potential source of organic changes in the brain. The authors use the example of a person that disassociates during a traumatic event as an indicator of a change to the basic function of the person's brain. When triggered by the following situation that is like the trauma, the person has an almost identical reaction. People undergo potential traumas throughout a lifetime of development.

Ugurlu et a., (2016) offer a theoretical framework that supports this interpretation of the impact of traumatic experiences and the impact on a developing brain as outlined. This effect can produce symptoms potentially

associated with changes in specific areas of the brain. These changes might be the source of identifiable symptomology and behaviours as a person progressed through the stages of development. An example might be a child who experiences a traumatic event that results in hypervigilance. This hypervigilance could be viewed on a brain scan and become a biomarker for PTSD. The Kira et al., (2014) framework supports the portion of the study regarding development and traumatic events.

4.6 Trauma and PTSD

Trauma is defined by the American Psychiatric Association as an emotional reaction to awful event such as natural disaster, accident or rape. Straight after this type of experience denial and shock are common. In some cases, people struggle to move-on and others might complain of flashbacks, unexpected emotions, or even physical symptoms such as headache or nausea American Psychiatric Association (no date). Among the refugees, trauma and stress from being exposed to the war is something common (United Nations Convention Against Torture, no date).

Wars can cause traumatic distressing involvements such as experiencing imprisonment in concentration camps, being away from family, dislocation, watching violence, and being tortured physically. All these above-mentioned events can lead to a serious risk for individuals and can cause mental and physical impairment and incapacity (Dahl et al., 1998, Steel et al., 2009).

Reports state that 35% of refugees from war worldwide have survived torture (Campbell, 2007; Dgani-Ratsaby, 2011). Both of these reports were published before the Syrian crisis started, and that gives a good reason for this study to add to the older data. Torture can be classified into two types: primary and secondary. Torture is defined as an individual being tortured or having viewed family members being tortured, while the secondary type is torture stated by family but not seen (Shannon et al., 2015).

Abu Suhaiban et al., (2019), carried out a critical review of the literature on demographics, predictors, mental health outcomes of torture, and integrated care for the mental health needs of refugees. Regarding the demographics across previous studies, religious harassment was a common cause for torture and compulsory migration, both Christians and Muslims were correspondingly affected (Abu Suhaiban et al., 2019). Observing torture and sexual torture were the most common events reported in all studies. Sexual torture was reported by women and men, but mainly in women. There are other forms of torture that were mentioned which are, ‘beatings, threats, forced stress positions, sensory stress, psychological manipulation, and separation from family and friends (Abu Suhaiban et al., 2019).

A cross-sectional study was conducted to find out the stressful events across the lifetime of refugees in terms of mental health. The sample consisted of 117 Vietnamese and 135 Kurdish refugees who fit the criteria model regards the impact of non-war stress, stress related to war and post-migration stress on their mental health (Hollifield et al., 2018). The researchers found that the war-related stress formed no direct but massive indirect impact via post-migration stress on mental health on

Kurdish refugees. As regards Vietnamese refugees, data showed modest direct war-related stress impact, but there was no indirect effect through post-migration stress (Hollifield et al., 2018)

One particular study was completed by Ibrahim and Hassan (2017) on ninety-one Syrian Kurdish Refugees. They have applied the Harvard Trauma Questionnaire (HTQ), Harvard Program in Refugees Trauma (HPRT, no date, a) (section I, IV, V), by using 2.5 clinical threshold score. Results revealed 38.4% of participants suffered clinically substantial post-traumatic stress symptoms (Ibrahim & Hassan, 2017).

Another group of researchers have measured the PTSD, depression and anxiety in 278 refugees from the Middle East who have been tortured and they have used the Hopkins Symptoms Checklist (HSCL-25) (HPRT, no date, b) and the PTSD Checklist for Civilians (PCL-C) (U.S. Department of Veterans Affairs, 2020). The results uncovered that people with PTSD are 56.9% of the participant group. For anxiety and for depression it was 81.3% and 83.8% respectively of the tested population (Song et al., 2015).

Odenat (2012) used HSCL-25 (cut-off score = 1.75) for depression and Part 4 HTQ for PTSD (cut-off score = 2.5) on 326 adult refugees who had experienced torture; 23% were identified as having PTSD. Leaman and Gee (2012) in their study of 131 African nationals who had experienced torture, reported depression in 94.7% of the participants and PTSD in 57.3%. Using the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition-Text Revision (DSM IV-TR, APA) (Segal, 2010) criteria, 69% of 30 asylum seekers in the United States were diagnosed with PTSD and 69% with depression (Asgary et al., 2013).

As Turkey holds a big number of Syrian refugees, many researchers had carried out different types of studies among them. A group of Turkish researchers (Tabur et al., 2019) conducted a study aiming to assess the Syrian Civil War impact on Turkish primary school students living near the border with Syria. The participants sample was 193 students. The measures were sociodemographic data, the Child behaviour checklist 4-18 (CBCL- 4/18) (Greenbaum et al., 2004) and the Post-traumatic Reactions Index for Children (PTRI-C) (Pynoos et al., 1993).

They found a large number of asylum seekers were suffering in terms of psychopathology, PTSD and traumatic experiences. 'Witnessing explosions' (26.9%) was the most common traumatic experience amongst the children (via parental report), followed by 'observing injuries for extended family and relatives' (21.8%), then 'seeing death of acquaintances' (17.9%). PTSD symptoms were found in 5.8% of the children through parental report scales and 48.1% through self-report scales (Tabur et al., 2019).

Hyland et al., (2018) conducted a study of 110 Syrian refugees who were seeking treatment and resettled in Lebanon which aimed to make an evaluation of the factor structure of International Classification of Diseases – 11 (ICD-11) (WHO, no date) PTSD and Complex Post Traumatic Stress Disorder (CPTSD) among refugees who are resettling in the Middle East. They found that complex PTSD (36.1%) was more common than PTSD (25.2%), and no sex or age differences were observed at the prevalence or symptomatic levels.

Latent Class Analysis (LCA) results supported a two-factor higher-order model consistent with ICD-11 PTSD/CPTSD. Qualitative findings indicated that the International Trauma Questionnaire (ITQ) (The International

Trauma Consortium, no date) is generally positively regarded, with some limitations and suggested modifications noted (Hyland et al., 2018). This study was conducted on the same refugee nationality but in a different country. This study supports the idea of the aim of this research and highlight the needs for mental healthcare needs among the sample group.

4.7 The Impact of Torture Trauma

Torture was defined by the United Nations Convention against Torture (CAT).

"Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions" (United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984).

This convention is the most used and known in the section. Torture can happen through two different ways, physical and psychological. In terms of physical methods, the most common ones are beating, electric shocks,

stretching, submersion, suffocation, burns, rape and sexual assault (Reyes, 2007).

Regimes usually are known to torture physically to lead the people indirectly into psychological methods (Reyes, 2007). The psychological methods of torture usually comprise of isolation, threats, humiliation, mock executions, mock amputations or seeing the torture of others, those are the most enduring complications on victims (International Rehabilitation Council for Torture Victims, No date: Online). Psychological types of torture are hard to be detectible by general people and officials, unlike physical forms which can be noticed when people suffer from pain and have visible marks on their bodies (Reyes, 2007). According to Reyes (2007) it is not easy to calculate the physical suffering as it relies on various factors of the victim, for example, religious beliefs, cultural background, health, gender, age and education. According to Momartin et al., (2004), among people who have survived torture experience the most common psychological diagnosis are PTSD and Major Depressive Disorder.

In the United States of America, a study was carried out on seventy-five refugees who have experienced torture, talking about important post-traumatic stress symptoms forty percent of them had scores over the 2.5 cut-off on clinical score on Harvard Trauma Questionnaire (HTQ) (Hooberman et al., 2010). Mollica et al., (1992) stated the HTQ is the most used measure in PTSD assessing widely in post-conflict societies and works well in multi-cultural backgrounds. Similarly, a study was conducted about PTSD in Turkey on fifty-seven asylum seekers and refugees, by using DSM-IV-TR criteria; 55.2% were identified with depression and 55.2% with PTSD (Tufan et al., 2013). This indicates the high percentage of mental ill symptoms and PTSD which gives this research a good reason to be

conducted and fully investigate the Syrian refugees in Jordan. By using HTQ and DSM-IV (Bandeira et al., 2010) studied PTSD in fifty-five people who had experienced torture and 69% of them had positive PTSD symptoms.

The same researchers separately recorded anxiety and depression on 74% and 91% of the survivors, by using Hospital Anxiety and Depression Scale (HADS) (Sexual Violence Research Initiative, no date). The HADS is a self-rating scale and it is valid and reliable; it is used in the community and hospital environments to measure anxiety and depression. The HADS provides good results as a psychological evaluating tool. This tool can detect the case severity, anxiety disorders and depression in clients with illness and can be used to test other population (GL Assessment, 2017).

'Fully standardized, HADS can detect the presence and severity of mild degrees of mood disorder, anxiety and depression using one brief questionnaire' (GL Assessment, 2017: online).

A study was conducted on seventy-eight people from Central Africa, Middle East, Southern Asian and South-eastern European, who had experienced torture, to examine the effect of culture, refugee status and gender in the mental and physical health. This study took place in Finland in a centre for torture survivors. The researchers have used the Impact of Events Scale-Revised (IES-R) and the Hopkins Symptoms Checklist-25 (HSCL-25). In the study, in terms of PTSD, Southern Europeans showed higher levels of mental ill health than other cultural groups that are more traditional collective societies in the Middle East, Asia and Africa. The Southern Europeans also seemed to have more depressive symptoms than Southern Asians. In terms of physical pain, reports stated that South Europeans had higher levels than central Africans. Across all cultures, women suffered

more than men in both PTSD and depressive symptoms. It was found that mainly in South Eastern European groups, asylum-seeking status was combined with anxiety symptoms (Schubert and Punamäki, 2011).

The (IES-R) is a self-report set of 22 questions, five of the questions were added to the original Horowitz (IES) to better capture the American Psychiatric Association (Christianson and Marren, 2012). This tool is not used to diagnose PTSD, it is good to measure the subjective response to certain traumatic events on older people especially to intrusion, avoidance and hyperarousal (Christianson and Marren, 2012).

A study was carried out in New Zealand by Cheung (1994) on Cambodian refugees to determine the impact of trauma, and to find out the correlation between PTSD and demographic variables, trauma experiences, coping style and post-migration stresses. The study data were collected from 223 Cambodian refugee adults and gathered basic biographic data, trauma experience, and symptoms of PTSD, coping style, post migration stresses, using the health Questionnaire 28-item version (GHQ-28) scores. The study found that the prevalence rate for PTSD was 12.1 percent. The researcher concluded that *"the most frequently reported posttraumatic stress symptom was a recurrent intrusive recollection of trauma. There was a significant association between PTSD and amount of trauma, coping style, and post-migration stresses" (*Cheung, 1994:17).

4.8 Depression

Depression amongst refugees is commonly reported in the literature. For example, Wadih et al., (2016) identified that the Syrian refugees were depressed through living in Lebanon for several years, and the depression rate among them was growing since the war began. Single individual surveys were conducted on 310 Syrian refugees who had settled in Lebanon to measure their depression rate within different timelines by using an Arabic version of Mini International Neuropsychiatric Interview (MINI) measure. The same study reported the prevalence of current depression was 43.9% compared to pre-war prevalence which was 6.5% (Wadih et al., 2016).

There appear to be several elements of the refugee experience that correlate with the development of depression. One of the elements that correlates with depression links to the effects of displacement, the apparent temporary nature of being a refugee and the harsh reality for many that a return to their home and their previous life becomes an impossibility. This has been the case for Palestinian refugees throughout the Middle East, who have been displaced from their country since the 1947-49 Palestine war and the 1967 Six Day War. Research on the long-term impact on Palestinian refugees is a helpful parallel to the Syrian refugees. A study was carried to find out the relationship between perceived health and right of return hopefulness to the seriousness of depression symptoms among Palestinian refugees in Jordan (Alduraidi and Waters, 2018). The sample size was 177 participants. Data were collected by the Patient Health Questionnaire for Depressive Symptom severity, the RAND-36 perceived health item, also, a statement of the refugees about hopefulness to return to Palestine (Alduraidi and Waters, 2018).

RAND (SF-36) *"is a set of generic, coherent, and easily administered quality-of-life measures".* This tool is used by the patients themselves (self-reporting) (RAND Health Care, no date: online). The results illustrated that 43% of the participants had moderate to severe depressive symptoms, 42% of them lived with a poor quality of life, 20% of them had fair or poor health. Even though 60% have a hope to go back to Palestine. For participants who had access to better health services and right of return hopefulness, it is reported that they were less likely to complain of major depression symptoms (Alduraidi and Waters, 2018). In a similar vein, about depression regarding refugees, Raghavan et al., (2013) stated that enhancement in depression was pointedly associated with the difficulties of obtaining immigration status.

There are several studies where comorbidity of PTSD and depression existed in the refugee participants. The PTSD was more frequently associated with the trauma the refugees had been exposed to prior or during their escape from their country. Depression was very frequently associated with the poor quality of life as a refugee. Refugee status is often linked with unemployment and poverty and this is then frequently associated with depression. Marshall et al., (2005), conducted a study by the application of cross-sectional, face-to-face interviews on a random sample of 586 Cambodian refugee society that are resettled in the US. The main aim of the study was to evaluate the prevalence, comorbidity, and associate symptoms of psychiatric disorders. By using the Harvard Trauma Questionnaire, the Survey of Exposure to Community Violence (SECV), the Composite International Diagnosis Interview (CIDI) Version 2.1 and the Alcohol Use Disorders Identification Test, they measured the refugees' experience of trauma and violence pre- and post-immigration, and detected high levels of PTSD, depression and alcohol disorder according to

Marshall et al., (2005). [Survey of Exposure to Community Violence (SECV) is a fifty-four-item survey that was developed by Richters and Saltzman (1990). This tool was created to measure the frequency of various types of threats that people been exposed to (Richters and Saltzman, 1990).

The Composite International Diagnosis Interview (CIDI) Version 2.1 (1998), is a structured interview tool that covers all main diagnostic disorders and substance abuse disorders. Each element serves the diagnostic criteria of DSM-IV and ICD-10 and reports if the diagnostic principles are met (Andrews & Peters, 1998)]. The outcomes of the study were that all the interviewed people had experience of trauma prior to coming to the US; 99% starved to near-death, 90% had a friend or family member who was killed, 70% of the participants stated that they experienced violence after coming to the US, PTSD was reported to be 62%, 51% for major depression, regarding alcohol use it is reported to be the lowest with only 4%. In terms of comorbidity of PTSD and major depression these disorders were the highest in the studied group (Marshall et al., 2005). Association was found between higher levels of PTSD and major depression with poor language skills, ‘unemployment, being retired or disabled, and living in poverty’ (Marshall et al., 2005).

The National Consortium of Torture Treatment Programs (NCTTP) carried out a study in the USA in torture rehabilitation centres, to evaluate the refugees’ who have been tortured from 125 different countries. They reported that clients who wait longer for treatment are at more risk for depression. Additionally, they reported that, of people been raped, 62.4% were diagnosed with depression (NCTTP, 2015).

Within the literature, the association between becoming a refugee and having been tortured or subjected to sexual violence or having witnessed

the torture of others is regularly reported. Whilst there is some direct association with PTSD, several studies link the after-effects of torture with depression. A group of researchers investigated the relationship between sociodemographic, pre-and post-migration variables with a high prevalence of mental suffering and international functioning in a mixed sample of people who have experienced torture (Song et al., 2015). They have applied the Posttraumatic Stress Disorder Scale (PCL) which is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD, Hopkins symptom checklist-25 (HCL-25), Global assessment of functioning (GAF) and the standard Office of Refugee Resettlement (ORR) questionnaire for demographic data (Song et al., 2015). They reported that there is a strong association between increased depression and torture severity in older people and females (Song et al., 2015).

One study looked at the experiences and mental wellbeing of one particular ethnic minority group within the Middle Eastern refugees. There is group of minorities called Yazidi and they are from Iraq. Due to the war and ISIS crimes in Iraq they emigrated to Turkey as asylum seekers. A study was conducted on this group to assess the frequency of mental illnesses among fifty-five adolescents and children. A semi-structured interview was employed *"Reliability and Validity of Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version-Turkish Version"* (Asıroğlu and Çeri, 2016:2941). The researchers found that twenty children complained of PTSD which is 36.4%, eighteen of them suffered from depression (32.7%), then followed by nocturnal enuresis is six (10.9%), and the lowest percentage was anxiety which is 7.3% and that is four participants (Asıroğlu and Çeri, 2016). The researchers stated that depression was associated with the following

factors: viewing violence/death and gender (female), (Asıroğlu and Çeri, 2016).

In Nepal researchers carried out an epidemiological study in 2008 on 720 adults that aimed to establish the prevalence rates of mental health issues, the reasons linked to poor mental health and the protective and risk factors in a post-conflict condition in the country. The methodology for this study was a cross-sectional and random sampling strategy. To authenticate the outcome measures of this study the researchers have applied the Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), Post-Traumatic Stress Disorder (PTSD)—Civilian Version (PCL-C) and locally created function impairment scale, resources and coping. They reported that depression in women and older people were higher than the rest of the targeted population according Luitel et al., (2013).

A study was accomplished by Nickerson et al., (2019) aimed to find out the correlation between mental health and social enclosure and insecure visa status among refugees and asylum-seekers living in Australia. Sample participants came to Australia since the beginning of 2011 and were from Arabic, Farsi, Tamil or English-speaking backgrounds, sample size was 1.085 refugees both secure (826) and insecure (259) visa statues. Data collection about assessing pre- and post-migration, mental health, disability and social engagement was done by an online survey. They reported that there is greater PTSD, depression symptoms significantly among the refugees who do not have visas. The same group also thought it would be better off being dead and were having suicidal thoughts (Nickerson et al., 2019).

4.9 PTSD And Depression

Post-traumatic stress disorder (PTSD) is a mental illness caused by a traumatic event, which is characterised by a special psychological injury that can cause suffering in almost all people (ICD-10, WHO, 1993). Post-traumatic stress disorder is usually associated with depression, anxiety, alcohol/rest dependence, and personality disorders. Despite the diagnosis of PTSD, ICD-10 presented another symptom called ‘personality change’ after a catastrophic experience, which included an unfriendly understanding of environmental factors, social withdrawal, and exposure to the atmosphere in constant danger.

Since the advent of post-traumatic stress disorder (PTSD) into the medical diagnostic manual (DSM-V, AMA, 2013), this psychiatric diagnosis has been continuously discussed. Interestingly, the early identification of post-traumatic stress disorder limited the diagnosis to people who had experienced violent events such as atrocities, torture, political violence, and rape (Tay et al., 2015). PTSD was initially identified as ‘shell-shock’ during the First World War but took until 1980 before it was officially installed in the DSM.

As has been shown, early work included a rich depiction of the symptoms of adaptation and mental ill health amongst survivors of World Wars who experienced inhuman conditions (Silove et al., 2017).

From an advanced point of view, the central symptoms are different from the general symptoms of PTSD, such as nightmares, shortness of breath, and decreased rest. However, the body of mental health problems

gradually becomes wider, full of sensory and intellectual symptoms (fatigue, anxiety, inevitability, anxiety, memory, and fixation).

It is important to note that children and youth make up the majority of the world's refugees, and the prevalence of their psychological impediments is expanding (Bryant et al., 2018). The mental health of refugee children is often associated with the severity of post-traumatic stress disorder (PTSD) among caregivers. Although the PTSD of refugee caregivers can affect the mental health of young people, there is little evidence that this affiliation is an important component (Bryant et al., 2018). The study analysed the impact of past trauma and increased stress levels by refugee carers on current PTSD, as well as the impact of this on the child's parenting behaviour and adolescent mental health (Bryant et al., 2018).

Adaptation in this way implies the psychological process of people reacting to stressful factors, while life problems are mediators in stress and psychological prosperity. In another study (Getnet et al., 2019), the use of different adaptation procedures was compared between individuals with post-traumatic stress disorder and the control group. It was found that, compared to a post-traumatic stress disorder, those who have post-traumatic stress disorder inevitably use emotions as a centre for dealing with stressful events. This type of adaptation can direct (strengthen or weaken) the relationship between other factors of universality and symptoms of PTSD (Getnet et al., 2019).

4.10 Trauma and The PTSD Diagnosis

Modern interest in the psychological impact of trauma has typically peaked during and after wartime, with research investigating the development of trauma in male soldiers of war emerging around the time of the First World War to rehabilitate soldiers for redeployment (Ugurlu et al., 2016). Psychological reactions to trauma, in the form of emotional and behavioural symptoms, have likely been part of the normative, evolutionary human response to life-threatening situations. Jones et al., (2005) wrote that PTSD is a frequent occupational hazard as a result of serving in the military.

Intense contact was the most common recognized and most powerful risk factor for PTSD. Jones et al., (2005) stated that PTSD is a common, well-recognised diagnosis and that it has the helpful features of clarity. They state that PTSD differs from the majority of mental illness diagnoses which are largely descriptive and their aetiology is not easily defined. Jones and Wessley (2001); Levav et al., (1979) Wagner (1946) stated that in World War Two, there was a relationship between the higher rates of killing and injuries and higher risk of psychological breakdown.

Jones et al., (2005) revealed that their systematic review and meta-analysis showed that influences for example, premature adversity, social provision and educational accomplishment affect likelihood like of PTSD after experiencing trauma (Bowman, 1999; Brewin et al., 2000; Ozer et al., 2000). These were all common to the Syrian refugees in the camp where the study was conducted.

The wars that have been visible throughout the history of humanity have intensified in nature, which naturally inspired the traumatic reactions of civilians. However, the military and cultural response to such injured

fighters has changed, depending on the obvious assessment of the war and the modern belief in the most effective way to respond best to this injury (Bryant et al., 2018). The trauma hypothesis currently conceptualizes sequential traumatic reactions that have had a significant impact on research in this area.

Modern research studies explain the difference between a wide range of traumatic encounters (e.g., brawl, embarrassment or deprivation, catastrophic events, relative cruelty, child abuse) when examining possible differences in the aetiology, physiological response, course of the disease, and strong recovery petition. The range of possible reactions to trauma ranges from a reaction to acute stress to post-traumatic stress disorder (PTSD) and severe stress disorder (Disorder of Extreme Stress Not Otherwise Specified - DESNOS), which are not indicated under any circumstances. This is a recently proposed diagnosis for the DSM-V Response Mechanisms (Nygaard et al., 2017).

In 2013, the post-traumatic stress disorder model was revised again in the fifth edition of DSM (AMA, 2013). Although the DSM V attempts to express psychological stress variants through trauma experiences, PTSD is currently classified as a trauma and stress-related illnesses rather than an anxiety disorder (Lee et al., 2016). DSM-V (AMA, 2013) points to a belief that symptoms based on anxiety or fear can explain only part of the disease, and the most obvious clinical connections are symptoms of pleasure and irritability, separating the symptoms of anger and compulsion from external symptoms. A selective conceptualization has been proposed that reflects a wider range of traumatic reactions.

DSM-V (AMA. 2013) focuses on a comparative description of the results of endless claims about an early relationship trauma called extreme stress

disorder without any other explanation. Although this is not the only indicative fact of classification, DESNOS is characterised by criteria of effect, motivation, memory, mindfulness, self-discrimination, and relationships, as well as the phenomenon of somatization and disturbing influence in an important structure (Thompson et al., 2018).

An important criterion for diagnosis is that in this case, the etiological operator of the traumatic event is the source of the disease, and not a typical individual defect (i.e., traumatic neurosis). Post-traumatic stress disorder is one of the psychiatric findings caused by traumatic experiences. Clinicians cannot analyse this disease if the patient no longer meets the standard for measurable stressors (Haagen et al., 2017).

The debate does however cover the importance of traumatic stressors and the possibility of a full understanding of the possibility of disease as a result of environmental events. Unilateral events (traumatic stressors) will cause enormously painful symptoms in almost every person and, as a rule, are not part of the normal human experience, which can lead to the diagnosis of PTSD during the correction of DSM. The dichotomy between traumatic stressors and various normal stressors depends on the assumption that under abnormal traumatic conditions, most of the stress can become too much, and PTSD is located at the extraordinary end of the continuity of the reaction. A standardised response was stated that the severity was mainly associated with trauma/stress (Lee et al., 2016). PTSD at that time reflected a disappointment in the adjustment because the typical reaction to stress did not allow itself to be corrected. Therefore, the pathology of PTSD is not determined by the pain or terminology of its symptoms, and not by the concept of disturbing effects.

However, it soon became clear that traumatic events were much more frequent than expected (Sifaki et al., 2017). Although there is a full understanding of the existence of people’s traumatic experiences, including dangerous diseases, loss of family and friends, assault, domestic abuse, torture, war, political cruelty, atrocities in cities, relocations, and catastrophic disasters, only a few people were subsequently affected by PTSD. Yehuda and McFarlane (1995) tested the belief of various analysts that the disease is an inevitable result of a traumatic experience and came to the conclusion that trauma is not a sufficient factor for determining PTSD; this point of view increases the possible presence of this disease.

Various potential candidates were examined, including genetic risk factors, family background, personal characteristics, previous history of injuries, previous history of behavioural or psychological problems, the nature of parental relationships, and other life events during the injury, as a post-traumatic factor, such as social assistance and the subsequent introduction of sources of stress management (Kulwicki & Ballout 2015).

A person's response to injury depends on the nature of the stressor, but also the obvious factors of the person. For most people, psychological trauma caused by serious dangers is limited to acute short-term exacerbations (Tinghöget al., 2017). Despite transient phenomena, such reactions can be minor and are usually characterised by specific phenomena which can usually be combined into three main areas:

a) A quick reminder (write down memories, thoughts of interference, bad dreams);

b) Activation (counting excessive arousal, sleep disturbance, anxiety, irritability, impulsiveness, and atrocities);

c) Inactivation (computational desensitization, avoidance, conclusion, confusion, unreality, separation, and frustration) (Silove et al., 2017).

In any case, for a small number of known people, psychological trauma caused by a serious risk will lead to a longer-lasting disease, which has been described in clinical papers, approved and called PTSD, and is often characterised by a long-term disability. In DSM-V, this is described as a set of symptoms that appear after an event that is considered life-threatening or the real authority of oneself or others.

The incident would be accompanied by unusual fears, weakness or offensive emotions, which may include fights, personal ambushes, torture, car accidents, fear-based oppressor attacks, and ordinary or human-made disasters. From about 12% to 25% of people experiencing traumatic events, this painful delayed consequence can serve as the basis for various psychological disorders characterised by DSM, the most notable of which is post-traumatic stress disorder (Muhtz et al., 2016).

An ongoing meta-study examines some sensory neuroimaging useful in anxiety disorders and acknowledges that unusual cases of PTSD activation contrast with a social anxiety disorder and sheer fear (Kulwicki and Ballout 2015). Compared to patients with depression, different studies have found specific examples of neural activation in patients with PTSD, and there is evidence that PTSD is a prime example of critical inhibition, negative for cortisol, compared with depression (Sandahl et al., 2017).

4.11 Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) has long been recognised as a mental disorder related to exposure to traumatic events such as assault, warfare, and other threats on a person's life. Historians such as Ntafoulis, have traced post-battle-related psychiatric symptoms as far back as ancient Greece and the middle Byzantine period. Over 2,000 years ago, Greek warriors would return from battle with symptoms that could not be explained by Hippocratic physicians. In the twenty-first century, PTSD remains a leading consequence of modern-day war. Today it is considered to be a signature injury, affecting approximately one in twelve veterans who served in Iraq or Afghanistan (Giacco et al., 2018).

Nyboe et al., (2017) noted that ancient historical methods used to care for damaged warriors, such as ritual cleansing and penance, would help ease the traumatic ruptures of self, time, and cognition. However, they were short-term solutions, because war-related trauma was considered a condition that medical providers of the time could not cure, long-term treatments were neither offered. Therapies currently used include trauma-focused psychotherapies and antidepressant medications. Building on this history has shown mental health practitioners that PTSD and depression are often co-occurring. Sandahl et al., (2017) have long recognised that PTSD and Major Depressive Disorder (MDD) can be linked in some manner.

Kostaras et al., (2017) found that comorbidity rates between PTSD and MDD can be as high as 36%. Each of these disorders could require different mental health treatment options. Difficulties differentiating between the two disorders carry significant implications (Kostaras et al.,

2017). These are not the only disorders that may need differentiation. PTSD can also be separated from other injuries and illnesses related to stress.

In these diseases, the introduction of clearly recorded trauma or stress events is the asymptomatic measure, such as reactive attachment disorder, inhibitory social participation disorder, acute stress disorder, adaptation disorder, anxiety disorder, obsessive-compulsive disorder, and dissociative disorder. Distinguishing possible trauma-related diseases can be an important part of ensuring optimal treatment (Muhtz et al., 2016).

Military personnel, police officers, firefighters, crisis specialists, and other reserve personnel are injured as part of their duties. Diagnosis and differentiation of PTSD from other disorders are typically accomplished through self-report assessments. There was some caution to the claims for diagnosis of PTSD. Yurtsever et al., (2018) reported that self-assessments lack validity and authenticity. Furthermore, Yurtsever et al., (2018) point out that the symptoms of PTSD can be coached and rehearsed before a person visits a mental health therapist.

Coaching and rehearsal can potentially be detected through malingering measures on assessments. Malingering is the exaggeration and feigning of symptoms for secondary gains and this occurs for many reasons (Bryant et al., 2018), including to gain access to medications, compensation, and benefits. This could be said for most psychiatric diagnoses, as the majority of mental illnesses are diagnosed through the description of symptoms by the patient and not by clinical assessment of observable criteria such as hormone levels etc. This study was not seeking to establish prevalence levels for psychiatric diagnoses, so this was not a concern. This study

sought to establish the participants views of their situation and their definition of their mental health problems.

4.12 PTSD Comorbidity with Pain

In the literature on PTSD amongst refugees, it is common to find comorbidity of other disorders, with stronger onset of PTSD symptoms being frequently associated with more distressing psychiatric disorders such as anxiety and depression, but also associated with increases in somatic disorders, especially pain. Fazel et al., (2005) stated that refugees who experienced trauma usually complained about strong signs of psychiatric disturbance, including depression, pain and PTSD. In another study, both PTSD and pain jointly present. The severity and length of the period and functional impact tend to rise according to the severity of PTSD (Harlacher et al.,2016; Ruiz-Párraga et al., 2014).

Researchers suggested that pain and PTSD might interrelate in a commonly keeping fashion via a mixture of mechanisms. It was signalled as important to improve identification in a way that might help in emerging further effective treatment (Asmundson et al., 2002; Otis et al., 2003; Sharp and Harvey, 2001). Some researchers that were focusing on the prevalence of depression reported that high rates of depression are correlated in patients suffering from pain and PTSD (Geisser et al., 1996; Morasco et al., 2013; Ruiz-Párraga et al., 2014). (Asmundson and Katz, 2009) found that depression might be another mechanism via which pain

and PTSD interrelate to worsen or preserve each other, but this variable is frequently ignored in examinations of communal maintenance.

One particular study was conducted to measure the effect of pain, depression, pain catastrophizing (PC) and Trauma related Beliefs (TRBs) on the severity of PTSD among refugees who have experienced trauma and are seeking treatment (Nordin and Perrin, 2018). They have found out that PTSD and chronic pain co-occur along high occurrence in refugees who have experienced trauma and may interact to raise every condition's severity and effect.

The results also showed that the participants showed high level of *"functional disability, PTSD, depression, anxiety, pain symptoms, interference from pain, pain catastrophizing and negative trauma-related beliefs"* (Nordin and Perrin, 2018:1502).

The relevance of finding this research within the literature was that I was aware of the difficulty for Arabic Muslim people to discuss their mental health problems because of the stigma associated with mental illness, I wanted to be open to the participants expressing their mental distress in other ways, such as describing psychological problems in somatic symptoms. This would not be a focus of this research but could form the basis of a very important extension to this research at a later date.

4.13 Stigma of Mental Illness Among Arabs

This study was conducted by an Arabic (Jordanian) researcher with participants all drawn from an Arabic (Syrian) refugee population. The study was however undertaken at a western university (in the UK), with the intention for the thesis and the articles generated from the study to be read by a global audience. It is therefore essential for a more complete analysis and understanding of the findings, to start with an appreciation of mental ill health from the perspective of Arabic culture.

In the Arab Muslim societies, Jinn, black magic and the ‘evil eye’ are all part of the belief in the supernatural forces which makes some people relate mental illness to possession by evil spirits (Aloud, 2004; Weatherhead & Daiches, 2010). The belief in Jinn is common across all Muslim populations. A good example of the research in this area was a study by Lim et al., (2018).

They conducted an investigation on forty-nine patients from a Muslim background by interviewing them using a semi-structured interview.
They examined the occurrence with which this attribution style is found in a mentally ill outpatient. The results showed that twenty-one of the participants stated that their mental illness had been caused by jinn; thirteen of them did not think jinn was the cause and fifteen were not sure. The researchers concluded that the idea of mental health and jinn associations among this population of Muslims were higher than the initial assumption. This highlighted the necessity of knowledge of Muslim explanatory types of diseases and for the use of certain techniques when conducting an interview into culturally sensitive topics (Lim et al., 2018).

Gearing et al., (2014) found that, as a result of the stigma associated with mental ill health among Arabs, this has a negative impact on people accessing psychiatric services with appropriate urgency. Al-Qutob (2005)

found that services provided by formal psychiatric hospitals are viewed in a negative way, and the Arabs in general have a low knowledge about their local services and the role the services could play in their recovery. Dardas and Simmons (2015) found that, among Arab families, to reach psychiatric services takes months or years before they accept the person in need for the mental illness care, and that this usually happens when the symptoms are severe and cause harm to others and can be identified by others.

In most Arab countries, mental health services are delivered by a mixture of private and public sectors. It is recognized that the proportion of psychiatric beds are insufficient compared to the population (Al-Krenawi et al., 2004). For instance, there are five hundred and sixty mental health beds in Jordan serving a total population of five million people (Gearing et al., 2014).

Gearing et al., (2014) highlight that in Arab countries, due to the poor knowledge in terms of the importance of follow-up after primary development of mental ill health, follow-up care is inadequate and there is a lack of community services provided. Gearing et al., (2013) found that in Arabic countries there was a lack of ‘reliable epidemiological psychiatric baseline data’, and that as a consequence this generated challenges in planning psychiatric services, education on mental ill health, and research in this area. Additionally, Al-Krenawi et al., (2004) found that Arab countries generally have no mental health regulation or recognized mental health guidelines and policies.

There are several major factors that have impacted the mental wellbeing of people across the Arab world including the Arab Spring and the various military conflicts. Amwai et al., (2014) found that the Arab Spring is

expected to have an impact on the mental health of Arabs from both the war and political issues. Some Arab countries, for instance Syria, Yemen, Palestine, Lebanon, Libya and Iraq, had and some still have experienced years of internal fights and that these impacted on individuals both directly and indirectly and this includes human rights violations and abuse. The consequences of these conflicts were predicted to result in a higher percentage of mental health issues and psychiatric diagnoses amongst the people, and setbacks to the mental health services and programmes (Amawi et al., 2014).

Bener and Ghuloum (2011), carried out a cross-sectional study about the beliefs, knowledge and attitudes towards mental illness in a different ethnicity and targeted Arabic groups residing in Qatar (Qataris and non-Qataris) as a part sample in their study. The study took place between October 2008 to March 2009. A questionnaire was created for the study's purpose and was filled by three thousand adults aged over twenty years. The findings were that the Qataris have a higher percentage of 50.6% compared to 44.5% of non-Qatari Arabs who believe that mental illnesses are punishments from God (Bener and Ghuloum, 2011).

Bener and Ghuloum (2011) found that describing the mentally ill person as 'mentally retarded' was higher in non-Qatari than Qataris with 45.1% vs 35.1%. Qataris compared to non-Qatari Arabs had less knowledge in terms of mental health and relating the illness to evil spirits (40.5% vs 37.6%). The researchers also investigated the perception of psychiatric medication addiction and reported that the Qataris believe in this thought, 61% compared to 57.3% for the other Arab groups. Non-Qatari Arab groups believed that substance misuse such as drugs and alcohol (86.6% vs

84.4%) causes mental illness and they think that brain disease could cause mental illness (80.6% vs 77.7%) Bener and Ghuloum (2011).

In terms on emotional issues, non-Qatari Arabs preferred to visit psychiatric services more than Qataris (83.4% vs 75.3%). On the other hand, this is reflected in the alternative approach taken as it was found that Qataris prefer to visit traditional healers (42.3% vs 36.4%). Non-Qatari Arabs have a higher percentage of positive attitudes to talking to mentally ill people compared to Qataris (36.6% vs 31.9%). Acceptance of having mentally ill neighbours was significantly higher in non-Qatari Arabs in comparison to Qataris (42.3% vs 38.4%) (Bener and Ghuloum, 2011). Non-Qatari Arabs showed more acknowledgement of common mental problems and this knowledge was obtained from media (65.4%), while Qataris gained the knowledge from friends and family members (38.4%), (Bener and Ghuloum, 2011).

In western culture, the same cultural connections with spiritual explanations for mental disorders are far less frequent, but there is still a strong association between mental ill health and stigma. The most prominent writer on the issue of stigma within mental health in the 20th century was Irving Goffman (1961, 1963). Goffman's most influential work '*Asylums: Essays on the Social Situation of Mental Patients and Other Inmates' (1963)*, brought to the attention of many people the impact of incarcerating people with mental health problems in asylums. Most large asylums were built away from the main population of major towns and cities because of the fear and stigma associated with mental illness.

They had been in existence for over one hundred years by the time Goffman started his study. He showed how the 'Medical Model' defined the behaviours of both patients and staff and created the 'Total Institution'

where everyone becomes ‘institutionalised’. Goffman continued his critique of the way society responded to mental illness and disability with a book entitled ‘*Stigma: Notes on the Management of Spoiled Identity*’ (1963). In this book he explains how the stigma associated with specific characteristics, such as a criminal record, cause people to cover up their stigmatised identity for fear of the shame they might experience from the condemnation of others.

In western culture stigma is not so clearly associated with spiritual beliefs. Irving Goffman (1963) wrote extensively about stigma and stated in his book that a stigmatized person sometimes works toward correcting his/her condition via indirect methods with higher effort to engage in what are perceived to be normal activities. This can be seen in a person with mobility issues such as an amputee who learns or re-learns to do some activities such as swimming or playing tennis, or a blind person who does skiing or mountain climbing. Goffman (1963) has identified three main types of stigma: the first one is about different body physical deformities; the second type is about marks of person’s character, unusual desires, unfaithful and firm beliefs, and untruthfulness, examples of these are mental illnesses, addiction, imprisonment, unemployment and suicidal attempts; the last type is the tribal stigma of country, race and religion and these can be carried by lineage and affect all members of family.

More recently, Suman Fernando has been a strong critic of western medical approaches to mental disorders and the dominance of psychiatric diagnosis as the primary definition of individual distress (Fernando, 2002). Fernando contests that the western medical model (as initially defined by Goffman, 1961) focuses exclusively on a ‘scientific’ approach and a ‘disease’ model of mental illness.

This system of diagnosis, dominated by the DSM and ICD, does not consider ‘spiritual’ explanations of mental ill health, such as the presence of Jinn, so commonly found in Arabic Muslim descriptions of mental health problems. The western medical model, Fernando contends, leads to a stereotyping of people with psychiatric disorders and the stigmatisation of certain individuals (2002). This leads to the institutionalised discrimination of minority ethnic groups in western medical establishments in particular (Fernando, 2002). Given these observations, it not surprising therefore to find distrust of western medicine and the limited level of understanding of the true nature of mental distress as understood by Arabic Muslim communities.

Fernando (2010) said that the stigma individuals experience can be accounted for by a certain type of diagnostic approach to illness. ‘Psychiatric Stigma’ is the term used by Fernando in the mental health field. As a result, this type of stigma results in discrimination against the mentally ill diagnosed individuals and this is particularly acute when dealing with schizophrenia (Fernando, 2003; Sayce, 2000). Linked to schizophrenia are alienness, fear, dangerousness and a lack of trust (Fernando, 2010). Across cultures, the illness concept is different, and the way they illness is perceived as well, and the explanatory models for illness (Kleinman, 1980 cited in Fernando, 2010).

There are concerns raised in the literature about the challenges Syrian refugees face in accessing services. Barriers for the refugees were investigated by Doğan et al., (2019). Their study looked at the Syrian refugees’ mental health and aimed to assess the adults’ experiences in terms of the services provided that were linked to their mental health complaints. The researchers have used phenomenological design by

collecting the data of twenty-four participants who were diagnosed with mental health issues, through a semi-structured focus group interview and by using purposive sampling method.

Colaizzi's method of phenomenological interpretation was used to analyse data. The findings via thematic analysis indicated that seven themes emerged, which were: self-confidence versus anxiety, discrimination, language barriers, deficiency of information, personal rights, issues in taking medication, and problems in making appointments.

Another study published in 2019 in Turkey about the Syria refugees' mental health started with the hypothesis that Syrian refugees might have serious mental health issues due to traumatic and violent experiences in Syria and during the trip from Syria, and that they might have incurred a failure of social life support and had daily life stressors when living as a refugee(Doğan et al., 2019). The aim of this cross-sectional survey study was to locate evidence on mental health and psychosocial support amid Syrian refugees who are resettled in Sultanbeyli Istanbul, Turkey. The participants were aged eighteen years and over. The researchers have applied the PTSD Checklist (PCL-5) (U.S. Department of Veterans Affairs (2020) and the Hopkins Symptoms Checklist (HSCL-25) for depression and anxiety to gather data about the refugees' mental health (Doğan et al., 2019). The HSCL-25 is originally derived from the 90-item Symptom Checklist (SCL-90) (Derogatis et al., 1974). It is a screening instrument that is created to allocate symptoms of depression and anxiety. The scale is composed of a fifteen-item subscale for depression and ten-item subscale for anxiety (Ventevogal et al., 2007).

They collected data about the operation of healthcare, barriers and awareness and attitudes about mental health (Doğan et al., 2019). The

data was analysed descriptively. A proportion of 249 participants' showed evidence of mental ill health regarding PTSD symptoms (19.6%), depression (34.7%) and anxiety was (36.1%). Fifteen percent of the participants were identified with positive PTSD, depression or anxiety. The participants self-reported emotional/ behavioural issues that had developed since they came to Sultanbeyli, Istanbul (Doğan et al., 2019).

In terms of the treatment gap, the people who did not seek care was 89% for PTSD, 90% for anxiety and 88% for depression. Refugees reported that the cost of mental health treatment was a burden for them, and their own thought was that symptoms would disappear with time. They feared being stigmatized, and they were unaware of information about where to obtain mental care assistance. It was reported that were some undesirable attitudes against individuals who are complaining about mental health issues (Doğan et al., 2019).

A further study (Kiselev et al., 2020), which used a qualitative design using in-depth interviews, into barriers in terms of accessing mental healthcare among refugees and asylum seekers, was carried out on Syrian refugees and asylum seekers who were resettled in Switzerland. This study looked at the structural and socio-cultural influences that were applied to the allocation of mental healthcare (Kiselev et al., 2020). The results showed that Syrian refugees and asylum seekers came across many structural and socio-cultural barriers. It was reported by the Syrian key informants, healthcare providers, and other stakeholders, that language, gatekeeper-linked issues, lack of resources, absence of knowledge, stigma and fear were an important obstacle to accessing care (Kiselev et al., 2020).

4.14 Literature on Syrian Refugee Mental Health in the UK

There is very limited research on Syrian refugee mental health in the UK that is available and relevant to this study, probably as a reflection of the low numbers of Syrian refugees that the UK has accepted. The UK government is committed to providing assistance to the refugee camps in places like Jordan on Syria's borders. The UK has undertaken to relocate 20,000 Syrian refugees by the year 2020 through the 'Vulnerable Persons Resettlement Scheme'.

The UK government is close to meeting this target and by June 2019, 17,051 Syrian refugees had come to the UK through this scheme (Refugee Action, 2020).

Tedeschi and Calhoun (2004) defined Post Traumatic Growth (PTG) as *"the experience of positive change that occurs as a result of the struggle with highly challenging life crises"* and they are the first to come up with this term (Tedeschi and Calhoun, 2004:255). Taher and Allan (2019) carried out a study in the UK on the Syrian refugees to explore the Post Traumatic Growth (PTG) among the displaced Syrian refugees who are residing in the UK. In a study that focused on mental wellbeing and resilience, rather than mental ill health, (Taher and Allan, 2019) utilized this definition of PTG to explore the positive gains for Syrian refugees after arrival in the UK.

According to Taher and Allan (2019) there is no previous study that concerns the Syrian refugees' mental health who are resettled in the UK. They have used mixed methods in this study and the sample was 123 Syrians. Taher and Allan's (2019:342) study uncovered that Syrian

refugees experienced growth in the UK in five diverse aspects, which are: *"relating to others, new possibilities, personal strength, spiritual change, and appreciation of life".*

The results illustrated that displaced Syrians in the UK had experienced high levels of PTG (Taher and Allan, 2019:336).

A similar study was undertaken by Rizkalla and Segal (2018) within the Syrian refugee population in Jordan. Rizkalla and Segal (2018) concluded that research demonstrates that income and PTG are linked in a positive way. These results need further investigations and a larger sample size. One important variable to consider also is the potential impact of class differentials. In the UK study, 67% of the participants had classed themselves as middle class, whereas in Jordan 88.1% of the participants in PTG study of the same group of people stated that their income was very low and not enough for living (Rizkalla and Segal, 2018).

The fact that the refugees who had been selected and integrated into the UK were largely middle class and the refugees that had only succeeded in escaping across the border to Jordan reflects the impact of 'wasta', which is discussed elsewhere in the literature review.

4.15 The Refugee Crisis

Research suggests that among other individual factors, prolonged, chronic stress or trauma may increase the risk of developing PTSD. The refugee and internally displaced population have experienced several stressful or potentially traumatic events over time, and these were compounded by an often long and complicated resettlement process. Today, the refugee

phenomenon is widespread (Sandahl et al., 2017). Current global migration rates are the highest in history; its proportions are increasing, with domestic problems spreading out to the international domain.

According to the United Nations High Commissioner for Refugees, by the end of 2014, the number of people forcibly uprooted by conflict and persecution worldwide stood at a staggering and unprecedented 59.5 million, 19.5 million of whom were refugees outside their countries and another 38.2 million others displaced internally. The year 2014 was especially challenging for the United Nations due to multiple and continuous refugee crises in which the number of displaced persons, both internally and outside their country of origin, reached and exceeded levels unseen since 1994's Rwandan genocide (Giacco et al., 2018).

After World War II, the United States for example admitted large numbers of refugees through its borders to accommodate the waves of migration occurring in the war's aftermath. Over fifty years, from 1945 to 1995, 25 interstate wars took place in different places, as a result of which there were 3.33 million combat programmes. Over the same period, there were 127 civil wars, the number of combatants reached 16.2 million, and civilian casualties amounted to almost 100 million (Jakko et al., 2018).

In particular, civilians prevailed in the failures of the civil wars, whose share reaches 90%. By 1980, the United States Congress had passed the Refugees Act which included recognising the global importance of refugees in the United States Refugee Act and accordance with the 1951 UN Refugee Convention (Naybo et al., 2017). The purpose of this legislation was very similar to the post-war Global Convention on Refugees formulated by the United Nations, which is to develop a permanent and methodological strategy for the movement of refugees, conduct

appropriate resettlement procedures for refugees and provide a legal basis for shelters.

Today, the US for example accepts 70,000 refugees annually—a small portion of the millions forced from their homeland. Despite the establishment of the protocol through law and refugee programmes, the exponentially growing population of displaced persons has put immeasurable stress on the infrastructure and health care systems of bordering countries. Before the collapse, refugees from time to time faced various pressures and life-threatening events, including war and destruction, social and political cruelty, expert harassment, detention, observation of brutal acts against friends and family, observation or sexual violence, threats death of oneself or family, relocation, loss of economic status and the threat of mourning (Sandahl et al., 2017).

The terror of persecution has led many men, women, and children to escape their country in order to seek asylum in foreign societies where they face challenges of isolation, the collapse of social support, loss of identity, and often poverty. Some of the refugees settle in refugee camps, where they are exposed to additional distress due to the difficult living conditions, over-crowdedness, and exposure to infectious diseases (Tinghög et al., 2017).

As a rule, refugee experience is divided into three categories: pre-flight, flight, and relocation. The pre-flight stage can include physical and mental harm to individuals or families, killings, and social changes. As teenagers deliberately or automatically become interested in violent scouts or aggressors, the family may break up further. Subsequent phases of the flight included indefinite travel from the host country to the settlement, where refugees may experience exhaustion from the travel, refugee

camps, and other detention priorities (Yurtsever et al., 2018). Children and adolescents are often separated from their families; others may take care of them and protect them.

Placement procedures include various difficulties, such as loss of culture, network, and language, just as they must adapt to other external conditions. Children and young people often interact with old and new societies, learning new dialects and social standards faster than their elders.

These meetings can provide jobs for each refugee person to shield them from developing mental illness or protect them from mental health consequences, just as it can have a positive effect on the health of a group of people (Silove et al., 2017). There are many difficulties in finding and successfully treating refugees, especially the mental health of people who have been physically injured. Social differences in context and quality, trends, and language boundaries may be associated with identifying obvious problems and corrective relationships.

Considering all the factors, there is little evidence to support the feasibility of one single, particular treatment. It seems from the literature that to develop a socially capable mental health system that takes into account individual and network needs, serious and complete work needs to be undertaken (Haagen et al., 2017).

4.16 Chapter Summary

In this chapter the literature relating specifically to the prevalence of serious mental disorders within refugees is collated and considered. The majority of the existing literature ignored or paid very little heed to the stigma associated with mental illness in Arabic countries. Stigma and labelling among the Arabic culture are a serious issue and can restrict mentally ill people from receiving proper medical intervention or even consuming appropriate medications.

It was reported that the war trauma can cause mental health issues such as PTSD and that it impacts mostly on refugees. PTSD was explained thoroughly in the chapter combined with trauma, refugees' crisis, depression. Literature about the Syrian refugees' mental health in UK was included.

In conclusion, there are several research studies conducted on the refugees globally and some of the Syrian refugees, which were concerned about the refugee mental health or quality of life. Throughout the literature review I have found a gap in the existent literature, that does not adequately cover the refugee's mental health and quality of life and the connection between them. There is no existent research about the quality of life and mental health of the current refugee's population in countries who are hosting Syrian refugees.

CHAPTER 5: Methodology

5.1 INTRODUCTION

In this chapter, the research method and approach that was used to complete this study on the ground will be addressed and explained to give a clear idea of how I carried out the research. This chapter includes a section on research design and the approach that was employed and an explanation for the choice of this method. The rationale for methods is discussed in some depth and then the various elements that contribute to a successful and valid research project - sampling, negotiating access, generalizability, researcher neutrality, ethical consideration, confidentiality, risk to participants, risk to the researcher, benefits for the participants, gaining ethical approval, recording, transcribing process, translating, analysis method, trustworthiness, study limitations, collecting the data, the interview questions, methodology evaluation, and the emerged themes.

I reflect on the dynamics of the researcher-participant connection and its inspiration on research methodology, in respect of research into the experience of adult male Syrian refugees. I also reflect on the significant matters that arise when interviewing adult male Muslim refugees. The participants' gender and age influenced my choice of methodology as it

did the cultural, religious and linguistic interpretations of the issues that emerged during the preparation for the data collection. From this I discuss how I arrived at the particular approaches to gather the data needed to address the research aims.

Qualitative research creates an opportunity for researchers to examine people's experience in a variety of areas, which can be carried out by different types of research methods, for example, in-depth interviews, focus group discussions, observations, content analysis, visual methods, and life histories or biographies (Hennink et al., 2011).

Denzin and Lincoln (2008) stated that qualitative research is about studying matters and issues in their normal settings, trying to make a meaning of phenomena that people bring to the researcher (Hennink et al., 2011).

To understand meanings and experiences, using qualitative research methods are convenient (Crowe et al., 2015). Therefore, these methods are significantly suitable in the mental health framework, as they can give novel understandings and information in areas that are hard to understand and complex. For instance, understanding and comprehending personal experiences of mental illness and their cure (Fossey et al., 2002).

5.2 RESEARCH DESIGN

There are two main types in qualitative research, which are the unstructured interview and the semi-structured interview (Bryman, 2012).

This research data was qualitative data, collected by semi-structured interviews. The semi-structured interviews usually are the sole data for the qualitative research study and are often arranged in advance. Semi-structured in-depth interviews are the most broadly used interviewing format for qualitative exploration and can happen either with one person or more than one person. Most commonly they are only carried once for an individual or group and take between 30- 120 minutes to finish (Adams, et al., 2002).

The semi-structured interviews approach in qualitative research tends to be much less restrictive and by using this method the researcher can depart significantly from any schedule or guide used. And new question can be asked during the ongoing interview, which cannot be done in quantitative interviewing (Bryman, 2012).

The individual in-depth interview permits the examiner to investigate intensely into community and personal issues, while the group interview permits interviewers to reach a broader variety of experience but, because of the public nature of the procedure, stops delving as deeply into the individual participant experience (Chilban, 1996). Individual in-depth interviews are broadly used in the health care research to produce meaning with interviewees by reconstructing perceptions of events and experiences linked to health and health care delivery. These interviews are capable of informing a broad variety of study questions as well (DiCicco-Bloom and Crabtree, 2006).

The semi-structured interview engages ready questioning directed through recognised themes in a reliable and methodical manner interposed with probes planned to excerpt extra elaborate replies. Therefore, the emphasis is on the interview guide including a series of

wide themes to be covered through the interview to aid lead the conversation toward the subjects and issues about which the interviewers want to learn. The semi-structured interview is the most common of all qualitative research approaches (Alvesson and Deetz, 2000).

The semi-structured interview is popular because it is flexible, intelligible and accessible and it can reveal significant and often unseen facets of human and organizational behaviour. Often it is the most efficient and suitable means of collecting data (Kvale and Brinkmann, 2009).

Since it has its foundation in human discussion, it permits the expert interviewer to adjust the style, pace and questions order to obtain the completest replies from the participants. Most significantly, it permits interviewees to deliver answers in their own terms and in the way that they think and use language. It demonstrates to be particularly appreciated if the investigators are to understand the method the interviewees observe the social world under study.

As a result, if the researcher is looking for qualitative data, they should use the semi-structured interview which is flexible and responds to the direction in which interviewees take the interview and perhaps adjusting the questions set (Bryman, 2012).

5.3 APPROACH

Research approaches are the plans and procedures for the researchers to be taken in the future while carrying a study research which involves detailed method of data collection, analysis, and interpretation. There are

three different types of approaches which are qualitative, quantitative and mixed methods. Choosing a research method is constructed on the nature of the research issue being addressed (Newman and Benz, 1998).

In this study, open-ended questions will be applied during the data collection period which is related to qualitative research rather than a focus on high numbers of respondents which falls under quantitative research (Creswell, 2014). The research questions are talking about the quality and mental health issues of the Syrian refugees in Jordan which lends itself to adopting a more qualitative approach.

Furthermore, there is a historical development to both methods—with the quantitative approaches ruling the forms of research in the social sciences since the late 19th century up until the mid-20th century. Throughout the last half of the 20th century, attention toward qualitative research increased and along with it, the growth of mixed approaches research (Creswell, 2014). Qualitative research is a method for investigation and understanding the people's in terms of social problems.

The research process contains developing enquiries and procedures, data typically collected in the participant's area, data analysis inductively constructing from specifics to general themes, and the researcher making interpretations the data to make sense and meaning. The concluding written report has a flexible structure. Those who involve in this procedure of inquiry support a way of looking at research that honours an inductive style, an emphasis on individual sense, and the importance of rendering the difficulty of a condition (Creswell, 2014). Furthermore, Hennink et al., (2011) added that the main feature of the qualitative approach gives the research path to see the issue by the participant's eyes and get to know

the meanings and interpretations that they provide to behaviour, experience or object.

According to Guest et al., (2013) have listed the basic approaches in qualitative research, which are, the phenomenology, ethnography, inductive thematic analysis, grounded theory, case study, discourse conversation analysis, and generic qualitative research.

Generic qualitative inquiry examines people’s reports of their subjective views, thoughts, attitudes, beliefs, or their experiences, of things in the outer world. Percy et al., (2015) they argued that the generic approach is useful when the researcher has a form of pre-knowledge/pre-understandings (categories or sub-categories of information) around the subject that they wants to be able to additionally describe from the participants’ viewpoint. For example, supposing that prior research has shown that employee morale relates powerfully and completely with their salary bracket, nevertheless nothing more is known than that. An investigator might inquire what the staffs think and feel about being in numerous income brackets (sub-question one) and in what way those feelings and thoughts effect their morale (sub-question two). Asking these two inquiries may enlarge the preceding data—that the two groups are connected—with the qualitative employee-perspective information (Percy et al., 2015).

5.4 SAMPLING

A sample is a restricted part of statistical population whose properties are investigated to know information about the rest of the people according to (Webster, 1985). Literature in social work in qualitative research emphasises how hard is it to allocate participants for the studies, influencing them to have a conversation with the researchers, and to be familiar in dealing delicately with the participants and not unconsciously offend them (Fine et al., 2000).

This research has targeted only the adult Syrian male refugees, which makes the sampling method limited to Purposive Sampling. Bryman (2012) stated that the purposive sampling approach is conducted with reference to the goals of the research, so that the elements of analysis are selected in terms of criteria that will give a chance to find answers for the research questions (Bryman, 2012).

Bryman (2012) stated that the purposive sampling is a non-probability method of sampling and it is not a random method. He also added that most sampling in qualitative research involves purposive sampling of some type. In Bryman (2012) he had listed three main types of the purposive sampling which are, theoretical sampling, generic purposive sampling, and snowball sampling.

Theoretical sampling was defined by Glaser and Strauss (1967) as the procedure of collecting the data for producing theory whereby the analyst mutually gathers codes and investigates his data and chooses what data to accumulate following and where to find them in order to progress in developing theory as it arises. The generic purposive sampling usually is used based on the candidates' selection. Also, it is often employed with a study sample of twenty participants (Bradbury-Jones et al., 2010).

Snowball sampling is about chain linked participants. In this method, the researcher starts with a small group of participants who are related to the study question, then the participants inform other participants who had the same experience that is related to the research (Bryman, 2012).

Moreover, Hennink et al., (2011) stated that the random selection of interviewees is often not suitable when conducting qualitative research which could end by not fully addressing the research question.

The purpose and focus of qualitative research are totally different from the quantitative research, which requires a different approach. The qualitative research usually needs a small number of participants to explore the issue in depth and necessitates recruitment of participants with specific characteristics that can best inform the research problem.

In qualitative research, the participants are chosen based on some categories and experiences that can contribute efficiently to the studied phenomenon. To identify people with exact characteristics it requires a non-random approach which will lead to applying the purposive sampling (Hennink et al., 2011).

A purposive interview is deliberate and flexible as the researcher can choose the participants who are applicable and have enough information

for the study topic. It is flexible as the researcher can change and refine the type of participants during the data collection period which rather than following criteria (Hennink et al., 2011).

The basis of gathering data will be provided by individual interviews, which assess the areas of psychological, social relationships and environment through an established set of questions. These questions will be available in the English and Arabic language. The individuals that will participate in the study will be selected from a convenient sample from each age group 18-35, 35-50, 50+ males. Due to cultural reasons, as I am a male and there are barriers, I cannot approach females for this study.

Data collection on other groups within the refugee camp namely women and children will hopefully form the basis of future research projects. The population size selected was twenty participants, based on Warren's (2001) recommendation which was mentioned in Bryman (2012). He stated that to publish qualitative interview research, the minimum number of participants should be between twenty and thirty (Bryman, 2012)

The participant number is usually small in a qualitative study because the depth of information and the variation in the information of experiences, therefore a large number would not have been sensible and not beneficial (Hennink et al., 2011).

Creswell (1998) recommends five to twenty-five and Morse (1994) suggests at least six. Although Patton (1990) stated that the qualitative sample size may best be determined by the time selected, resources accessible, and research aim (Patton, 1990). Hennink et al., (2011) stated that studies with more than one hundred participants are hard to manage

due to the big amount of data collected from each interviewee and the in-depth analysis needed.

Qualitative analysis normally requires a smaller sample size than quantitative approach. Gaining good interview data from most or all of the perceptions will lead directly to the achievement of data saturation. Saturation happens when even by interviewing more people in the study it does not result in providing additional useful information to the collected data. Glaser and Strauss (1967) recommend the theory of saturation for reaching a suitable sample size in qualitative studies.

Furthermore, regarding sample size, Onwuegbuzie and Leech (2006) acknowledged that the sample size should not to be so small that it makes it hard to reach data saturation, theoretical saturation, or informational redundancy. On the other hand, the sample should not be too large which would mean that it results in difficulty for the researcher or research team to analyse the data deeply (Brayman, 2012). Regarding data saturation, Farrugia (2019) said it happens when sampling more data that does not add more themes, notions or concepts on the analysis. As the research carries on, and the sampling of other data produces no additional themes/ideas/concepts on analysis, the point of data ‘saturation’ is touched, and sampling can stop.

Theoretical saturation is about sampling theoretically to reach enough saturated information on a certain subject or category (Bryman, 2012). Informational redundancy is similar to data saturation (Tuckett, 2004).

The deep aspect of the approach is significant as it supports the purpose of obtaining a comprehensive insight into the research problems from the point of view of study interviewees themselves. This mirrors the emic

perspective that is characteristics of qualitative research. To achieve the deep and emic perspectives (insider's perspective, perspective that comes with a culture) , in-depth interviewing involves*: "using a semi-structured interview guide to prompt the data collection; establishing a trust relationship between the interviewer and the interviewee; asking questions in an open, empathic way; motivating the interviewee to tell their story by probing*" (Hennink et al., 2011:109).

The purpose of an in-depth interview has different types of information that can be collected. Wengraf (2001) recognizes that the in-depth interviews can be used to identify the narratives regarding people's lives, the subjectivity of the interviewee, the circumstance in which the participants live. Thus, a researcher needs to build up trust with the participants and convince them to become a participant in the study and talk about their experiences. Streubert and Carpenter (1999) reported that creating and keeping a good relationship with the interviewee is an important part to interviewing applicants.

There were some limitations imposed on the sample for this study, some of them stemmed from cultural conventions and others were deliberate choices for this study. Within the Arabic Muslim community, it would be considered inappropriate and even unacceptable for a woman to be alone with any other man than her husband or very close relative such as her father. There were therefore restrictions on organising interviews with the women in the camp. I would have had to organise a female co-researcher to be present, which would have added to the complications of organising a series of interviews in a chaotic environment hundreds of miles away from where I was in the UK.

Alternatively, I would have had to organise for the female participants to be accompanied by a chaperone, which would have added to the already complicated organisation for the interviews. For an example of how this might have been overcome, a study was conducted in Bangladesh among adolescent females regarding reproductive health. Due to the cultural context the researcher and her team were females apart from one assistant man as it not safe or socially accepted for a woman to travel alone in remote villages. The man talked to the people in the villages about the study, while the female researcher and the team collected their data, and this made them feel safe and they were more accepted among the communities (Bosch, 2005).

More importantly, I had made a conscious decision to focus my study on the mental wellbeing of the adult men in the camp. As in all societies, the men and women in Syria play different roles, and the majority of the refugee camp residents came from communities in Syria where employment was dominated by manual labour. The responsibility to provide for their families is particularly acute in Arabic Muslim society, with every man expected to work and to provide food, shelter and warmth for their wife and children.

In addition, men have a huge responsibility to protect the lives and the honour of their wives and daughters. The men had been directly impacted from the conflict. Some had been injured, captured, arrested, imprisoned and tortured. All of them had huge material losses such as their homes and possessions. I wished to investigate the impact of the failure to provide for their family; the loss of employment, a home and the physical welfare of the family on the men in the refugee community, but I also wanted to investigate the impact of the failure to fulfil their duty as head

of the family to protect their family, including their wives and daughters being assaulted. For these reasons my sampling was purposive.

5.1 NEGOTIATING ACCESS

Hennink et al., (2011) listed five common strategies to recruit participants for qualitative research: using ‘gatekeepers’, formal and informal networks, snowball, advertisement and research-based recruitment. There is no completely ideal way to use and a researcher might use more than one way when doing the same study. Each method has its advantages and disadvantages.

According to Hennink et al., (2011) the gatekeeper is the most commonly used strategy in qualitative research. Gatekeepers are people who play a role among the targeted community for which they are recognized by the locals. The gatekeepers have knowledge about the characteristics of the targeted population for the study, although gatekeepers can be service providers such as health or education providers, religious leaders or any type of person or organization that can allow access to the community. Therefore, the gatekeepers play a good role in carrying qualitative research between the researcher and the targeted community.

Hennink et al., (2011) mentioned the benefits of taking assistance from gatekeepers. He first reason might be a protocol in the culture to visit the gatekeepers first and ask for their assistance which is showing respect to the targeted community and makes access easier. The second reason is gatekeepers can hold valuable information about the targeted population

which can be very helpful for the researcher in recruiting participants. The third reason why gatekeepers are good when recruiting participants, is that they often have significant influence in the local community to encourage them to take part in the study and be interviewed (Hennink et al., 2011).

In this study, I took advantage of my long-standing connections with the supervisors of the refugee camp to enable me to conduct this research. I already benefited from some legitimacy amongst the residents of the camp, but my role had to change from providing immediate essential support as a worker in the camp to offering the promise of potential influence through the publication of my research some years after the refugees had taken part in the study. Validation of my study within the camp from the camp supervisor as gatekeeper was therefore extremely important and contributed to the willingness of the men to participate as well as encouraging to them to be more open and trusting of my intentions.

5.2 GENERALISABILITY

It is not easy to generalise to other settings from a small sample when using qualitative interview. Bryman (2012) argued that *"the people who are interviewed in qualitative research are not meant to be representative of a population"* (Bryman, 2012:406). In its place, the results from the qualitative research are to generalise the theory, not the actual population. There are two types of generalisation that can be contingent from a qualitative study (Onwuegbuzie and Leech, 2010; Bryman, 2012).

The first kind is analytic generalisation which is mostly the same as the theoretical generalisation. The other type is called 'case-to-case transfer', which refers to generalising the findings from one case to another case that is mostly alike.

Polit and Beck (2010) stated that there are three different types of generalisation which are; classical generalisation model, analytic generalisation and case-to-case transfer model. The classical model is inferring from a sample to a population. This model is behind most of the quantitative studies (Polit and Beck, 2010). Analytic generalisation in the qualitative research happens when the analysis and interpretation start (Polit and Beck, 2010). Case-to-case transfer was proposed by Firestone (1990) as a case-to-case translation; this type includes using the findings of a totally different group's investigation and then applying it to people of a particular setting. It is more often known as transferability (Lincoln and Guba, 1985). It is been recognized as 'reader generalisability' (Misco, 2007).

Generalisability can be met through a 'reader generalisability' which is *"to claim user or reader generalizability whereby the argument or findings are applicable in different, unique, and specific contexts"* (Merriam, 2001; Tashakkori and Teddlie, 1998, cited in Misco, 2007:4)

Denzin and Lincoln (2013:89) said about generalisation, *"formal generalisation is one way of various methods of knowledge achieving and collecting. That knowledge cannot be formally generalised does not mean that it cannot enter into the collective process of knowledge accumulation in a given field or in a society"* Denzin and Lincoln (2013:89). Knowledge possibly transferable even when it is not officially generalized, according to Denzin and Lincoln (2013).

It was not expected that this study would be generalisable, but it was hoped that some of the findings could achieve some level of transferability. As discussed later in this chapter and in the conclusion to the thesis, there were limitations to the study and therefore limitations to the generalisations of the findings, so the intention following the completion of this study is to repeat the study with more and different groups of refugees.

5.3 RESEARCHER NEUTRALITY

Researcher neutrality is impossible in qualitative research. Many researchers have a debate about evaluation the qualitive research's reliability and credibility (Strauss & Corbin, 1990; Webb, 1992; Sandelowski, 1993; Koch, 1994; Popay et al., 1998; Morse, 1999). Neutrality in research indicates that the researcher's perspective, position, background, or conditioning circumstances are separated from the study's investigation and are unbiased. When researchers claim to be neutral when conducting research, the inquiry is also meant to be valid and reliable (Given, 2012). The term neutrality is usually linked to research to prove that it delivers a neutral and unbiased view of the object that is being investigated (Given, 2012).

Lichtman (2017) suggested using a neutrality strategy when questioning the participants by maintaining no direction in the interview. Additionally, he stated that this strategy places the person who conducts the interviews in a neutral position, neither for nor against in contradiction of something.

Information was defined as *"Knowledge communicated concerning some particular fact, subject, or event; that of which one is apprised or told;*

intelligence, news" (Oxford English Dictionary, 1989:Online). The Oxford English Dictionary had defined the opposite (misinformation) as systematic spreading of false information of ideas reflecting the interests of a certain person to gain certain attitude or responses (Oxford English Dictionary, 1989). Moreover, Cohen (2005) defined the misinformation as a desire or favourite towards a specific viewpoint and failure to provide a straight consequence. Ireton and Posetti (2018) argued that the misinformation is dangerous and that refers to the method of doing it, as it is often planned, resourced in a good way and strengthened by automated technology. It was essential to guard against generating misinformation.

There were particular challenges to maintaining researcher neutrality in this study. I entered into this study highly motivated to collate and share the important stories of the refugees, with a hope that my efforts would contribute to the improvements for the refugees I had met and in a small way to improvements for all refugees across the world. I also had prior experience of the camp, although I had never spoken in depth about any of the issues central to the study with any of the participants before. I had to be very mindful of the focus of my study, the openness of my questions and my interviewing manner and the balance that I applied to my analysis.

I collected the information honestly and ensured that the analysis of the information given is matching what the refugees have stated in their interviews. At the research stage, I was as conscious as I could be of bias during the interviews. I worked in the section in the past and collected data for the previous employer which gave me confidence and high skills to be able to not be unfair with the refugees as a Jordanian citizen. I checked and discussed my interviews and analysis with authorities in Jordan and when I went back the United Kingdom I sat with my supervisors

and discussed the interview analysis. Also, I referred to NGOs' members and checked the interpretation with them to make sure I am translating the information correctly.

5.4 ETHICAL CONSIDERATIONS

Ethics was defined by Maylor and Blackmoon (2005) as moral values that regulate and control how people act and think in certain circumstances and in terms of research it is about how the researcher carries out their work. In terms of research ethics, Brannick and Coghlan (2007) said it is about not causing harm, keeping the personal information confidential and not altering data. Billington (2003) stated some of the special features of ethics and morals which are:

- *"Every day all of us make ethical decisions, there is no one can evade moral decisions.*
- *Morality always involves other people when making ethical decisions.*
- *Ethical decisions are important- they impact on the others' lives.*
- *While morals are about incorrect and correct, there are conclusive answers. The theorist can draw a guideline*

regarding decisions, nevertheless the final choice is always to be taken by the individual.

- *Choice is what all the ethics is about- when a person has no option to choose, it cannot be viewed as unethical "(*Billington, 2003:217).

The ethical responsibilities of qualitative research are the same as the other types of research but may have more visible principles due to the nature of qualitative research for some reasons. The first reason is that qualitative research method is used to gain information about the participant's views, beliefs, and feelings by establishing a close relationship between the researcher and participants.

The second reason is that qualitative research methods are usually used when doing studies in sensitive issues like violence and sexual matters. When interviewing people about these types of experiences they might recall painful memories (Hennink et al., 2011). In this case I needed to be able to refer the participants to a counsellor when necessary which is indicated below in this chapter.

Hennink et al., (2011) stated that the ethical philosophies are more pronounced in the qualitative research due to two reasons. Firstly, qualitative research approaches are used to identify insight, views and feelings of people and hear their voices. Secondly, the qualitative methods are used to investigate sensitive issues such as, sexuality or violence. They also argued that this method can be used in more serious cases, for instance asking the interviewees about painful memories or experiences in their lives that can cause emotional distress (Hennink et al., 2011).

Working previously with the refugees on the ground has given me good knowledge about how vulnerable they are. As the research aim was to investigate the refugee's mental health and quality of life, interviews had particular people who suffered more from the conflict. My previous experience and training courses had enriched my strength to deal with the refugees. During recruiting participants, I took into my account the sensitivity of the refugee's current living conditions and past experience, along with the nature of study. I ensured that the given information prior the study was clear on printed leaflets about the study and with a consent form, hence they knew what were the rights, risk, loads, and benefits to them. I made sure that the survey language was jargon free and used language which was understandable to participants. This gave the participants chance to decide to get involved in this study or decline.

5.5 CONFIDENTIALITY

In research, confidentiality of the data is one of the values of assuring the participant's rights, according to Wolffers (1996). O'Hara and Neutel (2002) listed four phases of confidentiality to make sure it is met during the research, which are data collection, amalgamation, analysis and storage and disposal. The main researcher is responsible for keeping the data confidentiality all the time. It is also the researchers' accountability to make circumstances where the autonomy and dignity are considered through the research period among all team members, and these circumstances should be always addressed to insure the data confidentiality (O'Hara and Neutel, 2002).

Hennink et al., (2011) argued that complete confidentiality is hard to be fully met in qualitative research, because the researchers report the study findings and participants' quotes in the reports, anonymity can be ensured by eliminating all the identifiable information. On the other hand, they stated that researchers can limit the audience for the interviews' recordings to such as research members and those who are transcribing the interviews.

It has been argued that in some cases the researchers give a promise to the participants not to reveal any personal data, but in some cases the researchers hear illegal activities or crime and wonder whether to report it or keep the promise. In this case, Wiles et al., (2006) stated that the researchers have to break the confidentiality promise, when they know the study candidate has committed a crime, is willing to do a crime or has been a victim of a crime.

The principal investigator (PI) should be considered accountable for the maintenance of confidentiality, while confidentiality may be defined as being 'entrusted with another's secret affairs while confidentiality may be defined as being 'entrusted with another's secret affairs. The ethical issue in relation to sustain confidentiality and anonymity has also been addressed. Confidentiality was well-preserved between myself and my supervisors only. Each interview collection session was conducted separately and was not shared with anyone in the case study. The participants' collected data was stored and protected in the findings and reports by allocating codes and omitting any materials that could be source to identify the participants. Identifiers in the collected data were completely removed from the research data and there was no clue to the identity of any participant.

Participants were given numbers in this study to guarantee the anonymity. Among researchers replacing participants' names with pseudonyms or numbers is common practice and keeping matching number and names in a protected place (Hennink et al., 2011). Identifying data such as names, profession, address or place of work were removed or replaced with symbols or numbers to make sure there were no clues to any of the participants in this study. For instance, participant number (10) works in NGO (x).

The Data Protection Act (2018) (Legislation. Gov, no date) was followed along with the University policies/procedure to make sure that the confidentiality of the collected personal data was well maintained at all times. Collected data on papers from the interviews, voice records and consent forms were stored in the researcher's University office desk drawer. In this regard, the University regulations state that the research data should be kept for five years. The researcher data was kept on a password protected portable memory stick in a locked drawer by the researcher during data collection process and analysis.

5.6 RISKS TO PARTICIPANTS

Minimization of harm is not just about physical harm, it also about economic, mental or social harm (Hennink et al., 2011). Due to the nature of the study and the participants, there was a possibility that the participants may have experienced distress during the survey and the interview. I was careful and sensitive to distress. I was not planning to give direct support to the refugees if any distress took place, because I cannot do this in a research study, and I did not have the required qualifications to undertake this role.

In this area, Hennink et al., (2011) said, in qualitative research it is hard sometimes to know the direction of the interview as it might cause social harm to the partaker. However, I had completed training on the psychological effects of torture and the consequences of best practice, psychotropic trauma community outreach-based approaches and psychotropic trauma management. I gave the participants chance and time to compose themselves and options to continue the interview or end the session. Participants were informed prior the session that they could terminate the session at any time and erase their data from the study.

I discussed the distress issue when conducting interviews with JHASi field coordinator, and about the best action to be taken. He mentioned that I could refer cases to the International Medical Corps (IMC) by direct contact since I was conducting the interviews under JHASi regulations and rules. IMC have a psychiatric clinic in JHASi clinics, so it was easy to refer cases if the researcher was collecting data in there.

In addition, IMC’s contact list was given to the patients who need psychology support and services. An example of good practice in a qualitative study was conducted among people with positive HIV/ AIDS conditions; the researchers asked them about stigma and discrimination,

the questions for some participants triggered strong emotional responses, the researchers were members of an NGO that was working with people who were diagnosed with HIV, and that made the researchers able to refer the participants if required (Darak and Kulkarni, 2005).

Hennink et al., (2011) stated that there are many ethical issues that might arise with recruitment of participants in qualitative research. These issues can be minimised by providing clear information regards the study so the participants can decide whether to take part in the study or not (Hennink et al., 2011).

5.7 RISKS TO THE RESEARCHER

Manchester Metropolitan University has policies to reduce any possible risks to the researcher, that were followed carefully to avoid any incidence. Health and safety procedures were taken into the research considerations according to the University policies. University risk analysis and management forms were filled. If interviews were conducted in the refugee's homes, I informed a designated person before and after each session. During the collection data period I was in touch with my supervisor and informed him about each detail. As I went under JHASi's cover I had their badge and their vest with the NGO logo. I took training on how to handle people's distress and how not to be overwhelmed by hearing many sad stories from the refugees, and through this training I learned different coping mechanisms.

5.8 BENEFITS TO PARTICIPANTS

It is important to hear from people who survived and experienced war and were living in different life circumstances pre, during and post war. This was their chance to share experiences and talk if they were willing to talk, to make their voice reach the concerned people and people in authorities in this regard.

Research results will be shared with the participants if they wish to have it, and they can have a copy of the summary. The research results will be published for the organisations and health professionals, to increase the understanding on the refugee's quality of life and mental health, to provide better support services for the refugees. Some participants tended to show that they enjoyed the interviews and shared their experiences and their opinions or views about the study's' topic. By talking about their lives, participants frequently realise how they feel or think, which is usually viewed as an optimistic involvement and thus of taking part of this research (Peel et al., 2006). This study was about delivering the refugees' voices to stakeholders and authorities to alert them about the present issues. Hennink et al., (2011) said, a further benefit to the participant can be, by raising awareness of the problems the participants are facing and that might trigger actions that are beneficiary for them.

5.9 GAINING ETHICAL APPROVAL

Usually, researchers are required as a compulsory measure to seek ethical approval and formal assessment by institutional review committee to evaluate if the research will be carried out ethically (Hennink et al., 2011). The researcher filled out the ethics forms, those that are requested by Manchester Metropolitan University (MMU) are listed below:

- MMU- Ethics Check List
- Security sensitive information form
- Ethical Approval form
- Consent form
- Advertising details
- MMU- Research-insurance-checklist.

Hennink et al., (2011) identify that the researcher needs to gain permission to conduct the study which might be at different levels, for example, national or local. Sometimes the research study would be in a different country; therefore, the researcher should be aware of the rules and regulation of that country relating to research conduct. In this research study, the research was originally within Jordan where the study was carried out. The researcher was fully aware of the regulations and rules since he was working with refugees for a long period. The necessary documents were prepared prior arrival to Jordan. Ethical approval was obtained on the 18th of October 2018, see appendix Number (1).

5.10 RECORDING, TRANSCRIBING AND TRANSLATING

In qualitative research, the interview is generally recorded on audio-recorder and moved into paper-based documents when it is possible during or after conducting the interviews. Transcription was defined by Hennink et al., (2011) as writing down the interview record into paper for data analysis which are called transcripts. According to Oliver et al., (2005) the main point of the study influences the style of transcription that is conducted. An important element of qualitative analysis is not about what the participants say in the recording; it is also about the way they say it which it should be noted at as well according to Bryman (2012). Some notes were made of these issues when they arose during the interviews and these are included within the analysis data.

Heritage (1984) listed the advantages of recording and transcribing interviews: it is good because of our memory limitation and because of the instinctive glosses that we might place on what the participant says during the interview; it gives more time for the researcher to go thoroughly through what people said; the researcher can repeat what the participants said; it permits the data for other parties of the public to study it, which is called secondary analysis; it, as a result, assists to counter accusations that an analysis might have been influenced by a researcher's principles or unfairness (in Bryman, 2012).

In some studies, the interviews could be conducted in a different language to the researcher. In this study, the participants and I speak the same language and dialect, which made it easier for both sides to understand each question and answer clearly and that always was an advantage to understand the cultural norms and colloquial language which gave better translation.

This increased the level of confidentiality and anonymity as there was no third party to translate the records' data. The interviews were conducted in Arabic; I had to translate them to English as I am studying in the United Kingdom and the main language is English in the country.

5.11 ANALYSIS

Thematic analysis is the approach that is used for this study as it is the most common approach to qualitative data analysis (Bryman, 2012). An obtained theme is a good reflection of a particular sense and cultural-contextual message of information (Vaismoradi and Snelgrove, 2019). Thematic analysis is a procedure of interpreting the qualitative data and looking for patterns that have meaning. Thematic analysis approaches can be useful among a variety of theoretical and epistemological approaches (Braun and Clarke, 2006).

Maguire and Delahunt (2017) listed steps of doing thematic analysis which provide details on doing thematic analysis in six steps. They have stated that the thematic analysis is a process of setting up patterns and themes within qualitative data Maguire and Delahunt (2017). The first step is, become familiar with the data, which is by reading and rereading. A researcher should be well knowledgeable of his/ her own body of data. Step two is the researcher should start organizing data in a meaningful way. In this case coding decreases a big quantity of data and break sit into small chunks of meaning (Maguire and Delahunt, 2017).

Searching for themes is the third phase. A theme is a pattern that reflects something significant and is related to the main research question. They stated that some codes fit together into one theme in some cases. The fourth phase is reviewing the themes, at this stage the researcher should adjust and develop the preliminary themes that were located in phase three. Step five is define themes, which is the last refinement of the picked themes and the main purpose is to *"identify the 'essence' of what each theme is about"* (Braun and Clarke, 2006:92). The last step is writing up; this step is to wrap up and write the results or some kind of report (Maguire and Delahunt, 2017).

Thematic analysis was good to use in this study, because it is a very flexible method that can be altered to meet the requirements of several studies, delivering a rich extensive comprehensive, yet complex interpretation of information (Braun and Clarke, 2006; King, 2004). Moreover, it provides an additional form of accessibility of analysis, mainly for new researchers (Braun and Clarke, 2006).

The drawbacks of thematic analysis become more apparent when measured in relation to other qualitative research approaches. The lack of considerable literature on thematic analysis— compared to that of grounded theory, ethnography, and phenomenology. A simple thematic analysis is disadvantaged when compared to other methods, as it does not let researcher to make claims around language use (Braun and Clarke, 2006). Though thematic analysis is flexible, this flexibility can direct to inconsistency and a lack of rationality when emerging themes resulting from the research data (Holloway and Todres, 2003). Consistency and cohesion can be indorsed by applying and creation clear an

epistemological position that can logically reinforce the study's experimental claims (Holloway and Todres, 2003).

According to Cambridge Dictionary (no date: online) epistemology is "the part of philosophy that is about the study of how we know things". Hellebone and Priest (2008) stated that epistemology is a business research as a division of philosophy deals with the source of knowledge. Precisely, epistemology is concerned with potentials, nature, sources and boundaries of knowledge in the field of study. Moreover, epistemology emphases on what is recognised to be true (Hellebone and Priest, 2008).

Furthermore, Department of Philosophy in The University of Sheffield (no date: online) talked wrote that the epistemology is the theory knowledge. And it is the mind's connection with reality.

Generally, epistemology is the thoughts we create about the type or the nature of knowledge according to (Richards, 2003) or to find possible ways to know the world as stated by (Snape and Spencer, 2000). Crotty (1988) stated that epistemology is a method to look at the world and figure out knowledge of it.

This research is interpretivism constructivism, as it aimed to explore the people's experiences and meanings that are connected to certain behaviours to know them better. The individual participants actively constructed their social reality and talked freely about themselves and this was achieved by the researcher interactions with them through a qualitative research strategy. According to Bryman (2016) ontology is about the reality's view or nature, in connection to research that deals with social concepts, and that is related to the social entities' views.

Hennink et al., (2011) stated that the process of induction is a main character of qualitative study which is useful to develop theory and new knowledge form the collected data rather than discussing previous found knowledge and try to agree or disagree with it. This study has brought new Knowledge to the existed literature and discussed previous literature in line with the new findings as well.

Thematic analysis has a few prescriptions and procedures and the skills need to apply thematic analysis are easy to acquire. This makes it a great approach for researchers who are unfamiliar with qualitative methods (Braun and Clarke, 2006; King, 2004). Thematic analysis is also beneficial for investigating the perceptions among different participants, to find out resemblances and dissimilarities, and produce unseen insights (Braun and Clarke, 2006) and King (2004).

In this study, the language barrier was not an issue during data collection and data analysis, as I am from the same cultural context which made understanding and interpreting the data an easy process (Braun and Clarke, 2006). I was however very mindful of the advice of Holloway and Todres (2003) who argued that the flexibility in thematic analysis can cause inconsistency and lack of rationality when emerging themes from the research data.

5.12 TRUSTWORTHINESS

To establish trustworthiness in my approach I have used Lincoln and Guba (1985) procedure to meet the criteria. Lincoln and Guba (1985) evaluation criteria contain four elements which are, credibility, transferability, Dependability and confirmability.

5.16.1 Credibility

Credibility is about confidence in the honesty of the findings, and that can be reached by seven techniques when conducting qualitative research, which are, prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy and member-checking.

Prolonged engagement is about learning the culture and social settings by spending enough time on the subject area. This includes staying longer periods observing, speaking to people, and creating associations and rapport with the people of the targeted culture, thus, it builds up trust between the researcher and people of the aimed settings. In this study, prolonged engagement was a solid base for the researcher and for this study to start, as recommended by Lincoln and Guba (1985). I have spent several years amongst the refugees due to my previous work and they also live with us in our community. I have become very oriented within the settings and am confident that I have avoided distortion in the data. I went over my preconceptions and I built the trust with the participants.

Persistent observation is met by the researcher due to previous experience. Triangulation was ensured in this study by checking the consistency between the previous literature and the findings from this study.

Peer debriefing is defined as *"a process of exposing oneself to a disinterested peer in a manner paralleling analytical sessions and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind"* (Lincoln and Guba, 1985:308 cited in Robert Wood Johnson Foundation, 2008). I have reviewed my

interpretation and data with my supervisors and NGO members to stay unbiased and made sure the translation meets the exact aimed meaning.

Negative (Deviant) case analysis is about looking for and deliberating parts of the data, that looks like the opposite to emerging pattern from data analysis Patton (2001). In this case, there was no contradicting data against the emerged themes, but new unrecognized themes among the participants were noted in this study, such as favouritism among them and stigma and labelling, and those were not reported in the existing knowledge among refugees. In terms of referential adequacy, I have analysed all the data at one time to create codes and themes.

In terms of member checking, this process was not used due to the sensitivity of the data and the location of the participants (Jordan). Sandelowski (1993) stated that there are drawbacks in the member-checking procedure. For example, members face problems with abstract synthesis, member and researcher might contradict views of what is reasonable explanation, participants attempt to be viewed as a good people and researchers wants to be perceived as a good scholars, participants might regret telling some stories later on, or deny some stories and ask the researcher to delete them and participants might agree on data to please the researcher only.

5.16.1 Transferability

Transferability is about generalisation the data to be used by other researchers in their work, and this can be met by producing thick description so the other researchers can judge the transferability (Lincoln

and Guba, 1985). Lincoln and Guba (1985) defined thick description as a method of accomplishing a form of external validity. Holloway (1997) argued that thick description is about showing comprehensive understating of field experiences in which the investigator makes a clear pattern of cultural and social relationships and creates context for them. Transferability is met in this study by a thick description in a separate above subsection (Generalisability).

5.16.3 Dependability

Dependability can be achieved by showing a clear process that is rational, traceable, and well-documented (Tobin and Begley, 2004). The proper way to demonstrate dependability is via inquiry audit. An audit trail gives the reader a good insight into the researcher's selections and decisions in terms of methodological and theoretical issues through the study (Koch, 1994). Inquiry audit is considered the same as member-checking to a certain point. In this study, the whole process is traceable and rational, but due to the sensitivity nature of this study, a very limited selection of people were able to view the collected data at a certain point and external auditing was limited to the publishable data via an NGO member and that was just to check the interpretation and bias. The external member agreed with the interpretation and confirmed that there was no bias in the data.

Tobin and Begley (2004) warn that the external auditor could not know the whole data as the researcher and that might cause confusion and end up

by contradicting the main ideas or point of view. Although the external auditors were not party to the same level of detail as myself, there was broad agreement with my analysis and interpretations.

5.16.1 Confirmability

This criterion is concerning the researcher's data and interpretations and how to establish a solid demonstration that the findings and interpretations are obtained from the data, also, to show how the conclusion and interpretations have been reached (Tobin and Begley, 2004). Lincoln and Guba (1985) emphasise that confirmability can be met when credibility, transferability and dependability are met. Koch (1994) claimed that including the reasons behind choosing theoretical, methodological and analysis methods during the whole study can make the reader aware of how and why decisions are made.

Confirmability was achieved by techniques in this study which are the audit trail which was explained in the previous section and via reflexivity. Reflexivity is about the researcher's background and position, *"a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions"* (Malterud, 2001: 483-484).

In these terms, as mentioned before, the researcher is very knowledgeable of the targeted population's circumstances and spent years among them

and set up the aims and objectives of this study based on the extensive experience in the field.

5.13 LIMITATIONS

Written words sometimes do not reflect the exact meaning as external signs or internal meaning for people, but slightly can reflect some sense (Crowe, 1998). Thus, there can be a real limitation in a qualitative study especially if the researcher is from a different culture and speaks a different language to the participants.

As any other research method, there are numerous limitations of qualitative research were listed by different writers and authors. Ochieng (2009) listed some of these limitations which are:

- *“The aim of qualitative analysis is a complete, detailed description. No attempt is made to assign frequencies to the linguistic features which are identified in the data, and rare phenomena receives (or should receive) the same amount of attention as more frequent phenomena. Qualitative analysis allows for fine distinctions to be drawn because it is not necessary to shoehorn the data into a finite number of classifications.*
- *Ambiguities, which are inherent in human language, can be recognized in the analysis. For example, the word "red" could be used in a corpus to signify the colour red, or as a political categorization (e.g. socialism or communism). In a qualitative*

analysis both senses of red in the phrase "the red flag" could be recognized.

- *The main disadvantage of qualitative approaches to corpus analysis is that their findings cannot be extended to wider populations with the same degree of certainty that quantitative analyses can. This is because the findings of the research are not tested to discover whether they are statistically significant or due to chance." (Ochieng, 2009:17).*

Furthermore Hennink et al., (2011) summarised some limitations of in-depth interviews. A one to one interview is only giving information from individuals and does not include feedback from others. This method needs skills to establish trust with the interviewee, without which the quality of the responses could be inadequate to answer the research question. Another disadvantage was the need for flexibility to change the topic order during the interview to follow the participant's story. The last limitation was the need of a lot transcription which increases the possibility for misinterpretation (Hennink et al., 2011).

5.14 COLLECTING THE DATA

This section illustrates the process of collecting the data, the creation of a priori themes and the analysis of the data as well as ensuring the study carries the voice of the refugees as stated in the objectives of this study. Refugee statements have been included exactly as they were reported.

The researcher went to Jordan in December 2018 and conducted voice-recorded interviews in Za'atari camp. The recruitment process was successful and a total of twenty interviewees were appointed. Seventeen interviews were used, after interviews were filtered and the data was saturated.

Three interviews were excluded as the interviewees were hesitant to talk and did not match the level of aimed data and ended up by being eliminated from the findings. The limited data from the eliminated interviewees were matching previously collected data which meant their exclusion did not affect the overall outcome and didn't add any unique data.

As mentioned earlier in the methodology chapter, the researcher had arranged with Jordan Health Aid Society International (JHASi) to find the sample and use their facilities to conduct the interviews privately. JHASi had allocated a meetings room for the researcher and allowed me to put advertising details on the walls for one week before the date of collecting the data. This was in Arabic language which is readable for the Syrians as they speak Arabic.

In addition, the language used during the interviews was jargon free and was understandable for both the interviewer and the participants. The venue was accessible and there were no physical barriers to participation. The participants were offered the opportunity to do the interview in the venue or in their homes. All of them were comfortable to do the interviews in the clinic venue. All participants were offered refreshments prior the interviews.

Consent forms were filled prior to each single interview and the whole procedure was explained verbally to every candidate in terms of the aims

of the study; their rights of joining and dropping out at any time as well as printed leaflets were also provided. The psychology clinic was next to the meeting room and was informed about the study. They agreed to cooperate if the researcher needed to transfer any distressed cases due to trauma and PTSD recollection. Fortunately, none of the participants experienced distress symptoms and no referrals were made.

No limitations were recorded during the whole process as everything was planned through JHASi. The Syrian refugees in the camp were used to researchers, the various authorities and representatives of the NGOs coming to collect data from them which made introductions and explaining the purpose of the study easier for the researcher. An interview example has been translated fully and included in the appendices to give an idea of the conversations that the researcher had during the data collection period.

The participants were asked sixteen questions and the majority responded to all of them and gave clear answers. The following list (Table 1) contains the core questions:

After working for many years in the camp with the Syrian refugees, living among them within the same community and reading various articles about the refugees, I have decided to make this list of questions which tackles the daily life challenges that the refugees face, and what made them to leave Syria and how hard was the fleeing experience. I also wanted to obtain answers about the whole experience through the years.

In addition, I was hoping to get their views about the quality of life in the camp, their views about the NGOs services and facilities and how that impacted on their mental wellbeing.

I purposely asked the participants about the daily challenges to give them a chance to speak loudly about what they are annoyed about and this what the refugees want to say first, otherwise, each question will redirect us to the first question.

Table 1. Interview questions

1. How do you deal with daily challenges?
2. What made you leave Syria? What would you say was the main reason?
3. What was your situation when you came over?
4. How has your life been throughout the crisis? How has your life been affected during the 7 years?
5. How are you now? How do you feel now?
6. Did you see any health professionals during these 7 years?
7. What help did you get?
8. Was it helpful or unhelpful?
9. Were you diagnosed with any mental illness?
10. Do you understand this diagnosis?
11. Were you given any medication? Was it helpful?

was obtained. The language used in the interview was clear and understandable fully by the participants. The researcher approached the participants in the commonly used cultural way and had relaxed the participants to feel safe and explained the aim of this study very clearly and told them their rights during this study and guaranteed the full anonymity and confidentiality.

The open-ended questions set resulted in a great outcome. The questions triggered the disclosure of the main aspects of the refugees' lives and their actual sufferings, needs, life conditions and answered the main objectives of this study. Responses to questions about their mental health were useful. The participants talked about symptoms of mental health issues and discussed the stigma and labelling among them and the cultural impact, and other mental health issues such as PTSD as this was discussed in the literature review and the findings and discussion chapters.

Purposive sampling method was employed in this study and it was beneficial in finding the right sample for the aim of this study and they all met the criteria and had a good range of different cases and settings. The participants came to the assigned premises on the given dates and times

as it was published in the detailed advertisements and had an understanding of the interview purpose. The number of participants was sufficient, and twenty participants were interviewed. Which were only volunteered.

The interviews were audio recorded, apart from one participant as he preferred to have his interview written on paper, although he was told his details would be fully anonymous. Data saturation was reached by seventeen participants.

Interviews were transcribed, translated and checked for rigour before transferring into this study. Data to publish was checked with JHASi member and my supervisors to check the bias and rigor. JHASi Medical Field Coordinator's statement is *'I have reviewed Mousa's transcription and interpretation in a very confidential circumstances and I confirm that Mr. Jawasreh was unbiased at all in his transcribed data and gave the exact meaning of the original collected data'.* Collected data matched previous literature and has extended the previous knowledge and added new emerging themes. Thematic analysis was employed during the analysis process.

The researcher understood the data through reading and reading process, and that made it easier to identify the themes and to be able to include some reflection on the emotions expressed by participants. Data was coded into a separate sheet and had different categories and classifications of that data, which made it easier to create themes and to organize the data. Emerged themes were reviewed three times with the supervisors and compared to the existing literature too. Each theme was explained and defined with literature evidence alongside participants' statements.

During the researcher's previous experience in refugee camps, some refugees would complement certain NGOs just for the sake of obtaining better services or to avoid getting sanctioned and having blocks to the aid from them. During these interviews I have come across some participants who did that but explaining to them that I was only a student had given them the freedom to talk and open their hearts which resulted in good honest contributions to the study.

Similarly, language difficulties did not present as a problem for the study as the researcher had originated from the same region and was able to communicate clearly. Following the interviews, during transcription and analysis, the study conductor did not face any difficulty when the data was collected which reflects the excellent level of understanding of the language of the participants.

5.16 THEMES

After scanning and reviewing the collected data, two major theoretical strands emerged:

1. **THE IMPACT OF SOCIAL CONTEXT AND STRUCTURAL INEQUALITIES**
2. **MENTAL ILL HEALTH**

There was one main theme that emerged under structural inequalities and that was –

'*Social Environment: Daily life stressors and barriers'.*

Under Mental Ill Health there were two main themes –

'*Anxiety, Depression and Post-Traumatic Stress Disorder (PTSD)'* and *'Stigma and Mental Health'.*

Several sub-themes emerged very clearly from the interviews. These are expressed in two columns. The first is the thematic list of quality of life, social and environmental factors that contribute to mental health problems; the second is the thematic list of psychological factors that contribute to mental ill health. These themes are presented here in tabular form:

Table 2:

FINAL TEMPLATE

Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health

Theoretical Strands	**Main theme**	**Sub-theme**	**Sub-sub theme**
1 **THE IMPACT OF SOCIAL CONTEXT AND STRUCTURAL INEQUALITIES**	*1.Social Environment: Daily life stressors and barriers*	1.Jobs and employment (lack of work) 1.Loss of income 2.Loss of purpose 3.Loss of status	1. Anxiety 2. Depression 3. Frustration 4. Stress
		Education and schools 1. Concern for children's future **2.** Failure as father	1.Worthlessness 2. Pessimism 3. Shame
		1. Financial issues and very low income	1.Hopelessness 2.Anxiety 3.Shame 4. Stress
		2. Long-term Housing	1.Pessimism 2.Shame

(Reported in Chapter 6)		problems 4. Loss of privacy 5. Poor conditions	
		3. Wasta, Discrimination, Exploitation and Stigma	1. Worthlessness 2. Powerlessness 3. Anger

FINAL TEMPLATE

Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health

Theoretical Strands	**Main theme**	**Sub-theme**	**Sub-sub theme**
		1. Lack of safety	1. Anxious

2 **MENTAL ILL HEALTH** (Reported in chapters 6)	1. Anxiety, Depression and Post-Traumatic Stress Disorder (PTSD)	2. Violence in the camp 3. Lack of trust – neighbours/NGOs	mood 2. Fear 3. Distrust 4. Isolation 5. PTSD /paranoia
		1. Loss of family 2. Loss status 3. Fears for future of children's education 4. Poor access to health care **5.** Memories of a better life before	1. Powerlessness 2. Hopelessness 3. Pessimism 4. Frustration
		Trauma 1. Witnessing abuse and rape 2. Torture 3. Traumatic migration 4. Bombing 5. Theft of property	1.Nightmares 2.Flashbacks 3.Intrusive memories
		1. Poor take up of	1. Poor symptom

	2.Stigma and mental ill health	services 2. Poor service delivery in Arabic countries	control – anxiety, depression, PTSD
		3. Religion and jinn Punishments from God. Distrust of western medicine	1. Increased fear 2. Increased Anxiety
		3. Negative Community response 4. Fear of being identified as crazy	1. Increased Anxiety 2. Increased paranoia

5.17 CHAPTER SUMMARY

In this chapter, I have reflected on all the elements that work together to deliver a successful research project. I discuss the rationale for my sampling and the rationale for my approach to addressing my research questions. I consider all the pitfalls that could befall a study such as this

and demonstrate how I attend to each of the challenges for myself as a researcher and for the participants on the study. Finally, I include the thematic table that was generated by attention to the literature and from my interview data. This forms the basis of the structure from which I pursued analysis of the data and present my findings and discussion.

6.1 Introduction

In this chapter, the data from the transcribed interviews gathered in the study is analysed in the context of the review of previously published literature (Chapters 3 and 4). The interview data is explored in terms of the information on the mental health challenges that the adult Syrian refugee males were facing, in order to identify the gaps in the literature as well pinpointing any similarities. There will be attention to the major consequences of daily life experiences in the camp that are impacting on mental wellbeing. The interventions and methods that have been employed to help prevent or reduce the negative impact of the refugee experience is evaluated. Another goal of the analysis is to assess the efficacy of the aid provided by the organisations in the refugee camp. A deep focus on the mental health issues resulting from the traumatic conflict experiences of the refugees is considered in the context of current understandings of PTSD and associated mental disorders.

6.1.1 Note on the translation of the original Arabic.

More than three hundred million people around the world speak Arabic language, and it is the official language for twenty-two countries. Arabic language is one of the six official language in the United Nations. Arabic is Central Semitic language, closely linked to Aramaic and Hebrew. Standard

Arabic is called (Fusha) is the distinct language used in the formal speeches, media, newspapers and other settings.

In the other hand, there is the colloquial spoken language (Aamiya) which varies from country to another among different frictions in society (Sayed, 2015).

In this study, the researcher used (Aamiya) language to obtain better results and better understand which is more relaxed and understandable to the participants and breaks boundaries easier as it is not formal form of language.

To make the emotional and mental health section reflect more clearly the Arabic culture, I gave a

close cultural translation to certain mental health terms and the way they are pronounced in Arabic.

(Mohbat) ‘Disappointed’. This term is used when the person is not happy and cannot see a

good future ahead. This word can be used in several occasions and not necessarily to be related to mental illness. For example, it might be used after failing an exam.

(Sa’aed) ‘Happy’, (Murtah) ‘comfortable’. This term is used when the individual is comfortable,

or in some cases, people use it to show that they are not complaining of what God has given

them. Or the usual common answer would be “Alhamdulliah” which means thanks to God and it is more as religious answer.

(Murhaq Atefian), ‘Emotionally exhausted’. This term doesn’t necessarily reflect the exact

meaning, and this depends on the other person’s judgment and the way they say the word, and it is related romantic side more than normal life challenges.

(Ta’aban Nafsian), ‘Mentally tired’. Those terms are referring to a person who has seen too

much in a long experience or several events. And it can be a serious indication of a serious mental health issues.

(Asabiah). ‘Nervousness’ and it is related to a high level of anger.

‘I feel depressed’. This is a term can be used for a little reason or a big reason, and it does not

mean that the individual has a diagnosis of clinical depression; (Asha’aor bi Iktia’ab) in most

of the cases.

(Thakhet Nafsy), ‘Stress’, this means the person is under a high pressure and stress.

(Khawf) ‘Fear’. This term can be used in real fear situations and worry about the future for example the children’s future.

(Qalaq) ‘Anxiety’; ‘Worry’ also pronounced (Qalaq). This word is frequently used among Arabs

and can be used over very little things such as mother's worry when their children are outside until late, or can be used with higher level of stress.

(AlarowahTa'abaneh) 'Souls are tired'. This can really reflect a real deep emotional pain, and this is common term for the long resettlement trip of the refugees.

(Kha'aef) 'Scared'. This is a commonly used term over little and major issues. For example, 'I

am scared that my friend will not bring the ketchup', or 'I am scared for my life'. The understanding of this term refers to the subject and the way it is said.

Torop (2002) has said that translation, as a procedure of converting thoughts stated from one language into another, is entrenched in the sociocultural language of a specific setting and also described the translation process as basically a boundary-crossing amid two different languages. Clandinin and Connelly (2000) agree with the opinion of Lapadat and Lindsay (1999) that translation is mainly a conversional procedure of converting field texts to research texts by making choices at dissimilar phases for gaining equivalence in meanings and interpretations (Brislin 1970; Cauce, Coronado and Watson, 1998).

The procedure of finding "comparability of interpretations or meanings in qualitative research is often influenced by researchers' knowledge and understanding of intimate language and culture" (Frey, 1970, cited in Birbili, 2000, p. 2).

6.2 Reasons for leaving Syria and associated trauma

Refugees and Internally Displaced Persons(IDPs) may flee a country or an area as a result of direct experience of conflict and associated trauma, or as a means to avoid anticipated traumatic events. In this study participants were initially asked about the main reason behind leaving Syria, after the war erupted. Participants gave a variety of different answers, but mostly they left Syria due to a worsening of the war situation in their towns. The first participant said that he left Syria because the war had reached his area, and he left to protect the safety of his children. The same participant also stated:

Extract 6.1- (Participant 1, Lines 4 and 5),

"When I left Syria, the situation was a tragedy. The Free Army came to our area and expelled the regime forces which made them(the regime) attack the area in a very harsh way."

Participant number (3) answered:

Extract 6.2 – (Participant 3, Line 49),

"I left Syria because of my father. He was worried about me and my children due to the war."

Participant number (4) said:

Extract 6.3–(Participant 4, Lines 68 and 69),

"*I left Syria because of Bashar's army. They came to our town and were raping women and killing their families."*

Participant number (5) said about leaving Syria:

Extract 6.5 – (Participant 5, Lines 89 and 90),

"I left Syria in 2012. I left because of the war. My brother was required to join the army because of his age. I had many issues with relatives as well."

Participant number (6) stated:

Extract 6.6 – (Participant 6, Line 113),

"I left Syria in 2012. My brother got injured and he lost both of his legs, after that he was being treated in Israel."

[Israel accepted an average of a hundred Syrian medical patients every month who were crossing the borders from the Golan heights. The Israeli military was treating the patients in a field hospital, and the serious cases were relocated to main hospital buildings (Plotner, 2014)].

Participant number (7) describing his escape story, said that he left Syria in 2013; the reason was for his family. They travelled from their hometown to a different town and had to stay with relatives which made him feel shy and ashamed. He added that, on one occasion when they were walking away from the conflict, bombers were chasing them so they went to hide in a mosque which was full of people as well. He started crying and did not know what to do. He added that his father was working in Kuwait, so he called him and was very angry with his father that he had left them in Syria alone.

Participant number (8) stated about leaving Syria:

Extract 6.7 – (Participant 8, Line 107),

"I left Syria in 2012, because of the war, bombs in my area and that was a direct threat. I was worried about myself and my family."

Participant number (9) said that he left Syria because his house was demolished by bombs and he had no money.

Participant number (10) said:

Extract 6.7 – (Participant 10, Line 113),

“I left Syria because there was always shooting near my house. Some people steal your house in front of you and you can’t say anything. There was one guy - who raped his daughters front of him.”

Interviewee number (11) said:

Extract 6.8– (Participant 11, Lines 228 and 229),

“*I left Syria as my mother made me leave and she was worried about me. I paid for the Free Army to help me leave the country.”*

Extract 6.9– (Participant 13, Line 243),

Participant number (13) said that he left Syria because of his mother, as she had no one to go with her to Jordan.

Participant number (14) said that:

Extract 6.10– (Participant 14, Lines 253 and 254),

“*We left Syria because we couldn’t support either side as we might get killed. In 2013, I left because they were about to attack my town (regime).”*

Number (15) participant said that he left Syria because of his children’s safety.

Extract 6.11– (Participant 15, Lines 270 and 271)

He stated:

“I left Syria for my children, I have a young daughter, the regime used to take the young girls to rape them.”

Participant number (16) said:

Extract 6.12– (Participant 16, Lines 284 and 185),

“*I left Syria in 2014. I left because of my daughters. They arrested me three times and insulted me too, and someone advised me to stay away.”*

6.3 The role of wasta in refugee outcomes

These refugees’ statements show that they did not all leave Syria in the beginning of the conflict, which took place in 2011, and everyone had their own serious reasons for leaving the country. It is important to note that many of the participants left Syria at various different times within the previous seven years, not necessarily at the beginning of the conflict. Schon (2018), in a study of 170 Syrian refugees who had migrated to Turkey, was able to demonstrate that refugees who had wasta (influence)and often the financial capability were able to avoid many of the more traumatic experiences of the refugees in this study. Syrian refugees with wasta were able to leave Syria before the conflict entered their area, and on average left Syria twelve to eighteen months earlier than those refugees with little wasta. Refugees with wasta were therefore able to avoid the worst experiences of the conflict, and as a consequence had not witnessed or experienced the same level of trauma. Many of the refugees with wasta had been able to resettle in urban areas such as Istanbul.

Reflecting on the work of Schon (2018), would indicate that, the participants in the Jordanian refugee camp that formed the group for this study were not so fortunate and did not have the advantages Syrians with wasta benefited from. They had left Syria later into the conflict, when their area had been subsumed under the warzone, and they still carried the harsh memories and the trauma of those memories still brought them back to the day when they left.

In this study the participants have complained of the favouritism against the NGOs as they hire only the people they know and they people they know they only help their friends and relatives getting jobs and in obtaining NGOs services.

This section explains how the favouritism works. Favouritism is pronounced (Wasta) in Arabic, it is common in the Arabic cultures. It was defined as "*a form of corruption"* (loewe et al., 2008:259). Corruption is slightly different than wasta. In wasta there is frequently no money included and usually it happens between two or three people. Corruption takes place by using money, gifts or relationships to gain a specific benefits and advantages (Treisman, 2000).

Wasta usually is used to obtain jobs or services and it works when an individual knows somebody who works in a certain workplace and they ask them to help each other when they are not eligible for the work or the service. According to Kaufmann (2004) the favouritism is usually formed at the expenses of a third party and this is a form of corruption when it happens in a public service or private office.

The use of favouritism is for personal connections to obtain preferential services (loewe et al., 2008). In Asia it has had a bigger attention in the

last few years, while less research was carried out into the favouritism issue in North Africa and the Middle East.

The focus has been mainly on the influences of wasta on the business climate (Hutchings and Weir, 2006). There are some unseen and unspoken cultural forces that only can be understood by the Arabic people. Wasta is one of the hidden forces as stated by (Megheirkouni, 2016). Furthermore, wasta is *"a salient practice in an Arab context"* (Megheirkouni & Weir, 2019:641). Moreover, Hutchings and Weir (2006) argued that the wasta is a representation of links and bonds of personal networks.

Favouritism is usually is a special treatment or services of relatives, friends, neighbours, or other associates (Khatri, Tsang, & Begley, 2006). These connections can be created by birth and that is usually happening between relatives, by social connections building by giving gifts or doing favours to obtain favour back in the future, or via different people such as school mates or people living at the same area (Sardan, 1999). In terms of wasta in the Arab Middle East, Schwarz (2008) stated that it is an expression of informal politics and patrimonial nature of social relations and that it is running under informal group structures and neo-patrimonialism. Schwarz (2008:610) defined wasta as *a "social mechanism that determines allocation decisions in society, economy and politics*."

Based on the Social Identity Theory (SIT), when persons interrelate with others from a different cultural background, they tend to easily understand the traditional differences and they incline towards expressing in-and out-group prejudice (Tajifel and Turner, 1986).

SIT is defined as *"a classic social psychological theory that attempts to explain intergroup conflict as a function of group-based self-definition"*

Islam (2014:1781). Thus, people have a propensity to create and build a friendship with other in-group members, and usually have the same cultural understandings (Shinnar, 2008). On the other hand, people who keep a solid in-group favouritism usually have a habit of showing undesirable attitudes and insights towards out-group people (Brewer, 2007; Rustemli et al., 2000).

As an example from the interviewed refugees in this study, favouritism was among in-group and out-group when they worked outside the camp, as they said, that the farm owner did not pay them the same as Jordanians because they were Syrians, and that created the sense of favouritism and discrimination among the refugees.

Syrian refugees in Za'atari camp, do not have the opportunity to experience living within the host community, and for this reason the out-group relations and activates do not apply. Even though some participants had a little experience outside the camp, for a few hours and days, this cannot be generalised, because they were not living among the Jordanian community and it was a short period of experience with certain people only. There were Syrian refugees who were living within the Jordanian community, but this study targeted the camp's refugees only and that was because of the limited resources and complications in terms of interviewer safety to travel around different cities in Jordan.

There are studies relating to other ethnic groups or nationalities where this kind of 'in-group' and 'out-group' social system can be prevalent. For example, Kim (2012) argued that Korean immigrants females, who were residing in the United States, improved their understanding in terms of ethnicity and culture, and reported that they established friendships when doing leisure activities with out-group people. It does not seem that these

other systems are quite so pervasive or deeply harmful as wasta in the Middle East.

6.4 Unemployment, frustration and helplessness

The literature (e.g. George et al., 2015) showed a direct relationship between settlement experiences and mental ill health. Having escaped from the immediately frightening aspects of the conflict zone, the refugees were then confronted by the powerful emotions linked to displacement reality. They frequently had the distress of their family being scattered across other camps in other countries, loss of many relatives or having no knowledge of the whereabouts of some members of their family. The participants expressed frustration at their predicament and anger towards the Syrian regime.

As well as, managing the emotional challenges of living amongst other refugees where there were continual reminders of the conflict and its traumatic impact, the refugees were struggling to find a way out of their predicament. Building the resources to become independent again, would require earning enough money to leave the camp and find somewhere to resettle, but the refugees were barely able to keep themselves alive with the income they received. This was expressed in a sense of helplessness and frustration. Participant (no.10)said, he would do any type of work, he

had just come back from the olive oil factory where he had worked 12 hours for 14 JOD. He said:

Extract 6.14– (Participant 10, Lines 204 and 205)

“I work to pay off my debt. I lost too much of my weight. Life is too hard.”

There was a general feeling, that the refugees were innocent victims in the middle of a conflict where they could not trust either side. Number (10) participant was very frustrated. He said:

Extract 6.15– (Participant 10, Line 210)

“They are all liars.” referring to the regime and the Free Army.

Continuing about the issue of frustration, interviewee number (12) stated that he had ongoing stress as half of his children were back home in Syria. He had no money and that he was old and did not have any means of earning anything. He admitted that, he felt very frustrated and had lost everything, money, home and his sheep.

6.5 Material and emotional loss

Hassan et al., (2015), reported that the effect of conflict on Syrian mental health and psychosocial wellbeing are profound. One of the common psychological impacts came from the numerous losses the refugees had experienced. Participants had talked about their emotional losses such as losing family members, relatives, friends or separation from each other, such as number (12) participant. They had major financial and material losses having lost their homes, their land and their jobs. They had also suffered huge psychological losses such as, the loss of security, loss of

status and loss of purpose. Bonanno (2009), very helpfully helps explain the enormity of the damage to emotional wellbeing that people can suffer from experiencing loss:

"if we understand the different ways people react to loss, we understand something about what it means to be human, something about the way we experience life and death, love and meaning, sadness and joy" (Bonanno, 2009:3).

6.6 Poverty, unemployment and frustration

Hynie (2018) found that the impact of losing homes, material possessions, savings, businesses, professional and legal documentation in traumatic migration was inevitably correlated with unemployment and poverty. Many of the refuges were already from low socio-economic groups pre-migration. Hynie (2018), found that such refugees found securing employment extremely difficult, leaving them in long-term poverty and that this had very damaging impacts on the mental health of the refugees.

Securing a job was found to be a big problem for the refugees interviewed in this study. The majority of the refugees came from working in manual labour in a different area, and their lifestyle had been like that for many generations, working as farmers, builders or as craftsman. Escaping their country and resettling in a camp doing nothing, was a hard experience for them and their families as they stated in their interviews. That experience created family problems for some of them.

For example, interviewee number (9) said:

Extract 6.16– (Participant 9, Line 195)

"I used to fight with my wife over little reason, because I don't work".

Prior to conducting this study, when I used to work in Jordan with the Syrian refugees, I had noticed that in Za'atari camp, there were no actual jobs other than NGO careers, which were very limited and in small number compared to the huge population in a closed camp.

The Jordanian Government and UNHCR allowed the refugees to open their own shops inside the camp to give them a source of food and other life needs, to give the refugees an opportunity to make money, and to keep them busy as they had started to have fights almost every day. The shops idea had helped a very small and limited population in benefiting them financially, but that still left the rest unemployed and with no means of income, which did not provide a complete solution or help the whole community in this sense.

Syrian refugees who had entered Jordan legally through the borders with a passport had the right to work in Jordan with a permit, but not the Syrian refugees who had crossed the unofficial borders (International Labour Organization, 2015). This was the case until the first of January 2016, when this changed and the government issued work permits for those who applied for them (Ministry of Labour for Jordan, 2020).

Even when the work permits were given, the refugees still had many difficulties. First of all, the location of the camp was not suitable for finding jobs nearby. The nearest city (Al-Mafraq) is slightly over ten miles distance from the camp, and it is in a desert area with very few employment opportunities nearby such as in factories. Another problem was that the employers did not keep to the national minimum wage, and mostly the

refugees got paid less than this and had to accept whatever they were given in order to make a little amount of money for their life essentials. Moreover, the employers made the refugees work for seven days a week, which made them very exhausted, and they therefore did not want to go back to work again.

The daily expenditure of leaving the camp to go to work was not worth it for many of the refugees, as they had to pay for travel expenses and food from their own pocket, when they were only earning only between 10-15 JOD (Jordan Dinar [JOD]; £11-16) a day. Of great concern was that in some cases the employers did not pay them at all. The lack of work, low or zero income was a major and often the main issue among the Syrian refugees that I interviewed, and every participant talked about it. In the interviews, they frequently linked their mental health problems to this matter.

For example, interviewee number (1) said he used to make 2000 JODs every month back home in Syria, now he gets only 100 JOD from the UNHCR coupons from which left him with only 10 JOD after he had bought the basics for the home .He also said that he did not have enough money to even cut his hair. The same participant stated:

Extract 6.17– (Participant 1, Lines 6 and 7)

"*I have been living in the camp for five years, and these five years I have lived in debt. It is a very bad life."*

The interviewee was asked if something would make him feel better. He answered:

Extract 6.18– (Participant 1, Lines 24, 25, 26 and 27),

“Increase the visa amount, jobs, ease the immigration process. Life is too expensive in Jordan and I feel so good when I leave the camp for few hours.”

In this study the participants were desperate for a change in their circumstances and to escape this hopeless situation. The majority of the participants had expressed strong feelings on this matter and wanted to better their condition, by either the provision of jobs or an increase in the money provided from the UNHCR. Some participants asked me for advice on how they could emigrate to Western countries and escape the camp’s life.

Participant number two said that the money from the UNHCR was not enough for the whole month and so he worked outside the camp in farms, but they frequently did not get paid. It was clearly very distressing to have escaped the horrors of the conflict in Syria, then to be further abused by Jordanians in a place where they were supposed to be safe. He was looking for a job to better his life. Escaping the current situation and the possibility of change were a very major and important role for the refugees’ attention. This would have helped the hopelessness of the situation as the participants in the study had lost hope and made many statements that showed without a doubt signs of lost hope for the future as was discussed earlier in the literature review.

In a different example about the financial issues of the refugees, participant number (3) talked about the unpredictability of employment. He had previously been employed for a few months by a humanitarian NGO organization in the camp. Unfortunately, for several months he had not been offered any work. He also said that the life for him had become

very hard and tight regarding money. As a result of losing his job he was now in debt and he could not pay off the loan he had taken.

Another example of the unpredictability of employment was participant number (2), who said that he had a six months' contract as a security guard, but that had ended.

Two examples of the low pay and exploitation were a young participant (No.6), who was working at the time in a small kiosk for his cousin near the JHASi clinic, but was only making 150 JODs (£165)a month, and Participant number (7), who said that he went to Amman (Capital of Jordan) and worked for ten days, but after expenses he came back with only 10 JODs (£9).

Participant number (7) stated about this issue:

Extract 6.19– (Participant 7, line 136),

"I work all the time, but I don't save any money and I can't even open my own business.

Participant number (8) stated:

Extract 6.20– (Participant 8, line 153),

"Sometimes I work outside the camp with very low pay-rate and we have accepted it to fulfil our needs".

Interviewee number (10) talked about his work experience and said:

Extract 6.21– (Participant 10, line 204 and 205),

"*I do any type of work. I just came back from an olive oil factory. I have worked for twelve hours for only 14 JODs (£13). I work to pay my debts. I have lost too much weight. My fingers hurt so bad"*.

Participant number (15) said:

Extract 6.22– (Participant 15, line 274 and 275),

“I am only not happy because I can’t find a job. Sometimes I work as cleaner and my wife does as well”.

Participant number (16) also said about the work:

Extract 6.23– (Participant 16, line 294),

“My wife sometimes works as cleaner. She works for one week only every few months and that is with the (x) organization”.

Interviewee number (7) said:

Extract 6.24– (Participant 7, lines 121 and 122),

“I can do any job such as handling and carrying. All the NGOs’ jobs are run by someone I know. I live day by day, if I work, I eat.”

He also said:

Extract 6.25– (Participant 7, lines 133 and 141),

“*I struggled in the past five years in money matters. The money we get from UNHCR visa is not enough”.*

The same participant suggested that, it would be much better if the employers gave the jobs to many different people and split the work into shorter periods such as three months instead of six months, so that many people could get opportunities to have some cash from the jobs. Participant number eight sometimes worked outside the camp, but he was getting very low pay. He said that the refugees have accepted the low pay because it was the only way that they were going to be able to fulfil their needs.

Participant number (9) had a different opinion about the NGO jobs as he was happy and worked for the organization (x). He said:

Extract 6.26– (Participant 9, lines 179 and 180),

“The organization (NGO X) helped me as I benefit them due to the skills I have from my previous job as I am a trained blacksmith. Now I work as a maintenance supervisor with Organization (NGO X). I have a good wage”.

Mostly, the refugees stated that the money from the UNHCR visa was not enough , and this was the reason that forced them to look for jobs and accept any work for any amount of money regardless of how poor the wage was.

It is evident from the interview data that fifteen participants were complaining about the jobs and they wanted to work. They were not dependent people who were content with relying on the money that they obtained from the UNHCR in cash-assistant form. Several researchers suggest that employment is the most vital aspect in securing the integration of migrants into the community (Coussey, 2000; Bloch, 1999; Robinson, 1998; Joly, 1996). Unfortunately, this important factor for assimilation was not achieved among the Syrian refugees in Zaatar’ camp in Jordan. The individuals who participated in the study were highly motivated to engage in work, to fill their time purposefully and to address their needs. In contrast, according to Bloch (1999), refugees who live within the host community cope more easily than the refugees who live in camps, as the jobs chances were higher. There is a visible correlation between Bloch’s findings and my findings with the Syrian refugees in Jordan. The lack of employment was highlighted in this study as the most frequently discussed issue and finding employment that paid a reasonable

salary was seen by the refugees as the most likely factor that would improve their quality of life.

In their guidance to organisations that provide services to Syrian refugees, Almoshmosh et al., (2019), highlight the importance of employment as a counter-measure against depression and anxiety. For the Syrian refugees in this camp, they had not been completely relocated to an alien environment in a western country. They were not disadvantaged by having to learn another language as described by Panter-Brick et al.(2018) because they might have been in the refugee camps to the north in Turkey or in a relocation programme in some European country, Australia, Canada or the USA. They had skills that would have been directly transferrable to the Jordanian environment as their way of life and culture was very similar to the Jordanian culture. This was often not the case for refugees who frequently found themselves in situations where their skills were not compatible with the host country or where their qualifications were not accepted or transferrable, as discovered by Smeekes et al., (2015). Similarly, many refugees who had travelled or been transferred to the EU, Australia, Canada or the USA had to overcome a number of hurdles created by the immigration and asylum-seeking processes. As highlighted by Canetti et al. (2016), the adversities refugees face with multiple asylum applications, detention in institutions frequently and difficulties adapting to a new culture can exacerbate serious mental ill health and can be a greater predictor of depression, anxiety and PTSD than the pre-migration traumas.

It is important to explain why almost all of the participants were very worried about job security and why it was very important to them. In Arabic culture men are usually the only providers for the home and the

women are expected to stay at home and fulfil the traditional role of a housewife. This puts a huge burden on the men, especially in these stressful circumstances. Therefore, employment for the men is a very important element and gives the sense of wellbeing for all the family. Not having a job for many years or a job that does not help the financial situation can cause mental stress and frustration among the refugees, and that is what became very clear from the interviews. Javanbakht et al., (2019) also emphasise the important role employment can have in reducing social isolation and the link isolation can often have in depression, although it is important to note that social isolation was not just a problem for male refugees. Hendrickx et al., (2019) do stress that in their study social isolation was a far more serious problem for women and older people than it was for male refugees.

Feeney (2000) reported that when the refugees move to a new community and if they struggle to locate work this is the most important barrier to them being able to integrate into society. As an example of the impact of unemployment on mental wellbeing, Coid et al., (2006) carried out a study on the prevalence of unemployment and the correlation with personality disorder, by using a Structural Clinical Interview for DSM-IV AXIS II disorder interview on a sample of 626 participants. They reported that the weighted occurrence of personality disorder was 4.4% (95% CI 2.9-6.7). Among the separated and unemployed men, the personality disorders rates were highest. In a study of refugees, in the terms of the psychological impact of finding employment, the refugees who are powerless and dependant on the host country, when they start a new job, they feel psychologically better than the host population (Robinson, 1998).

Amongst the refugees in this study there were accounts that reflected the positive impact employment could have on mental wellbeing. Interviewee number nine said that he left Syria in 2014 and came to Jordan with no money, and as mentioned earlier, he was working and making a good wage. The same participant stated that he visited a psychologist in 2015 to get help with resolving his traumatic memories. The psychologist helped him by finding a job. Participant (9) said that obtaining a new job was the right turn in his life, as it changed his life by encouraging him to leave the home every day and see other people. As a consequence, the same participant stated that he was going out with his family and had money to spend, whereas in the past he said he used to fight with his wife over little issues. He raised the issue of influence and favouritism that comes from having wasta. He said that refugees only get jobs in the camp by the use of wasta.

6.7 Value of kinship

Seker et al., (2015) reported that the refugees struggled to make friends among their peers when they arrived in a new country. This was not an issue among the refugees in Jordan as the camp was huge and all the refugees in the camp were Syrians. As most of the refugees had come from the same governorate (Dara'a) but from different towns and villages, they were able to make new friendships mostly with people from the same town or they were able to make contact with their own relatives who had arrived at the same camp, but there was still the problem that they made fights and issues with others from different towns. The refugees in this

camp were very frequently relatives and had the same cultural background; big families and neighbours had travelled together and resettled together in the camp. In Syria, if a person has the same family name, they will call each other ‘cousin’, and this will make the social integration easier. In the Syrian community, people are very friendly, and they socialise very much. The boring life in the camp also forced the people to make friendships and spend time with each other as it was the only escape for them.

6.8 Quality of life and daily stressors of displacement

One of this study’s objectives was to uncover and report the quality of life and the daily displacement stressors. During the interviews, the refugees reported issues related to the topics which will be discussed further in this section. Experiences of conflict-related violence and concerns about the situation in Syria were compounded by the daily stressors of displacement, including poverty, lack of basic needs and services, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community support.

In terms of the life quality in the camp, the first participant clearly stated:

Extract 6.27– (Participant 1, line 7)

“Very bad life, but it’s very secure.”

The feeling of new-found security among the refugees was obvious once they had settled in Jordan and once they began engaging with the

Jordanian community. There were however other essential aspects of a stable community that were still to be established such as the construction of adequate schools. The same participant (No 1) said:

Extract 6.28– (Participant 1, line 8)

"I am worried about my children's future and their education; there is no good education in the camp."

The provision of education and the poor quality of education were an issue among the refugees which will be discussed later in this chapter.

Another feature of a stable community beyond physical security is a secure home and a clean environment. These issues were causing stress to the refugees. In the interview with the same participant (No 1), he stated:

Extract 6.29– (Participant 1, lines 14 and 9)

"When it rains, it gets very muddy and dirty everywhere which makes us unable to travel around, and the roof usually leaks water when it rains."

Participants number (7, 15 and 16) talked about the same topic and complained about the state of the muddy roads during winter. The nature of the land where the Za'atari camp is located is sandy, so with a slight amount of water the streets and area flood easily; only the main streets are asphalt, the rest of the streets had not been constructed.

Some participants complained about the distance and privacy between each caravan. For example, participant number (1) said:

Extract 6.30– (Participant 1, line 9)

"The distance between me and my neighbour is only two metres."

In Syrian and Jordanian towns and villages there are no terraced or semi-detached houses; mostly the people live in detached houses or flats. Culturally and by law the houses have to be far from each other, but this was not an option in the camp. The proximity of neighbours and the lack of privacy from living very close to each other made it an issue for the refugees, who did not feel comfortable living like this.

The electricity in the camp was available only for twelve hours from 4:30 pm to 5:00 am, which made the life even harder for the refugees. Participants number (1, 2,5,12 and 16) had mentioned it and they were not happy about it. For example, participant number (1) said:

Extract 6.31– (Participant 1, line 11)

"*The electricity comes on only for twelve hours; from 4:30 pm to 5:00 am."*

Participant number (2) said:

Extract 6.32– (Participant 2, line 34)

"The electricity doesn't come on for enough time"

Participant number (12) stated:

Extract 6.33– (Participant 12, line 236)

"The electricity comes on for twelve hours only."

Participant number (7) stated that the he used solar power for small purposes as the electricity comes on only for twelve hours.

The participants have talked about the water issue as well, stating that the water tank sizes are not big enough, especially when they have larger numbers of family members and they live in the desert. The camp authorities set a limit of 1000 litres per week for each family which numbered less than eight and 2000 litres for families of eight members

and over. Participants number (2, 5, 11, 12 and 15) said the water allocation was not enough for one week and sometimes they had to pay for extra water and it was very expensive for them to afford it.

For instance, participant number (2) said:

Extract 6.34– (Participant 2, line 33)

“The supplied water is not enough. I get 2000 litres for one week”

Participant number (4) said:

Extract 6.35– (Participant 4, line70)

“I have seven persons (in my family) and the water is not enough”

Participant (5) said:

Extract 6.36– (Participant 5, line 88)

“There is a shortage in the water especially in the summer.”

On the other hand, participant number (1) said the water amount was fine for him.

Prices in the shops and the shopping mall (as they call it, in fact it was just a big supermarket) were expensive according to the refugees. They stated that there was a long waiting time to buy from the shopping mall which was the only place where they could use the UNCHR coupons. The UNCHR’s coupons were limited to certain products; buyers therefore sold some of their groceries to a different shop to get cash and buy things for other needs.

For example, participant number (2) *said:*

Extract 6.37– (Participant 2, line 32, 37)

“I face big challenges in the shopping malls, long queues and too expensive – there are double prices in the shopping mall.”

Participant number (8) said:

Extract 6.38– (Participant 8, line 151 and 152)

“I have issues with the shopping mall as the money we have is low. I sell part of the food I get from the visa to buy other life needs.”

Number (15) participant also stated that the shopping mall was expensive.

Interviewee number (17) commented about this supermarket:

Extract 6.39– (Participant 17, line 304 and 305)

“Life is hard here. I get 140JOD from the Visa and it is not enough at all. All the basic needs are very expensive from the shopping mall. Everything else I buy from my own money”.

The basic domestic needs were present in the caravans, but not in a good quality. These basic needs were items such as fridges, cookers, televisions etc. I visited some of the refugees’ caravans to get a clear idea about the situation they were living in in the caravans. The ventilation and heating methods were not appropriate or safe. In some cases, the roof leaked, the windows or doors did not close fully. There were kitchens but often the kitchen was not in a great condition and not fully equipped; in some caravans the cooker was on the floor, which was unsafe and risked contamination from dirt.

There was an absence of appropriate safe heating. The caravans were very hot during the day as the roof was made of steel with no insulation. The caravans were too small to fit bigger families for over seven years, with no privacy. Mattresses and bedding kits had been in use since the

refugees had arrived in Jordan. There were no sewage connections and during the summer the weather was very hot and dusty due to the location in the desert. The caravans had started to have rust on them due to the age and having had no maintenance. The overall environment was very dirty and insanitary.

Participant number (7) said about the caravans:

Extract 6.40– (Participant 7, line 178 and 128)

“I am always afraid of fire, as we live in caravans because they catch fire very easily. Once the cooker caught fire while I was sleep. I ran out all while the caravan was burning.”

Participant number (8)’s statement about the caravan was:

Extract 6.41– (Participant 8, line 154)

“Very hot, insects inside the caravans, small caravans, and the roof is made of metal.”

Number (9) candidate said about the caravans:

Extract 6.42– (Participant 9, line 182 and 183)

“Caravans are very bad; people are still using the same mattress since they arrived in 2014. Some caravans are made of wood internally, which is very bad.”

Participant number (15) said that he was married to two women and they were still living in one caravan.

Participant number (17) stated:

Extract 6.43– (Participant 17, line 307)

“I have fixed and carried out changes in my caravan from my own money.”

There were nevertheless different views about the state of the camp and the facilities. It became clear that some refugees were living in situations that they were relatively comfortable with, sometimes because they had different priorities. As reported in the previous sections, some refugees have declared few positive points about the quality of life in the camp, but others were more content with just feeling safe after all the problems avoiding the conflict in Syria.

Taking participant number (1) as an example, he stated that life was bad in the camp but at least it was secure. In his view the area was clean; the sewage system and the water provision were fine.

Participant number (7) had established some compensations:

Extract 6.44– (Participant 7, line 124 and 125)

"There is a privacy. I have solar power. I use it for small purposes."

Participant number (9) summarized the situation for the majority of refugees:

Extract 6.45– (Participant 9, line 181)

"For seventy percent of the people the situation is acceptable."

Participant number (10) was also reasonably well settled:

Extract 6.46– (Participant 10, line 212)

"*Now I feel better. We have electricity, water, caravans and safety."*

It is undoubtedly clear that the negative statements are more frequent than the positive statements and that the positive statements are not applicable to all the refugees in the camp. These are individual cases that reflect certain people and some areas in the camp, but together the

statements reflect the experience of most of the camp residents, most of whom were very realistic about their expectations.

For instance, participant number (14) said:

Extract 6.47– (Participant 14, line 260)

"*Now I live in a small caravan, which is nothing compared to what I had back in Syria."*

In this subsection this study illustrated part of the obstacles that the refugees faced during their daily life routine. In the previous literature, other researchers had reported some of these same issues. For example, Akinyemiet al., (2014), when reporting on the participants in his study, stated that to consider resolving the quality of life concerns, housing and security should be met. In the Syam et al., (2019) study, they reported a lack of proper accommodation, a complete lack of any educational system, no electricity or power, or even drinkable water. In Abo-Hilal and Hoogstad's (2013) study the participant women had a pressure on them due to the debt, poor quality of life and the lack of unemployment. It was reported also by the Kenya Human Rights Commission and the National Network for IDPs in Kenya (2011) that the refugees had a limited access to fundamental life needs such as water, food, sanitation, health services and education. Other studies have also talked about the same issues as being problematic (Saleh et al., 2018; Akgün, 2016).

6.9 Education and schools

Seker and Sirkeci (2015) conducted qualitative surveys on refugee children of school age who were resettling in Turkey. They found that there was a lack of the Turkish language ability and absence of attending school, education, obtaining a job, housing, financial problems, accessing general services, cultural barriers and variation, social issues.

Schools had been constructed within the camp in this study. They were staffed by Jordanian and Syrian qualified teachers. The culture of Syria is very similar to Jordanian culture, so there was a clear understanding of the expectations and aspirations of the refugees. The language barrier was not an issue among the Syrian refugees who were resettling in Jordan as the spoken language is the same, which is Arabic, and I did not face any difficulty with communication when the data was collected which reflects the level of understanding of the language previously discussed. Participant number (6) had a fight with the teacher in the school and left the school afterward, and he was the only individual that had an issue in the schools. This reflected the fact that he was the only young adult male refugee that I interviewed and that he had been of school age when he arrived at the camp but was now an adult.

In terms of the concerns for their families, mostly the participants were worried about their children's education and their future. They stated that their children had lost many years without education or had not received appropriate education. They stated that their children could not attend a university level of education as it was too expensive and it was impossible to afford. There was a general concern among the refugees that the education was expensive in Jordan, especially the private universities.

Participant number (6) had had arrived at the refugee camp whilst still of school age, although he was an adult at the time of the interviews. He had a story to tell the researcher. He said:

Extract 6.48– (Participant 6, lines 109 and 110)

"I had a fight with the teacher, because I wasn't focusing. He had verbally insulted me. Then I hit him. I have complained to the management, but nothing happened. Due to that I have left the school since then."

Participant number (17) stated:

Extract 6.49– (Participant 17, lines 302 and 302)

" The teachers are not good enough, because we are refugees. They don't educate the children or teach them very well. They tell the students to go home and learn alone".

Referring to the statement mentioned above 'because we are refugees', the refugees always had the sense of being considered low level among the host community and they always felt that the other people in Jordan downgraded them. The same participant said:

Extract 6.50– (Participant 17, lines 301)

"My son is not focusing very much as the teachers give them a big load of homework".

Moreover, referring to the education, participant number (1) said:

Extract 6.51– (Participant 1, lines 7 and 8)

"I am worried about my children's future and their education. There is no good education".

The expectations among the refugees were high in terms of education and other matters, but they had lost the trust in the service provided by the authorities and had lost hope with the years they had spent in the camp as nothing much had changed in terms of the basic quality of life and their wellbeing. This strong feeling of frustration was obvious towards the NGOs and the services they provided as well.

In the literature previously discussed, many studies such as Syam et al., (2019) have talked about the education needs among the refugees and highlighted that there is a lack in the educational system. Akgün (2016) stated that the educational needs of refugees are of paramount importance. The Kenyan Human Rights Commission and the National Network for IDPs in Kenya (2011) talked about the importance of addressing the educational needs of refugees. The studies found in the literature search have however talked about the educational needs very briefly and did not explore it in great depth. There was only one study found in the literature that addressed the educational matter and that was the study of Seker and Sirkeci (2015).They reported a lack in understanding of the Turkish language had contributed to poor progress in the education of the Syrian refugee children in Turkey and that this had led to an increase in absences in attending school. Accordingly, there is a gap in covering this issue, which directs a need for further in-depth studies about the refugees' children education and the potential consequences of uneducated generations. Despite the majority of the refugees in this study coming from relatively poor areas of Syria, their children's education was of great importance to them. It was of even greater importance now that their children could not anticipate growing up and inheriting employment from the businesses their families had previously established in Syria.

6.10 Non-Governmental Organization services and the role of wasta

Overall, the interviewed participants were not satisfied with the services provided by the NGOs, mostly in all aspects. Referring to the NGO jobs, there was a big issue related to this among most of the participants as they stated that they had to gain work through a middle man to get a job with any of the camp organizations as that would have helped them a lot in their life. This system of favouritism/wasta was stressful and resulted in problems of trust amongst their peers. The impact of wasta is very common in Jordan and in the Syrian community as well. In the refugee camp this worked through a person who worked for the NGOs who would recommend only the people who are important for him/her, resulting in discrimination in the distribution of employment and not giving the chances equally within the same community.

Taking participant number (10)'s statement as an example when he was asked about jobs in the camp; referring to NGOs', he said:

Extract 6.52– (Participant 10, line 215)

"I have applied for jobs many times; they only hire by wasta".

Candidate number (11) also stated:

Extract 6.53– (Participant 11, lines 2018 and 221)

"Not good, as jobs are all by wasta; all the people are suffering from wasta."

Moreover, participant number (15) stated:

Extract 6.54– (Participant 15, lines 264)

“In 2012, I had been working with Save the Children for two years, now I can’t find a job due to wasta.”

Applicant number (16) said about wasta:

Extract 6.55– (Participant 16, lines 290)

“NGO jobs are given only by wasta.”

Furthermore, participant number (17) stated:

Extract 6.56– (Participant 17, lines 315)

“Wasta in jobs. Some people have been working for the same NGOs since 2014”.

Participant number (11) said:

Extract 6.92– (Participant 11, lines 218 and 2019)

“Sometimes I talk to the organizations’ people. They reply, ‘It is not your business’. All I want is only one month. Some people they stay in their jobs for seven years”.

Evidently the statements reflect the frustration among the participants towards the NGOs’ method of giving the jobs and that added another issue for the refugees to handle as the Syrian community is a working community and they were all complaining about this issue as they wanted to break the boring routine and bring a good income into their home and to have a better quality of life.

6.11 Medical services and the impact of wasta

Among the participant reports was a repetitive matter when they were asked about the NGOs' healthcare services, which was the shortage of medication. Living in an isolated camp meant limited options. Participants had to obtain the medication from the medical health facilities in the camp or to buy it from the only pharmacy in the camp, which (like the shopping mall) was expensive as they stated, otherwise they had to travel to the nearest city to buy it. For example, participant number (1) statement:

Extract 6.57– (Participant 1, lines 13 and 7)

"The medical facilities have a shortage of medicine. The pharmacy prices are very much more expensive than outside the camp."

Whilst participant number (2) said:

Extract 6.58– (Participant 1, lines 13 and 7)

"The *pharmacy prices are much more expensive than outside the camp. Sometimes the medications are not available, and we have to wait in a very long queue."*

Participants (4,5, and 15) stated:

Extract 6.59– (Participant 4, 5 and 15, lines 81, 84 and 268)

"Sometimes I pay for medication, as there are no available medications in the healthcare facilities".

Participant number (5) added:

Extract 6.70– (Participant 5, line 86)

“I sell my coupons to pay for my medications”.

Interviewee number (6) said:

Extract 6.71– (Participant 6, line 116)

“*Some medications are not available”.*

Another statement from candidate number (12) was:

Extract 6.72– (Participant 12, line 233)

“I have been buying my own medication in the last two years. The pharmacy is expensive”.

Participant (16) and (15) stated:

Extract 6.73– (Participant 16 and 15, line 267 and 281)

“There are n*o medications*”.

And participant number (17) said:

Extract 6.74– (Participant 17, line 313)

“Medication is not always available”.

Medication is an essential product that has to be always available for the patients and that can cause more harmful impacts on their health and their financial status as they have to travel to buy it or pay for expensive medication.

Participants were asked about the medical health services provided in the camp. Answers were divided into two categories, negative and positive, but mostly they were negative. Some of the participants praised certain healthcare facilities and criticised others. Numerous replies and complaints were about the long waiting time. Participant number (1) said:

Extract 6.75– (Participant 1, line 13)

“There is always a long waiting time”.

Participant number (2) has stated:

Extract 6.76– (Participant 16, line 278)

“There are v*ery long waiting times. For example, the people come to register at 6:00 in the morning and have to come back at 12:00 in the afternoon*”.

Participant number (2) stated:

Extract 6.77– (Participant 2, lines 44, 45 and 46)

“*Once I brought an old man in his 60s as he was complaining of chest pain. The ambulance took thirty minutes to come. When we arrived at the clinic, they said they did not have oxygen cylinders and he passed away on my lap”.*

A further example of poor medical services was provided by the interview with applicant number (3) who said:

Extract 6.78– (Participant 3, lines 61, 62 and 63)

“Health services take a long time in serious medical cases, not the normal cases. All the medical facilities provide only a primary service; I wish they provided comprehensive services as it’s a long hard trip to go outside the camp”.

Participant number (9) stated:

Extract 6.79– (Participant 9, lines 184)

“After 6:00pm, it’s hard to get medical help, the ambulance takes a long time to come”.

The same participants added:

Extract 6.80– (Participant 9, lines 198, 199, 200 and 201)

“The medical services are all bad. Only one is good, which is the Moroccan medical health centre. It is the best because it doesn’t have wasta. The other medical health services are organised by wasta and some people can jump the queue and others wait for hours; we need dentist services”.

There were complaints that the level of medical services was at a relatively low level and that people with complex medical needs did not receive the care they needed, with quite tragic consequences. Candidate number (11) stated:

Extract 6.81– (Participant 11, lines 226 and 227)

“Major surgeries take a long time. My father had cancer. I was waiting for his treatment, then he passed away”.

The limited level of healthcare was also expressed as a frustration at the limited level of concern about the welfare of the refugees. *Extract 6.84– (Participant 17, lines 313)*

“Health services providers. They provide medium care. When you see doctors, they don’t examine you”.

Commenting on long waiting times, participant number (14) said:

Extract 6.82– (Participant 14, lines 249)

“I had to leave my home at 7:00 to take an appointment”.

Participant number (12):

Extract 6.93– (Participant 12, line 221)

“All people are suffering from wasta; long waiting times”.

Participant number (14):

Extract 6.94– (Participant 14, line 251)

"*There are not enough care providers and workers, bad management, always a shortage in medical supplies".*

Participant number (16) stated:

Extract 6.83– (Participant 16, lines 278)

"I have been waiting since 8:00am and its 12:00pm now". Participant number (17) said:

Participant number (14) said about JHASi healthcare centre:

Extract 6.85– (Participant 14, lines 252)

"JHASi is always very busy. Many false patients also come, just to spend some time".

The same participant stated about the United Arab Emirates field hospital:

Extract 6.86– (Participant 14, lines 262)

"In the UAE hospital, there is no wasta. That is why I like it".

Participants number (15 and 16) both complained about the staff manner. They reported that the health services' staff dealt with them in an un-respectful way.

The overall views and statements did not show a good impression about the health services provided in Za'atari camp and that was another main concern for the refugees and the authorities as well.

The participants I interviewed had expressed other issues when they were asked about the NGOs and what they obtained from the NGOs, as they

talked freely, and I have documented all the concerns to be delivered in this study. For example, participant number (1) said:

Extract 6.87– (Participant 1, lines 21)

"I was registered with NGO (X) and NGO (X) for maintenance work and have never seen them and never did any help". Participant number (5) said:

Extract 6.88– (Participant 5, lines 103)

"*If you are a friend with someone in the organizations, then you get whatever you want*".

There were examples in the accounts from the participants where some of the workers in the NGOs based in the camp used their privileged position in an abusive way. This is another example of the power of wasta. Participant (5) worked for NGO (X) as a cleaner and made 170JOD, but keeping his job depended on him being submissive to the NGO staff even if they mistreated him. He stated:

Extract 6.89– (Participant 5, lines 104)

"I get insulted by the organization's workers, and I can't say anything; I can't leave for a breakfast break sometimes."

Another example of the same issue was provided by participant (7) who said:

Extract 6.90– (Participant 7, line 138)

"Sometimes they used to deal with us as though we are not humans."

Number (10) participant explained that the abuse of wasta was not limited to the allocation of jobs and that allocation of accommodation was also a

very visual symbol of who benefited from the privileges of wasta. He stated:

Extract 6.91– (Participant 10, line 214)

"The *NGO (X) is not fair at all. They give the people who don't deserve them caravans*".

Number (17) member stated:

Extract 6.95– (Participant 17, line 307)

"Services are only given by wasta; I fixed and have done changes in my caravan from my own money".

6.12 Refugee experience of NGOs

All the statements like these would give the sense of the frustration and anger that the refugees were having towards the NGOs, who are the only hope for them when living as a refugee and especially in a closed camp.

On the other hand, some participants reported positive statements about the NGOs' services. For instance, a statement was given by the fifth participant:

Extract 6.96– (Participant 5, lines 97 and 98)

"The NGO (X) helped me. They gave me 108JOD this month and I paid my debt off".

Participant number (17) said about the NGOs' help:

Extract 6.97– (Participant 17, lines 298 and 299)

“Slowly the life changed. They gave us caravans, toilets, kitchens, and at the end of 2016 they gave us another caravan. We have electricity now”.

The negative statements do however over-balance the positive statements in all aspects towards the NGOs. During my previous experience, some refugees would complement certain NGOs just for the sake of obtaining better services or so as to not get blacklisted or blocked from receiving aid from the NGO. During these interviews I came across some participants who had done these things and complimented the NGOs in order to get a particular service, but explaining to them that I am only a student had given them the freedom to talk freely and open their hearts which resulted in a good honest outcome.

In the previous studies, the researchers did not focus to the same level on the dissatisfaction with the services that were provided by the NGOs, they just mentioned the lack of the services briefly, for example Chu et al. (2013) and Abo-Hilal and Hoogstad(2013). This was one of the issues that this study was able to highlight more substantially because of the particular local knowledge and language skills I possess and an issue that was not addressed as well previously.

Culbertson et al., (2016) published a report about the coordination of services for refugees in urban areas and addressed the crisis issues in Jordan and Lebanon. They reported that the existence of NGOs would not last for the long term and the funding from external bodies would be stopped eventually and result in the NGOs leaving the country. They stated that some officials from foreign countries have found a lack of the essential skill-set among some the NGOs that work in countries that have a middle-income(such as Jordan), but that the international NGOs in Jordan

and Lebanon are doing organised work through International NGO Forums, rather than delivering the services directly(Culbertson et al., 2016).

In the same report (Culbertson et al., 2016) stated that the local NGOs run their work via a fund that comes from governments, donors, international organizations or other private sources. Local NGOs' level of coordination and competence varies. The local NGOs' costs to run a programme is cheaper than international ones. Sometimes the local NGOs might lack in capacity, it was explained that that can happen due to having less experience in obtaining funds from UN agencies or donors and that can occur due to language barriers and weak capabilities in writing proposals which can result in blocking larger roles too (Culbertson et al., 2016).

Yet there are not enough studies that have been completed on the refugees' thoughts and feelings about the services provided by the NGOs' and to what point they are satisfied which shows a clear need for further studies in the future to be conducted to improve the NGOs' services.

6.13 Social and Behavioural Issues: Unemployment and boredom

Taking social and behavioural issues in hand, Hassan et al., (2015) found that the social and behavioural manners are affected by leaving their home and becoming IDPs or refugees whether it is inside the same country or outside the country borders. Some of the issues reported for example were withdrawal, violence, aggression, and lack of safety despite being in a refuge. I found that the Syrian male refugees had noticed some negative changes in their social behaviour. For example, interviewee number (6)

said that he did not like the community he now finds himself in and it made him get nervous very easily. He said that some people made fights in the street for no reason. The same person had had a fight with the teacher in the school and had left the school afterwards. In terms of violence, participant number (9) said he used to fight with his wife over very little things, and this was a clear sign of frustration and stress due to the environment that they were stuck inside and that could lead to violence, and that had continued to happen throughout the seven years among the refugees.

As I chatted to the community during the data collection period and during the breaks, the people were stating how much the community was fed up and many fights were happening in the streets almost daily. The participants explained that the camp was divided into groups and each group was from a different town or village back in Syria, and that if any person became embroiled in fights, then most of the group from his area would come and fight with him. For example, participant number (6) said:

Extract 6.98– (Participant 6, lines 111)

“Some people, they cause fights with me in the street for no reason”.

Another participant (13) stated:

Extract 6.99– (Participant 13, lines 242)

“L*ife is hard here, some people are bad, some guys follow the girls in the streets”.*

The younger generation was living with extreme boredom in their life and their daily routine was mostly empty. They had been left with nothing to do other than walking the streets and that was the primary cause of issues

and fights in the streets. Talking about war and the Syrian regime was always filling them with anger and hate as well.

In Syria, the community targeted in this study had a full and normal life. They had cafes, cinemas, parks and other entertainment to keep them busy and to occupy the day, unless they were working. Cafes are the common places for the people to go to in Syria and Jordan and people would spend hours there watching football matches, playing games and smoking shisha-pipes. With all this life missing, it seemed inevitable that this would leave a gap which again could lead to violence and stress.

Some Syrian refugees had been in Jordan for over seven years by the time of this study and their journey was getting harder and longer. The lack of cultural orientation was a good reason for the levels of depression and frustration with few opportunities to develop. Back in Syria, the life they had was totally different, they had a normal life and used to have different entertainments available to them such as cinemas, theatres, cafes, parks and other sources of fun. This has fully changed to be living in a caravan in the hot dusty area with almost nothing in terms of entertainment or local infrastructure.

Being locked up in the camp was a significant factor in having a low income. These post-migration factors can have a direct impact on the refugees succumbing to health difficulties. George et al., (2015) reported that the lack of cultural orientation was related to more depressive symptoms. They identified that surviving on a low income and living in social exclusion in the post-migration circumstances can lead to high health disparities(George et al., 2015).

In chapter three, in describing the situation for Syrian refugees in Lebanon, Syam et al., (2019) described the tensions that existed between the

refugees and their hosts. Their finding was that the level of tension within the refugee camp reflected the pressure of living in a confined space, with little opportunity to work and with very little money. Syam et al., (2019) found there was violence erupting between the refugees, but that the violence that caused the most concern was that experienced by women who were often the recipients of domestic violence. In this study, the participants were all male, and domestic violence was not an issue that was disclosed. The main concern in this study was the violence that occurred between males from different families and different backgrounds. In Za'atari camp the boredom, financial issues, unemployment and other factors, had impacted highly on the refugees' behaviour and had caused a significant amount of aggression.

6.14 Uncertainty, frustration and loss

During the interviews, I felt a general sense of loss was floating on all the conversations, as the refugees did not feel stable and settled, as they said on several occasions:

"*When we go back - if we ever do.*"

This statement clearly reflects the feeling of loss of the stability that was frequently reported in the interviews that having a safe, secure home provides. When they have talked about their life conditions, they never had the sense of stability and staying in the camp permanently. The trait of uncertainty was a big issue for the refugees and that was very clear in their statements such as:

Extract 6.70– (Participant 1, lines 8)

“I am worried about my kids’ future and their education, no good education.” [Participant (1)]

Extract 6.71– (Participant 2, lines 40)

“The time is stopped. “[Participant (2)].

Extract 6.72– (Participant 3, lines 60)

“These *five years, I don’t count them of my age. It feels like I am not alive.”* [Participant (3)]

Extract 6.73– (Participant 7, lines 114)

“*I am here doing nothing. I have the future ahead, marriage, building a home, joining the military.”* [Participant (7)]

Extract 6.74– (Participant 8, lines 156)

“*My experience is very bad. I can’t see my future as the situation is foggy.*” [Participant (8)]

Extract 6.75– (Participant 9, lines 191 and 192)

“*Seven years gone for nothing. Now if go back to Syria, how many years will I need to build my life and house again.”* [Participant (9)]

Extract 6.76– (Participant 13, lines 245)

“*I don’t see any good future in the camp.”* [Participant (13)]

Ugurlu et al., (2016) stated that uncertainty about legal status during resettlement has a great impact on the refugees’ mental health.

Extract 6.77– (Participant 17, lines 311)

“Whatever you do here you don’t feel stability.” [Participant (17)]

All these statements clearly identify the uncertainty, frustration and loss of feeling that can lead to emotional and mental health problems over the years.

Being trapped in the camp was another big problem for the refugees. The refugees expressed their thoughts and feelings about being locked up in the camp and being unable to leave without permission for certain hours and days. Refugees stated several times that they felt like they were in a prison. Some of them even said that if they had known that life in the camp would be this way, they would not have even gone there. Living far from the Jordanian communities was an additional stress. The refugees were made to feel the isolation of being in the desert as they could not get access to facilities to meet their needs and the amenities available to local Jordanians. These were places where they would also have been able to find jobs. (Dahl et al., 1998, Steel et al., 2009) clearly stated that wars can be the reason behind traumatic distress connections like, living in crowded camp and feel imprisoned, life away from family and displacement, consequently can lead to a serious risk of mental and physical issues and incapacity too.

The loss of jobs, status, house and home and relatives has a visibly great impact on the refugees, and that was clear on their statements and body language. This clearly reflects the numbing symptoms that are mentioned under the following section on emotional distress. The feelings of tiredness and exhaustion were another two symptoms of loss were declared frequently by the participants; this too is clearly stated in their statements too under the emotional subsection. In the previous literature, the researchers had identified some of the distress symptoms such as, Carta et al. (2005) and Tinghög (2010) who talked about the loss of status, Sifaki

et al. (2017) who reported the loss of family or a friend among the participants in their study, Tinghög et al., (2017) and (Smeekes et al., (2017) who have stated that the participants in their studies felt the loss of their social identity.

6.15 Emotional Issues

In terms of emotional states and problems, Hassan et al., (2015) stated that the emotional issues most commonly found in the refugees in their study were sadness, grief, fear, frustration, anxiety and anger. When the issue of frustration was explored in this study, participant number (2) said that he was not optimistic and not pessimistic, which shows clearly the frustration for change and renewal and the despair of semi-permanence and hopelessness in his statement. This statement could direct us towards a conclusion that this is an example of ‘numbing’ after trauma, but this is not what was recognised and diagnosed among the statements of the Syrian refugees in this camp. Stevens et al., (2018) carried out a study on the effects of trauma exposure history in a large cohort study of people suffering from PTSD and examined the effects of trauma chronicity and severity on symptom presentation and brain function. They reported that the experience of trauma that is repeated multiple times is more likely to cause numbing symptoms, in particular if the trauma were abuse during childhood period. This might be connected to a form of disconnection or dulling of the brain’s emotional reactions to danger (Stevens et al., 2018). The sense of numbing was often present in the accounts of the refugees.

The first participant said:

Extract 6.78– (Participant 1, lines 12)

“I feel very disappointed all the time, I am very tired mentally. I am always depressed.”

Participant number (3) said*:*

Extract 6.79– (Participant 3, lines 53 and 63)

“I am not happy and not comfortable.’ He added: “*Every single person is suffering from issues, but the people take it easy.*”

Participant number (5) stated:

Extract 6.80– (Participant 5, lines 53 and 63)

“I feel I have very big tiredness and am emotionally exhausted. Everyone is mentally tired. “

Participant number (6) said:

Extract 6.81– (Participant 6, lines 115)

“I feel nervous very often; I don’t like the community. I feel disappointed in myself.”

Participant number (8) stated:

Extract 6.82– (Participant 8, line 169)

“I get very nervous. I used to be very calm. Now I get very nervous because of the war and what I have seen in Syria.”

Participant number (9) said:

Extract 6.83– (Participant 9, line 189)

“*I want a psychologist because I want to clear my memory, I feel depressed*.”

Participant number (12) stated:

Extract 6.83– (Participant 12, line 234)

"*I have continuous stress as half of my children are in Syria. I feel very frustrated. I lost everything; money, home, my sheep, everything."*

Participant number (13) stated:

Extract 6.84– (Participant 13, line 246)

"Sometimes I feel frustrated."

Participant number (16) stated:

Extract 6.86– (Participant 16, lines 283, 286 and 288)

"I feel frustrated. I am always thinking, worry, big changes. I used to have a good life and now as you see, I feel depressed for sure'"

Loss of economic status (Sandahl et al., 2017) is clearly an issue among the participants and have a great impact on them socially.

Participant number (17) said:

Extract 6.87– (Participant 17, lines 309 and 310)

"*No one is happy here. Life is tragic and souls are tired.*"

These are prime good symptoms of the numbing after trauma and emotional distress which reflect the emotional image back in Za'atari camp. Participant number (4)stated that he was suffering from stress and had issues with others around him due to this. He said he felt great tiredness and he is emotionally exhausted. The same person said his brother became very nervous due to his illness and the general situation in the camp. Conrad (2011) wrote that experiencing too much stress over a long period of time can make adverse consequences on behaviour and

health. The Mayo Clinic Organization (2019) stated that the stress symptoms can impact the body, a person's feelings and thoughts, and the person's behaviour. Additionally, it has a health consequence and can cause hypertension, heart disease, diabetes and obesity.

Moreover, participant number (8) said he cannot see any future ahead as the situation is 'foggy' at the moment. This sentence illustrates the frustration among the refugees which was heard from participant number one as well. The same candidate stated that he gets very nervous easily, but he used to be calm in the past. For all these participants, the war and what they have seen back home in Syria has changed them. Given the participants' statements about the future draws a full image about their feelings and uncertainty about the future. They have talked about their previous life in Syria on several occasions which they cannot go back to it and comparing it to what they have now. The participants had been in the camp for up to seven years by the time they were interviewed for this study and they had lost hope of going back and had little optimism for the future and this can be a good reason for mental ill health symptoms to appear among the different generations of men I interviewed.

6.16 Trauma

It was anticipated that conducting interviews with refugees who had fled what has been widely reported as a very brutal conflict would inevitably uncover numerous accounts of traumatic experiences. There were some reports from the participants of psychological disturbance as a result of witnessing or experiencing distressing events.

As an example of direct impact participant number (14) said:

Extract 6.85– (Participant 14, line 259)

“The fear and anxiety are because what I have seen back in Syria.”

Current understanding of the impact of trauma shows that experiences do not necessarily have to be graphic and immediate to generate troubling symptoms. George et al. (2015), presented findings of the relationship between settlement experiences and mental health and wellbeing of immigrants in Canada. Regarding cognitive problems, it has been reported that refugees suffer from loss of control, helplessness, worry, ruminations, boredom, and loss of hope as well. It has been noted that the Syrian refugees and IDPs suffer from physical indicators such as sleeping problems, fatigue, and appetite loss (Hassan et al., 2015), These symptoms are common among the Syrian refugees that I interviewed in Jordan.

Participant number (10) said:

Extract 6.13– (Participant 10, Lines 213),

“I feel sad when I call my relatives back home in Syria and I cry straight away”.

In this case, this might be a re-traumatization case. Communicating with their relatives who are still in Syria can cause re-traumatization and bring to mind the war memories, in addition to the stories that their relatives are telling them about their situation in Syria.

Schutz et al., (2012), stated the re-traumatization term can be used in two different ways; one is related to revictimization and that can take place when an individual experiences another similar traumatic event in a

different occasion. The second one happens in individuals that had experienced a traumatic event, and it reactivates trauma-related distress. According to studies, this can have a greater psychological impact and can occur with repeated experiences of trauma (Schutz et al., 2012).

The seriousness of the impact of having to remain longer in the conflict zone and the frequency with which the participants witnessed or experienced trauma is highlighted by Ugurlu et al., (2016), who identify that experiences as described by these refugees are frequently associated with the development of PTSD post-migration. Similarly, Sifaki-Pistolla., (2017), similarly found that torture, war and the loss of loved ones were frequently associated with PTSD and depressive mental illness.

Keyes (2000) talked about the effect of war and the mental health of people who experienced trauma and stressful situations in their journey. Keyes found that those people would be at higher risk of having mental health issues.

Interviewee number (9) had some interesting points regarding their emotions and the journey from inside Syria then subsequently migrating into Jordan. The participant stated that he travelled through seven towns with his family then ended up in a mosque in Syria. After that he came to Jordan. In Jordan he went to see a psychiatrist, just to clear his memory of what he has been through back home in Syria; he also said he suffers from depression. Depression, anxiety and post-traumatic stress disorder seemed to be the highest reported mental illness among the refugees in Fazel et al. (2005).

For Syrian refugees the escaping journey to Jordan was a big burden on them, as they had to hide and always choose safe routes; usually routes that were secured by the rebels. In many cases the refugees had to pay for the rebels to secure the routes for them to take them to the Jordanian border. Some of the refugees travelled for several days to reach the Jordanian border and these groups included vulnerable people such as pregnant women, children, and older people. They were then confronted by another problem when reaching the border. Jordan used to close the borders for many days at a time in some cases due to the huge number of fleeing refugees. So, the refugees had to wait for many days in the outdoors. This stress had clearly added a great burden on the refugees' mental health as they were still talking about the trip a long time after escaping Syria. There are several contemporary videos available that report the Syrian refugee journeys that corroborate this finding. For example, UNHCR has published a short video titled 'Syrian Refugees: Crossing the Border to Jordan' (UNHCR the UN Refugee Agency, 2013).

6.17 Post-Traumatic Stress Disorder (PTSD)

PTSD is very common among the people who experiences crisis, especially war experience (see Chapter 4). PTSD is a chronic disorder that is present in individuals that have experienced distressing and threatening events (Van et al., 1988; Bradley et al., 2005). PTSD was only added to the Diagnostic and Statistical Manual in 1980 (DSM-III, American Psychiatric Association, 1980). Prior to this, there were challenges to the identification of the impact on survivors of extreme experiences of, for instance, torture,

sexual assault and political persecution (Herman, 1992). As the main focus of this study is the mental health issues among refugees, I decided to include a separate chapter (Chapter 4) about the mental health problems and related issues among refugees.

Oluwaseun et al., (2012) in their study stated that the most common mental ill health symptoms were obsession, Post-traumatic Stress disorder and mania. Cheung (1994) found that there was a correlation between PTSD and demographic variables, trauma experiences, coping style and post-migration stresses, the study found that the prevalence rate for the PTSD was 12.1 percent of 444 participants. For a diagnosis of PTSD, the DSM V (American Psychiatric Association, 2003) uses the following criteria: 'You experience at least one of the following intrusive symptoms associated with the traumatic event: Unexpected or expected reoccurring, involuntary, and intrusive upsetting memories of the traumatic event'.

In this study, participant number (8) stated that he had seen a psychiatric doctor twice and stated that what he had seen in the war made him sick as he had lost many relatives. He had lived in two different camps. The doctor said he was suffering with panic attacks, as he recalls a bad memory. He said some buses in Jordan look like the buses that had been used to carry soldiers in Syria; and that made him very scared. He said that if aeroplanes flew over, it made him scared. This experience is reminiscent of the work of Nosè et al., (2017) and their Traumatic Framework. This can be classified as a flashback and triggered case, as Nosè et al., (2017) said, the rush of adrenaline, dopamine, and other chemicals in the body through activation of the sympathetic nervous system is one potential source of organic changes in the brain. Flashbacks were defined by Mind Organization (2017) as a vivid experience in which

the person recalls some parts of traumatic experiences or feels that the situation is happening at this moment again. This might take place when watching a video of the event sometimes, but flashbacks can happen without viewing any pictures or videos. People who experience flashback might go through these feelings: recalling pictures in full or partial details of what happened, noting connections to trauma like smells, sounds or tastes, they also might feel the pain or the pressure, and as for emotions that they felt during the trauma, they might feel them again (Mind Organization, 2017).

Participant number (14) was the most mentally disturbed of the men who were interviewed. He said that he went to see a psychiatric doctor as he was living with very bad mental health problems. He added that he was suffering from hallucinations, anxiety, disturbed sleep, Alzheimer's disease and stated that the psychiatric doctor prescribed medication for him.

Cheung (1994) concluded that

"the most frequently reported posttraumatic stress symptom was a recurrent intrusive recollection of trauma. There was a significant association between PTSD and amount of trauma, coping style, and post-migration stresses" (Cheung, 1994:17).

When talking about war and torture, we cannot ignore the possibility of suicide and suicidal thoughts. Suicide was not mentioned by any of the participants during the data collection sessions among the Syrian refugees. This is not an unexpected finding because suicide is forbidden in the Islamic religion and culturally is not accepted at all. In Islamic countries there are core-valued religious sanctions against suicide, and it is illegal in most of the Islamic countries (Khan, 1998; Lester, 2006). Generally, the suicide rates in Islamic countries are reported to be low (Khan, 1998;

Lester, 2006). Oluwaseun et al., (2012) found out that the lowest symptom among the refugees was the suicidal ideation.

Oluwaseun et al., (2012) found 19% of the refugees in the study they conducted consumed some alcohol. In this study, the researcher did not come across any participant who stated they consumed alcohol at all. This finding was anticipated for many reasons, such as religiously and culturally it is forbidden and not acceptable at all, so it was unlikely that any participant would disclose drinking alcohol even if they had. It is a culturally sensitive topic which is one of this study limitations, as the researcher could not ask the participants about it, as mostly people will feel insulted, or they will laugh at the question if they are from a young age group. In the Arabic culture, drinking is the equivalent of committing a crime, and being a drinker even for one occasion can damage the person's reputation for generations. In addition, it is very expensive and alcoholic drinks have high customs taxes on them. Furthermore, it was not available for the people in the camp, even though it was available in the local Jordanian market. Some people in Arabic culture drink alcohol, but they would not admit it as it is a very shameful thing to do and will affect their standing in the community if you are Muslim, whereas for Christians, it is acceptable to drink alcohol. There is however evidence in the literature to indicate the use of alcohol and psychoactive drugs amongst Syrian refugees. Hassan et al., (2015) reported that alcohol and psychoactive substance use is limited within the Syrian refugees; traditionally alcohol drinking is low due to cultural reasons.

In terms of psychoactive drugs, Berns (2014) conducted a study on the Syrian refugees in Iraq and found that illegal drugs were not obtainable. In the future, there might be an increase of the data on the illegal drugs due

to the increase of manufacture and trade in illegal drugs among the refuges because of the war back in Syria. Kane and Greene (2018) have mentioned very briefly the substance abuse in Syria and stated, the presence of fenethylline (Captagon) and suspected prevalence is quickly increasing. They discussed that there is almost no research on substance abuse in refugees' circumstances (Kane & Greene, 2018).

In terms of the Syrian refugees in Jordan that the researcher interviewed, none of the participants talked about drug abuse as for Muslims it is a shameful subject to talk about. In terms of legal painkillers and drugs to numb mental pain, it is legal to use only with a prescription through the medical facilities in the camp or outside the camp if needed.

6.18 Stigma and labelling

In chapter 5 - Methodology, the advantages of using a local researcher are discussed. The benefits were particularly well defined by the relative ease with which the participants disclosed their feelings around the stigma associated with mental ill health. In the literature review of mental health issues (Chapter 4), various authors (Aloud, 2004; Nasir & Al-Qutob, 2005; Weatherhead & Daiches, 2010; Gearing et al., 2014) describe the influence of stigma associated with mental illness as well as the belief in 'Jinn', or evil spirits. During the data collection period, I noticed participants and people from the community saying things like;

"I cannot go to see psychologist, as the people will call me crazy."

For example, participant number (1)said:

Extract 6.89– (Participant 1, lines 15 and 16).

“I can’t say I have mental issues, because all the people will call us crazy. If you go around all the camp you will find everyone suffering from mental issues from poverty”.

He also stated that he was mentally tired and always depressed.

Many interviewees stated that they could not say that they had mental health issues as the community around them would call them ‘crazy’.

As confirmation of this finding in the literature (Chapter 4) participant (8)said:

Extract 6.90– (Participant 8, lines 163, 164, 165 and 166).

“Many organizations tried to help me, but I don’t accept it, as I don’t like to be called crazy. I think 90% of the people have mental issues, but they can’t talk about it, as everyone will call you crazy. For example, if someone want to marry my daughter, the other will say he will marry the crazy’s daughter.”

The same participant added:

Extract 6.91– (Participant 8, lines 175 and 173).

“They tried to give me medication, but I refused to take any as the others will judge me and call me crazy. ‘Mental patient’ means’ crazy’ in our community”.

This is a common issue in the Middle East area as the person who is complaining of mental health issues will be called ‘crazy’ and most people would try to avoid dealing with them in any way. Searching into this topic, it appears to be an issue that is related to Labelling Theory. Labelling

theory is referred to social reaction and how social groups view and define deviant behaviour (Shulman, 2005).

Participant (9) said they did not want to use medication for their mental illness because they were concerned that they would be depending on it for the rest of their lives. Interviewee (7) said that he used to work in a kiosk just in front of the psychiatric clinics and that sometimes the people threw their medication away as soon as they left the clinic. They therefore decided not to take the medication as they thought it would make their illness worse or they would depend on the medication for the rest of their life and they chose to manage their symptoms alone.

The participants talked readily about their mental health problems, using a lot of words that expressed their emotional and psychological distress; depression, anxiety, frustration, anger. There was evidence that they all suffered from mental health problems to some extent and some had serious consequences from their experiences, including potential diagnoses of PTSD. They were nevertheless reluctant to engage with the mental health services provided. Their experiences had led to mental health disorders and psychosocial distress, which can be seen in other studies where refugees were found to be suffering from a wide-ranging variety of emotional, cognitive, physical, behavioural and social problems (Hassan et al., 2015).It became evident that if the refugees were unlikely to pursue a western medical model of treatment for their mental distress, then an alternative approach was required.

Musisi and Kinyanda (2020) have talked about the impact of civil war trauma, over the past two decades the war in the African continent has caused terrible trauma and stressors linked to mental health consequences (Musisi, 2004). Musisi and Kinyanda (2020) stated that

many reports illustrated the common trauma syndromes of PTSD, “the anxieties, depression, psychosis, traumatic brain injury, epilepsies, and other physical injuries, all with their attendant complications/associations including substance abuse, epidemics e.g., HIV, cholera, Ebola etc” Musisi and Kinyanda (2020: 2).

It is important to note that the stigma of mental illness pervades all societies and has been widely reported over many years, in particular by Leff and Warner (2006). It is not surprising to find the fear of labelling within the refugee camp, but in western societies there is probably greater acceptance of mental ill health among people who have experienced major trauma such as torture, imprisonment, bombardment, death of family members etc. According to Corrigan et al., (2001) mental illness is widely misunderstood by society, and in the media mental illness is frequently represented in negativity and inaccurately. It is also linked to certain behaviours such as weakness, dangerousness and incompetence (Corrigan et al., 2001). The stigma of the mentally ill person can take two paths; one is related to the public (public stigma) and one is about the person him/herself (self-stigma). The public stigma is concerned with the behaviour and attitude of the person in the public in terms of mental illness. The self-stigma is related to the internalization of the stigma amongst the persons with mental illness. Both stigma forms have a negative impact on mentally ill people such as discrimination, loss of socio-economic status, low self-esteem and increase in the mental illness symptoms (Link & Phelan, 2001).

The impact of stigma has been discussed for some time in the literature. Meadow (1969 in Spickercited in McLaughlin, 2020) wrote that stigma can lead directly to a big loss in social rights, standing and existence. For

instance, he refers to the fact that individuals who were born with hearing or speaking disabilities during Roman times found that their full rights as a citizen were not given as they were not able to get married and they worked as guardians only.

6.19 Chapter Summary

In this chapter, I have illustrated the main findings of the collected data and linked them to the previous literature review chapters. At the beginning the of this chapter, solid reasons for leaving Syria were explored and they showed the seriousness of the situation back in Syria. The subsequent data reflected the fact that the refugees have been living in the camp for up to seven years. One of the main emerged themes among the refugees was the challenges of securing a job and the frustration that they felt with the system of wasta that opened or closed doors for the refugees according to their personal level of influence. Most of the participants in this study complained about the jobs shortage and how that had a great impact on their lives and their ability to build a future for themselves and their family.

The participants in this study were pessimistic about the future, some of them viewed their prospects as difficult to predict at that moment and others viewed their potential in a very negative way. The quality of life and daily stressors were addressed, and participants' main points were included such as shortage in the basic life needs (e.g. water and electricity).In this study, the refugee participants were unhappy with the education that their children obtain in the camp and worried about their

children's future. When talking about the NGOs' services and medical health facilities, the majority of participants were not happy and raised an important issue which is wasta. The impact of wasta on the quality of life of the participants in the refugee camp is one of the important findings of this study.

In terms of mental health, the participants have expressed their feelings and thoughts of the current situation and about their lives in the camp. They have shown some signs of powerful negative emotional issues such as uncertainty, loss, frustration and hopelessness. PTSD symptoms were reported by some of the participants. Stigma and labelling were a main issue among the interviewed candidates, and that made them decided whether to obtain psychiatric clinics or even take medication for their mental illness. The impact of stigma on the participant's response to mental health problems is an important finding of this study.

CHAPTER 6 : CONCLUSION

7.1 INTRODUCTION

This chapter summarises the core findings and outlines the main contributions to the existing knowledge. The principal motivation of the

researcher was to explore the issues in sufficient depth to be able to make some tentative recommendations for authorities and NGOs supporting refugees and these are included in 7.4. This study was conducted by a researcher familiar with the local area, language and culture and the benefits of the insights this created are outlined in 7.4.

The focus of the study was on the mental health issues presenting amongst the adult male Syrian refugees. A method appropriate to exploring these sensitive issues was essential and this is explained in 7.5. As a result of the testaments of the participants, the study was able to contribute to the theoretical discussion around mental ill health, its causes and its solutions. This is summarized in 7.6. There were some limitations to the study. These are explained and the possibilities for addressing these limitations are outlined in the suggestions for future work. Finally, conclusion summary is provided.

In this thesis, I examined how the adult male Syrian refugees were resettling in Za'atari camp in Jordan and what issues they were facing in terms of quality of life and mental health. To observe these problems, I conducted a research study that investigated the participants' views through semi-structured interviews which were recorded electronically. Their statements were transcribed and translated from the Arabic into English. Some of the key Arabic terms that relate to mental wellbeing and their close translations are explained in the study.

This study has addressed the research objective of highlighting all the problematic mental health issues from the refugees' point of view and has documented these problems meticulously, supported with their own statements. This makes this study unique in a way that reflects a real

problem as reported by the adult male Syrian refugees from the Za'atari camp and carries their voice. My primary objective was to ensure that their voice was heard by the outer world and this thesis will form the basis from which I will generate research articles for publication.

A quote from Suzy Kassem's book 'Rise Up And Salute: The Writings of Suzy Kassem' (2011) has influenced and encouraged me through this period to achieve my humanitarian goal:

"*To really change the world, we have to help people change the way they see things. Global betterment is a mental process, not one that requires huge sums of money or a high level of authority. Change must be psychological. So, if you want to see real change, stay persistent in educating humanity on how similar we all are than different. Don't only strive to be the change you want to see in the world, but also help all those around you see the world through commonalities of the heart so that they would want to change with you. This is how humanity will evolve to become better. This is how you can change the world. The language of the heart is mankind's main common language*" (Kassem, 2011:3).

In this dissertation's introduction, I explained that the majority of the available literature focused on the direct mental health problems and was not centred on the really deep issues, such as the sense of instability, sense of loss and other issues of the NGO services in the eyes of refugees. There was no literature that carried the refugees' direct words in many aspects of current circumstances and their hopes and fears for the future. In this study, I have been in direct contact with the refugees in Jordan in which I carried their voices, and messages successfully aiming to fill the gap in the existing knowledge.

The main aim of this study was to understand the impact of displacement on Syrian refugees settling in Jordan on their quality of life and mental health. Also, the aim was to focus on mental health related issues such as torture, trauma experiences and common mental health conditions.

The research objectives were:

- To explore the lifestyle and circumstances of adult male Syrian refugees and how this relates to their quality of life and mental health living in Jordan.
- To look at the background of adult male Syrian refugees and report the changes such as, culture, education, and work they have engaged in since 2011 until the data of collection in 2018 to evaluate the effect on their mental health state throughout the years.
- To overview the effect of the services that adult male Syrian refugees obtained via the NGOs throughout the years of being asylum seekers.
- To identify positive interventions for the adult male Syrian refugees, which could be applied to world refugees and to any cases of forcible migration that can happen in the future.
- To provide recommendations for the non-governmental organizations (NGOs), hosting communities and decision makers regarding the refugees in the Middle East and North Africa (MENA) and Europe.

In order to achieve these objectives, I used a qualitative method. This method was selected because the aimed data was about the quality and narrative interviews. The qualitative methods provided the opportunity to

study the refugees' views of the current situation and to gather statements that highlight issues related to their mental health. This research was completed in one phase and the data was collected in one period of time in 2018. Overall, material was gathered from interviews with twenty participants. Three interviews were eliminated due to the data's saturation and the hesitancy of the participants to disclose much information. Data was collected by face-to-face purposive interview that had a set of sixteen questions that were informed by the literature review.

7.2 BRIEF SUMMARY OF THE FINDINGS

- Syrian male refugees had fled with their families to Jordan after experiencing or witnessing seriously traumatising events: bombing, torture, rape.
- The journey from their home to safety in Jordan was, for adult male Syrian refugees, a source of traumatic memories.
- Some of the adult male Syrian refugees were experiencing symptoms of PTSD as a result of trauma they experienced prior to arriving at the camp.
- Adult male Syrian refugees described suffering from poor mental health because of the combination of frustration, despair, helplessness, loss of status, loss of control, hopelessness, numbing, stress, uncertainty.
- The predominant mental health problems for the adult male Syrian refugees stemmed from having already spent

several years in temporary status with little apparent prospect for positive change.

- The adult male Syrian refugees used a range of terms to describe their mental health. These Arabic terms translate closely but not exactly into the English equivalents.
- The mental health of adult male Syrian refugees was negatively impacted by the system of wasta that pervades many aspects of the social structure including the allocation of employment, housing and medical services.
- Securing long-term gainful employment was found to be the single biggest issue adult Syrian males defined as the likely to resolve their sense of frustration and despair.
- Stigma and labelling in respect of mental illness are widespread in Arabic Muslim culture and influence the willingness of adult male Syrian refugees to discuss or seek help for their mental health problems, despite common acceptance of the negative impact of conflict trauma and despair.
- The adult male Syrian refugees identified several quality of life issues that were negatively affecting their mental wellbeing: lack of employment, poor housing, poor basic services (water, electricity, paved streets), access to healthcare, availability of medicines.
- Adult male Syrian refugees were in general not satisfied with the services provided by the NGOs, in all aspects of the service delivery.
- Worries for the future of their children due to the poor quality of education available and the fact that they could

not afford the private or university education, contributed to the overall sense of loss of hope for the future.

- The location of the refugee camp in a desert area of Jordan, contributed to the poor prospects and low quality of life: harsh weather conditions, lack of access to employment or meaningful resettlement.
- Social conflict and neighbour disputes resulting in aggression and violence contributed to the lack of safety and raised anxiety of the adult male Syrian refugees.

7.3 RESEARCH CONTRIBUTION

At the beginning of the interviews, the refugees were asked about the main reason behind leaving Syria. The common answer was:

“The regime army or ISIS reached our town and we had no choice other than leaving to a safer town or village, then we ended up in Jordan as the towns were not safe to stay in.”

Some of them said that they had left based on their families’ wishes to go and stay in a safer country. Thus, the refugees did not leave their country as soon as the problem started; they generally stayed in their homes and town until the actual danger reached them and it then took them several months or years to leave depending on the situation when they forcibly fled the country.

This study reported evidence that the refugees were willing to work and were not depending on the NGO’s aid. The issue of unemployment is of huge importance culturally and therefore it had a big impact on them socially and mentally. A gap in the literature was in relating the job

insecurity to the self-esteem and social status of the refugees. The previous literature focused on the general unemployment and related issues. For example, in Syam et al., (2019) and Abo-Hilal and Hoogstad (2013), both studies have talked about the women's worry about jobs among the Syrian refugees in Lebanon.

Most of the participants complained about the shortage of jobs and they hoped that the jobs would be given out fairly to everyone in the future and that "wasta" (favouritism) would be eliminated, as they wanted to make their lives better and change their situation.

The subject of unemployment among refugees was tackled several times in the existing literature, but there was a gap in defining the relationship between the favouritism (corruption) in jobs among the refugees themselves. In terms on language and cultural barriers, these were not an issue for obtaining jobs among the refugees, as they spoke the same language and had the same regional dialect. This should have facilitated finding employment, but the study found that there was substantial prejudice and exploitation by the Jordanian employers, which added to the distress of the refugees. This prejudice and the level of exploitation had not previously been so clearly articulated in the literature.

Culturally, Syria and Jordan are mostly similar as they both are a part of Bilad Alsham. There is a huge parallel in the diet, language, traditions, understanding of the norms and other aspects of social life. A lot of the previous studies have investigated Syrian refugees in other surrounding countries such as Turkey or Lebanon, where there are significant language or cultural differences. This study was conducted in the refugee camp in Jordan located closest to Syria, so the refugees were in an environment

closest to their own culture. This study was able therefore to focus on the very specific issues that confronted the Syrian refugees without the complications of being resettled in a Palestinian refugee camp in Lebanon or in a Turkish-speaking environment across the northern border of Syria.

Mental health problems were reported in the study by the refugees such as frustration, despair, helplessness, loss of status, loss of control, hopelessness, numbing, PTSD, stress, trauma, uncertainty and loss. These symptoms were common in the previous literature. Mental health issues with serious symptoms that would reflect a likely diagnosis of PTSD under the DSM-V were only reported among one participant, while the rest of the participants described a variety symptoms associated with anxiety and depression which were frequently connected to their various social distresses rather than reports of serious mental illness requiring psychiatric treatment.

The participants mostly had linked many of their feelings and emotions to the current situation and life poor settings such as lack of employment, their financial situation, housing, the uncertainty of the future, the lack of provision for their children's education, limited access to outside community, deprived and harsh circumstances, the lack of basic life needs, poor medical services and poor NGO services.

The participants were asked about the future, all the answers were negative and indicated clear worries about their future and their children's future. This feeling was generated due to the length of the ongoing war and unsettled life conditions they were experiencing in Za'atari camp. The refugees had originally had the feeling that this crisis would not last long, which gave them hope for what might have happened after a long period in the camp, until they realized that they are stuck in the camp. This

reminds many of us from the area of the Palestinian crisis, as the refugees in Jordan are still keeping their house keys for their home in Palestine and their land registration deeds that they had had since 1948. They have nevertheless become resettled in Jordan and now they are part of the country. Some of the Palestinian refugees have built houses on the original site of the refugee camps, while many thousands of them have spread across Jordan and have mixed very well within the Jordanian community.

An important aspect of Arabic culture is privacy within the domestic environment. This was not discussed in the available literature on Syrian refugees. Quality of life and daily stressors of displacement were topics that this study was aimed to address. The refugees complained of several issues in terms of living conditions, such as water and electricity shortages, the state of the caravans and streets, harsh weather conditions, poverty, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community support and other issues. All these were causing a high level of stress for them all.

Among these issues, the lack of privacy was noted by the participants, as they were forced to live very close to each other because there were around eighty thousand refugees living in an area of two square miles. Privacy is a sub-theme in the thematic table and occurs four times in the section in chapter 6 - Quality of Life And Daily Stressors Of Displacement. When they used to live in their hometowns in Syria, they were much more likely to be living in a separate detached house. The need for privacy is very sensitive topic in the Arabic culture and was causing much aggression and many fights in the camp.

The challenges of poverty were found frequently within the literature. In this study, the most frequently discussed financial issue related to the

difficulties with obtaining employment and gaining an income. There was one interesting detail however; it was reported that the UNHCR visa money was limited to purchasing certain basic goods. The participants stated that they had to sell some of the goods in order to buy different items that more appropriately met their needs. This issue was not reported in the previous literature.

In the case of many of the other studies in the literature review the core block to accessing education was about the language barrier; as stated by Seker and Sirkeci (2015) for example. In this study, the refugees showed clear worries about their children's educational future, as they stated that the children had lost many years without education or with inappropriate education. This was causing significant distress to the men as most of them were fathers and as fathers and head of the household they were responsible for providing not only food, shelter and security, they were responsible for ensuring their children could become productive and fulfilled.

Many of the refugees had fled the conflict zone to protect their children. For them to feel hopeful for the future, they needed to feel that their children had the promise of a safe and prosperous future. In this study, the problems for the children's education was about the lack of availability. The blame for this was placed at the door of the NGOs, but the men felt the failure to provide education for their children reflected on their inadequacy as fathers, which further fed their frustration.

This study aimed to address the effectiveness of the NGO services, as the participants viewed them. In general, the refugees were not happy with the services provided by the NGOs in all aspects, such as health care, financial assistance, jobs affordability, basic services of water and

electricity, camp infrastructure, and aid distribution. The participants in the study mostly focused on the issue of favouritism which featured so prominently in the way that the NGOs were distributing the jobs and services. These reports were unlike what Shin et al., (2018) stated in their article about the INGOs' effectiveness, where the analysis showed that the INGOs' healthcare infrastructure development and provision of medical supplies have been notably good.

There are however other studies in the literature that argued that there was an issue among the people in terms of trusting the NGOs, largely because of some member organisations' inappropriate activities (Gilberman and Gelman, 2004; Prugsamatz, 2010; Vangen and Huxman, 2003).

In this study, the participants reported some social and behavioural changes such as aggression and violence. It was reported that the men were frustrated because of unsolved war, unchangeable conditions, feeling of being locked up in the camp and suffering from boredom for several years. That feeling created a high volume of stress among the refugees, this was like ticking bomb. For some of the participants, it created violence among their household members, for others it caused fights and aggression among a bigger circle in the streets. It was noted by the participants that the behaviour of the younger generation boys become bad, and they did unacceptable behaviours such as smoking, chasing girls in the street, fighting for no reason, engaging in violence and aggression.

In the interviews, the participants were asked if they ever had been diagnosed or taken medication for their mental health illness. An interesting issue that was found to dominate to subject was stigma and labelling.

The participants that said that they had a mental health condition stated that they could not tell anybody about the subject because it was shameful to do so. Thus, they were forced to remain silent about their mental distress and keep it to themselves. This is an issue highlighted within this study as the participants were very reluctant to seek professional help with mental health problems or to even discuss it with friends or family. This pressure stems from the stigma and labelling common in the Arabic culture.

The stigma associated with mental health problems means that any person who has a mental health issue usually is called ‘crazy’ and that the other people in their community would avoid them in all aspects. This is what worried the interviewed refugees, as disclosure of this problem could destroy their reputation and their whole family too. The participants stated that they would not take medication for their mental illness, as they feared that they would become dependent on it for the rest of their lives.

Poor understating of the culture and the norms can delay or prevent assisting a refugee with mental health illness. Mental Health Foundation in Scotland appears to understand the stigma and the misunderstanding of the consequences for refugees. They published a brief overview for policy makers and service providers to make them aware of their findings about the refugees’ mental health stigma and discrimination.

This paper aims to list a recommendation in dealing with new communities in terms of mental health needs (Mental Health Foundation, 2016). Generally, a very low level of attention has been paid to stigma related to mental illness for refugees (Knifton, 2012). It has been reported in the UK that refugees often do not have a good knowledge about mental health (Mental Health Foundation, 2016).

Participants have expressed their thoughts about the future in a negative way when they were asked about their thoughts of the future. This negativity has built up through the years and has disappointment at the centre of the reasons. For example, they are concerned for their children's education; this had made them very worried all the time, they cannot see any means of escaping, and the only way is to work. Some of the refugees stated that they need many years to have what they had back home in Syria.

7.4 IMPLICATIONS OF THE STUDY: POLICY AND PRACTICE

In-depth investigation over the target group has exposed some significant key points and suggestions that may be articulated in changing the refugees' lives and circumstances:

- Most of the interviewed participants talked about jobs need and wanting to work and earn desperately, because that would give them a sense of responsibility and would make a rhythm in their lives similar to how it was in Syria. The participants came from a hand-labour area (Dara'a) in Syria, where it is mostly a male-dominated working environment. In our (Belad Alsham) region, the lifestyle is like this: the men work outside and provide the house needs for everyone; the women stay at home and do not have to earn anything but must look after the house and children. Usually, the men

prefer that their wives stay at home even if they have degrees or any profession and could earn an income. According to Hakim (1995), females are less connected with employment and their income is secondary in the family (with poorer working circumstances).

Moreover, Strandh et al., (2013), argue that, the environment that encourages females to do housework and have less participation in the labour marker, might provide the predicted alternative tasks. This can contribute to decreasing the normative pressure to find a job and consequently to the psychosocial need for a job in comparison to men. For men in this study, staying currently in a closed camp, doing nothing for several years, has impacted badly on them in numerous ways such as financially, mentally and socially as they are not able to provide the needs for their families, which caused the feeling of powerlessness and having no control, frustration, issues in the family's feeling of being stuck in this situation without the possibility of improving their lives.

Creating jobs can help improve their feeling of frustration, boredom and can create a regular base in their lives, and that can improve their mental health and financial situation greatly. In this study, the participants had emphasized very much the job need and even asked the researcher if I could help them in getting one. I explained again to them the main reason for these interviews and their words might impact on the authorities and NGOs to look into this issues. As mentioned in the findings and discussion chapter, two participants had a life turning point when they obtained jobs

in the camp, as it changed their daily life routine as they started to leave the house every morning and earn.

- Living in the camp for several years, created and was still creating unwanted mental health problems. For example, frustration, numbing, disappointment, depression, discomfort, unhappiness, nervousness, stress, anxiety, fear, flashbacks, worry, mental tiredness, emotional exhaustion and PTSD.

Participants were not optimistic about the future and they were worried about what it held for them. They were also worried about their children's future. One of the participants said a statement that is still stuck in my mind until today:

"*My experience is very bad. I can't see my future as the situations is foggy."*

Another participant stated:

"*I want a psychologist because I want to clear my memory, I feel depressed*."

These two statements reflect the status of the participants and how desperate they were to change their current situation. After interviewing the refugees and having a clear view of their situation, their mental health might be improved by spreading the refugees within the host communities when possible and changing their daily routine.

- This study's findings also suggest that policy makers and NGOs should always review their rules and policies and investigate any internal corruption. In this study, the participants reported a corruption type called "wasta"

(favouritism), which was related to the allocation of NGO jobs and services. As they are distributed unequally among them, wasta means doing favours for relatives or friends, when other persons deserve it more. This subject was mentioned frequently by the participants and it had a huge impact on their feelings towards NGOs. The current study suggests that NGOs should do a regular review on their policies and procedures to make sure the jobs and services are given equally. It also recommends that a survey among the refugees to be conducted frequently by the NGOs and authorities to measure the happiness and satisfaction with the services provided, so that the NGOs can improve the services provided.

- Generally, the interviewed participants were not diagnosed with mental illness apart from two of them. The rest of the participants had stated that they had some symptoms of mental illness, but none of them wanted to see the psychotherapist due to cultural (stigma and labelling) and common understating reasons (effect of mental illness medications). Refugee mental health problems can be partially addressed by providing secret mental health consultations or via phone consultations to eliminate the shame feeling, stigma and labelling. The importance of mental illness medications should be explained to every patient, next to the risk of not taking the medication. That is because the participants think the mental illness medication is not good for them. That is found to be a common thought in Arabic culture. Another solution would be to treat the roots

of the mental health problems and its consequences such as violence and aggression.

7.5 METHODOLOGICAL EVALUATION

When conducting cross-cultural studies in a different language to the researcher, there is always a risk for interpreter bias. In addition to a failure to take into consideration the language differences there is also a risk of the researcher not fully acknowledging or understanding the differences in the local culture (Lopez et al., 2016;2008).

A local researcher can make a big difference in the efficacy of a study and can produce more accurate findings. They are more likely to understand the culture very well; in the case of this study - cultural issues such as, (wasta), understanding the jokes and hints and the secret meaning of some words.

A local researcher is much more likely to be able to build up the bond and trust quickly, interpreting the real meaning of words without the need for an interpreter that might deliver an incorrect meaning, especially as Arabic is spoken across a very wide area, but has significant regional differences. (Denzin & Lincoln, 2003) argue that, while there a principle of accuracy for collecting the data, analysis, interpretation and qualitative data reporting, there is no criteria or standard for translation of multilanguage qualitative research.

A researcher with extensive experience in the same targeted field can add better value in the outcomes. I had spent three years and a half working closely with the Syrian refugees and I knew how to approach them and build up the trust. I had heard many tragic stories already and knowing that I already had that knowledge made the participants talk comfortably about their experiences of torture, murder of their families, and other personal issues. An inexperienced interviewer may have found this too difficult. Participants may have withheld things for fear of upsetting the interviewer.

Conducting a research on any population would be better if it has a person that understands the unseen and unspoken norms, as they give a clearer insight of the real meanings. Allen (2017) stated that, scholars should consider that culture influences the interaction and responses to the research. Research that does not consider the participants' cultural perspective is invalid, or their findings are not accurate when representing the perceptive of participants (Allen, 2017).

This point had played a good role for me, as I am from the same cultural context and my findings and data are very accurate in a way that reflects a real picture of the participants' situation. Transcripts' translation to a language is time consuming and there are opportunities for the original meaning to be changed or lost during the translation process. In some dialects and languages, some words have no direct translations and some words have numerous meanings that can be used (Tsai JH-C et al., 2004).

This study had a declared aim to present the voice of the refugees, so it was essential that any translation retained the authenticity of the voice of the participants. Another example was given by (Twinn, 1997; Twin 1998) about translating from the Mandarin language. He stated that Mandarin

grammar structure is significantly unlike English language, which means an interview's narrative might not be translated precisely. This was one of the challenges for this study, although the researcher was relatively competent in English and had already completed master's level study in the UK.

I grew up and lived within the same geographical area as the refugees and I come from the same ethic and cultural population. My hometown is only forty-five minutes distance by driving to the centre of Dara'a, Syria, where mostly the refugees came from. This gave me a powerful starting point to understanding the refugees' way of talking and a deep insight into where other researchers cannot access, and I could translate and interpret what the participants really meant when they gave their statements. For instance, when a participant said, "ana Ta'aban Nafseen" means "I am mentally tired," it did not necessarily mean that he had mental tiredness. It might mean that he is just not happy at the moment and this is a common term to be used in some cases over little issues. During the interviews, the refugees often stated that their mentally related symptoms were momentary, and they can be changed to happiness easily by improvements to their living conditions and changes that would meet their desires.

To understand this, an investigator must understand the context and must be able to interpret the body language alongside the cultural norms to differentiate between seriously harmful mental symptoms and unserious ones. This played a very important role in the interviewer being able to accurately record the real meaning of the statements given in this study, which made these findings and this study unique.

Using an in-depth semi-structured interview method for data collecting was a good choice as every participant had a chance and enough time to express their feelings without limitations on the answers. Every participant was interviewed only one time as there was no need to conduct secondary interviews because all the required data was obtained. The language used in the interview was clear and understandable fully by the participants. The researcher approached the participants in the commonly used cultural way and had relaxed the participants to feel safe and explained the aim of this study very clearly and told them their rights during this study and guaranteed the full anonymity and confidentiality.

The open-ended questions set resulted in a great outcomes. The questions triggered the disclosure of the main aspects of the refugees' lives and their actual sufferings, needs, life conditions and answered the main objectives of this study. Responses to questions about their mental health were useful. The participants talked about symptoms of mental health issues and discussed the stigma and labelling among them and the cultural impact, and other mental health issues such as PTSD as this was discussed in the literature review and the findings and discussion chapters.

Purposive sampling method was employed in this study and it was beneficial in finding the right sample for the aim of this study and they all met the criteria and had a good range of different cases and settings. The participants came to the assigned premises on the given dates and times as it was published in the detailed advertisements and had an understanding of the interview purpose. The number of participants was sufficient, and twenty participants were interviewed.

The interviews were audio recorded, apart from one participant as he preferred to have his interview written on paper, although he was told his

details would be fully anonymous. Data saturation was reached by seventeen participants.

Interviews were transcribed, translated and checked for rigour before transferring into this study. Data to publish was checked with JHASi member and my supervisors to check the bias and rigor. JHASi Medical Field Coordinator's statement is *'I have reviewed Mousa's transcription and interpretation in a very confidential circumstances and I confirm that Mr. Jawasreh was unbiased at all in his transcribed data and gave the exact meaning of the original collected data'.* Collected data matched previous literature and has extended the previous knowledge and added new emerging themes. Thematic analysis was employed during the analysis process.

The researcher understood the data through reading and reading process, and that made it easier to identify the themes and to be able to include some reflection on the emotions expressed by participants. Data was coded into a separate sheet and had different categories and classifications of that data, which made it easier to create themes and to organize the data. Emerged themes were reviewed three times with the supervisors and compared to the existing literature too. Each theme was explained and defined with literature evidence alongside participants' statements.

During the researcher's previous experience in refugee camps, some refugees would complement certain NGOs just for the sake of obtaining better services or to avoid getting sanctioned and having blocks to the aid from them. During these interviews I have come across some participants who did that but explaining to them that I was only a student had given

them the freedom to talk and open their hearts which resulted in good honest contributions to the study.

Similarly, language difficulties did not present as a problem for the study as the researcher had originated from the same region and was able to communicate clearly. Following the interviews, during transcription and analysis, the study conductor did not face any difficulty when the data was collected which reflects the excellent level of understanding of the language of the participants.

7.6 THEORETICAL CONTRIBUTION

This study has showed the men's social needs such as employment which was a vital need for them such that all the participants have talked about it, and the how the jobs are given unfairly. This social need was causing a noticeable stress among them, making them feel low and caused issues in the street from boredom that led to violence and aggression. The previously mentioned issues might be resolved easily, by rotating the jobs and by creating more jobs in the camp and in the host community. Previous research showed that unemployment had an undesirable mental impact on men (Andersen 2009, Clark 2003). In addition to NGOs' distribution of jobs fairly, the thing that can surely eliminate the frustration would be to remove the wasta, as it results in spreading the feeling of injustice. Solving this matter could reduce the mental illness among the refugees.

Anderson (2009) and Mckee-Ryan et al., (2009) have argued that there are variables that inspire the negative effect of joblessness on mental health

such as ethnicity, social class, gender and previous work experience. Joblessness is obviously a serious matter in this study as the participants came from a men's working background culture and this had a consequence on the families and the camp's community.

7.7 LIMITATIONS OF THIS STUDY

There were several limitations in this study. Firstly, the sample was limited to only investigating males due to the complications arising from cultural circumstances in the Syrian community. In many situations, the male members of a family would not accept another male to discuss and sit with their female relatives, and the females themselves would not be comfortable to give completely honest and accurate answers. Al Subeh and Alzoubi, (2019) have talked about how this subject is common across all Arab countries; they highlight that there are cultural and religious barriers to keep in mind, which can impact negatively on women's rate of inclusion in participation in research studies and clinical trial studies.

Al Subeh and Alzoubi also stated that Muslim women are required to cover their whole body apart from face and hands, and only men from first degree relatives can touch or see certain parts of their bodies. This can limit the quality of communication, particularly when dealing with sensitive subjects such as this study, where body language can be an important indicator of mental wellbeing and discomfort. They also found that women can refuse to deal with a male researcher, particularly if the study requires taking blood samples or has a physical examination (Al Subeh and Alzoubi, 2019).

Even though a significant level of trust was achieved by the interviews being conducted by a local researcher with extensive experience of the refugee camp, there were some topic areas that were difficult to explore. Certain questions such as asking about alcohol consumption, drug abuse and sexual abuse were not explored directly due to the cultural traditions especially among older people as they could have felt offended. Even if they had drunk alcohol or abused drugs, participants would not have admitted to it.

This issue returns to the religion and culture of the participants. Most Arab countries are predominantly Muslim. In Islam drinking alcohol is forbidden and culturally it is considered very disrespectful behaviour. Even though some Arab countries permit the selling of alcohol, people still drink secretly, and would be socially outcast and labelled as a ‘drinker’. This can seriously impact the person’s family socially. This applies to using drugs as well, as Islamic religion forbids any sedatives unless it is for a medical reason. To conduct research into topics such as alcohol or drug abuse would have required a very different research method and would have changed the nature of the study.

In this study, the researcher did not come across any participant who stated they consumed alcohol at all. This finding was anticipated for many reasons, such as religiously and culturally it is forbidden and not acceptable at all, so it was unlikely that any participant would disclose drinking alcohol even if they had. It is a culturally sensitive topic which is one of this study limitations, as the researcher could not ask the participants about it, as mostly people will feel insulted, or they will laugh at the question if they are from a young age group. In the Arabic culture, drinking is the equivalent of committing a crime, and being a drinker even

for one occasion can damage the person's reputation for generations. In addition, it is very expensive and alcoholic drinks have high customs taxes on them.

This study was completed under the academic supervision of Manchester Metropolitan University's Faculty of Health, Psychology and Social Care. It was also completed with the cooperation of the directorate of the Al'atari refugee camp. Accessing the participants' caravans in some areas would have been dangerous, so the JHASi's staff advised the researcher to carry the interviews in their premises as it was safer. This has limited visiting many caravans to take a clear picture of their status Although visiting the caravans was not absolutely essential to the study, it might have helped enrich the data in two ways.

Firstly, the participants may have felt more confident in their own home, especially when talking about the services from the NGOs. Secondly, the researcher would have been able to see and record the physical environment of the participants, which would have added some depth to the statements about the level of poverty and the proximity of neighbours and lack of privacy, for example. Although, I have visited a few nearby caravans in the company of the JHASi's staff, where they took me to a key person's caravans in the camp, I still cannot produce a full image nor generalise a statement on the caravans' situation.

The study was limited to the camp refugees only. This group only represents the camp's refugees and not the refugees within the host community. Travelling in different cities in Jordan to reach Syrian refugees was not a suitable option in this study, because it would have taken considerable organization and time gaining the permissions, carrying out the additional interviews, as well as adding to the high cost.

Interviewing participants from one or two cities in the region would not have provided sufficiently high numbers to generate any good representative or generalisable sample. In addition, the refugees who have resettled in Mafraq governorate, in the region around the Alza'atari camp are not living the same life as refugees who have resettled in Amman (the capital) for several reasons such as, environment, weather, jobs, culture, etc., so would not be representative of all the Syrian refugees living outside the government camps. In summary, there are Syrian refugees living in many different environments within Jordan, within the Middle East, across Europe and elsewhere in the world. Some of these can form part of a future extended study.

Furthermore Hennink et al., (2011) summarised some limitations of in-depth interviews. A one to one interview is only giving information from individuals and does not include feedback from others. This method needs skills to establish trust with the interviewee, without which the quality of the responses could be inadequate to answer the research question. Another disadvantage was the need for flexibility to change the topic order during the interview to follow the participant's story. The study was limited by the restriction on the access to the camp due to the tensions at that time. It would have been preferable to adopt a more narrative style interview approach with greater time for each interview and open questions supported by topical probes as recommended by Hennink et al. (2011). The last limitation was the need of a lot transcription which increases the possibility for misinterpretation (Hennink et al., 2011).

7.8 AREAS FOR FUTURE RESEARCH

It is clear from the findings of this study that future research on the mental wellbeing of Syrian refugees in Jordan should be undertaken. This study investigated the experiences of refugees who had already spent up to seven years in camps. It showed that the long-term impact of prolonged insecurity and hopelessness was having a seriously damaging effect on the mental wellbeing of the adult male refugees. This study was targeted in one place and on one section of that community.

To achieve a complete picture further studies would need to be undertaken in the camp with the adult female refugees and the children. In addition, there is a need to repeat the same study with the refugees who have resettled within the host communities, from both genders (males and females), with a wider population from the different governates in different geographical locations. In order for this to be completed, future study might include two researchers, male and female, to be able to conduct a wider set of questions and highlight all the different aspects of mental wellbeing and quality of life.

There are some specific issues that warrant further exploration such as stigma and labelling, favouritism (wasta) and sexual abuse. Stigma associated with mental illness is pervasive across the Arabic community, as discussed in Chapter Four. As outlined earlier, approximately twelve million Syrians have been displaced by this conflict, half of whom have become refugees and the other half internally displaced. These twelve million people have experienced all the horrors of war; bombardment, imprisonment, torture, rape, loss of loved ones, loss of their homes and jobs and a loss of hope for the future.

This study has shone a light on the mental wellbeing of only a small sample of the population. The impact on the mental wellbeing of these

twelve million people is likely to reflect the findings of this study. Further study could investigate whether the stigma of mental illness is as strong now amongst the displaced Syrians as it is generally within the Arab population, or whether, as happened in many countries after the First World War where sufferers of shell shock were offered treatment rather than punishment as they had previously.

I have explained that the local Jordanian community are in fact from the same cultural and ethnic background as the refugees. Another avenue for future development of this research would therefore be to undertake a comparison between the established Jordanian community and Syrian refugee community.

It would also be a good idea to undertake a comparison study between the camp's refugees and the refugees who have been accommodated within the local host communities. During my previous work within the humanitarian sector, I used to do home visits for the refugees who were residing in the host communities. I came across many different issues among them that needed addressing well, such as rent problems, using all their savings and even selling their wives' gold, Jordanian community discrimination, employer's abuse, labelling, anger from the Jordanian community towards them as they think they shared the resources and job opportunities with them, health insurance and big operations coverage, children refugees labour and others uncountable matters.

There is another very important group that did not appear in any of the literature that I have searched. In Jordan, I came across many small illegal refugee camps; mostly they are scattered in the desert or live near farms and work there. Their life conditions were harsh, as they did not have the same level of support as the legal refugee camps. They usually had no

regular water or electric water supply. They also did not have medical insurance, no food supply, their kids worked in the farms (they were not attending school) and there was no means of safety that is available in the camp. Further research is needed on those refugees to carry over their serious suffering. The previous literature found in the searches for this study outlined the refugees who were residing in the camps and host communities and there were no studies talking about this type of illegal camp or groups.

I remember once in my previous work, I was going out with the outreach team across desert area East of Mafraq; I have noticed a small tent by itself in the desert near a small farm. We went to the tent where there was an only one old sick man. He was lying down in a sandy place with no means of basic life needs in a very hot dusty weather. He said that he had one daughter and she was out looking for work to bring food for both of them.

I reported the case to the UNHCR immediately and action was taken to bring them to safety, by offering them a house and financial support.

This study focused on the mental health and other life aspects of the adult Syrian male refugees. All these suggested additional studies with other sample groups would generate a much fuller picture of the refugee experience and the impact on their mental health and would assist in making the findings more generalizable or transferable. To completely accomplish a descriptive sample, a full study would have to comprise a bigger sample number in the refugee population. Sampling is an important component to be considered in terms of the generalisability and transferability in any study. This would give a chance to generalise the

study findings and compare it with other refugees from other nationalities, or even with the Syrian refugees in other hosting countries.

7.9 CONCLUDING SUMMARY

This study explored the quality of life and the impact of settlement experiences of adult male Syrian refugees living in Jordan with a focus on the Mental Health. A qualitative methods approach was applied, to measure the participants' satisfaction level in terms of the services provided, their social and mental wellbeing by conducting a face to face interviews that have a set of sixteen questions. This study revealed the unseen issues in the targeted community, such as poor life conditions, poor mental health that is related to reasons other than trauma or PTSD.

The study found that after seven years in a refugee camp, mental health problems were more frequently reported as originating from the current life conditions and were less often attributed to the traumatic experiences of bombardment, imprisonment, torture and displacement.

This study suggests that, based on the participants' views, there are weakness in the NGOs' systems as a result of the lack of opportunity, and the apparent likelihood that the situation for the refugees is unlikely to change in the near future. The system of favouritism causes frustration and anger and adds to the sense of helplessness, which is at the root of depression amongst the refugees. Stigma, labelling, cultural norms and hidden psychological problems were spotted in this study and were made clear of the reasons and what can be changed to better the refugee's lives.

APPENDICES

APPENDIX 1. ETHICAL APPROVAL

12/10/2018

Project Title: Syrian Refugees' Mental Health and Quality of Life

EthOS Reference Number: 1174

Ethical Opinion

Dear Mousa Jawasreh,

The above application was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 12/10/2018, was given a favourable ethical opinion. The approval is in place until 31/10/2020 .

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Project Proposal	PhD Proposal Mousa	01/04/2018	1
Recruitment Media	Advertising details Mousa	08/05/2018	1
Consent Form	Consent-Form Mousa	08/05/2018	1
Information Sheet	Information sheet Mousa	28/09/2018	updated 2
Consent Form	Consent-Form Mousa	28/09/2018	updated
Information Sheet	Interview Participant Information Sheet Ethics App.docx Mousa Jawasreh (2)	09/10/2018	updated

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make a change to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

HPSC Research Ethics and Governance Committee

APPENDIX 2. ETHICS CHECKLIST

This checklist must be completed **before** commencement of **any** research project. This includes projects undertaken by **staff and by students as part of a UG, PGT or PGR programme**. Please attach a Risk Assessment.

Please also refer to the University's Academic Ethics Procedures; Standard Operating Procedures and the University's Guidelines on Good Research Practice

Full name and title of applicant:	Mousa Haron Mousa Jawasreh
University Telephone Number:	
University Email address:	
Status: All staff and students involved in research are strongly encouraged to complete the Research Integrity Training which is available via the Staff and Research Student Moodle areas	Undergraduate Student ☐ Postgraduate Student: Taught ☐ Postgraduate Student: Research ☑ Staff ☐
Department/School/Other Unit:	
Programme of study (if applicable):	
Name of DoS/Supervisor/Line manager:	
Project Title:	Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health.
Start & End date (cannot be retrospective):	
Number of participants (if applicable):	20
Funding Source:	Self- Funded

Brief description of research project activities (300 words max):

This research is to investigate the Male Syrian refugees mental health and quality of life who settled in Jordan. Researcher will go to Jordan for the data collection, to gather data from twenty participants during the year 2018 after preparing the full approval form Manchester Metropolitan University. Researcher will go back to the United Kingdom to analyze the data and produce findings and recommendations for the interested and concerned people and authorities.

	YES ☐	NO ☐
Does the project involve NHS patients or resources? If 'yes' please note that your project may need NHS National Research Ethics Service (NRES) approval. Be aware that research carried out in a NHS trust also requires governance approval. Click here to find out if your research requires NRES approval Click here to visit the National Research Ethics Service website To find out more about Governance Approval in the NHS click here	☐ ☐ ☐	✔ ☐ ☐
Does the project require NRES approval?	☐	✔
If yes, has approval been granted by NRES? Attach copy of letter of approval. Approval cannot be granted without a copy of the letter.	☐	✔

NB Question 2 should only be answered if you have answered YES to Question 1. All other questions are mandatory.	**YES**	**NO**
1. Are you are gathering data from people?	☑	☐
For information on why you need informed consent from your participants please click here		
2. If you are gathering data from people, have you:	☐	☐
a. attached a participant information sheet explaining your approach to their involvement in your research and maintaining confidentiality of their data?	☐	☑
b. attached a consent form? (not required for questionnaires)	☐	☑
Click here to see an example of a participant information sheet and consent form		
3. Are you gathering data from secondary sources such as websites, archive material, and research datasets?	☑	☐
Click here to find out what ethical issues may exist with secondary data		
4. Have you read the guidance on data protection issues?	☑	☐
a. Have you considered and addressed data protection issues – relating to storing and disposing of data?	☑	☐
b. Is this in an auditable form? (can you trace use of the data from collection to disposal)	☑	☐
5. Have you read the guidance on appropriate research and consent procedures for participants who may be perceived to be vulnerable?	☑	☐
a. Does your study involve participants who are particularly vulnerable or unable to give informed consent (e.g. children, people with learning disabilities, your own students)?	☐ ✔	☐
6. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited (e.g. students at school, members of self-help group, nursing home residents)?	☐ ✔	☐
Click for an example of a PIS and information about gatekeepers		
7. Will the study involve the use of participants' images or sensitive data (e.g. participants personal details stored electronically, image capture techniques)?	☐	☐ ✔
Click here for guidance on images and sensitive data		
8. Will the study involve discussion of sensitive topics (e.g. sexual activity, drug use)?	☐ ✔	☐
Click here for an advisory distress protocol		
9. Could the study induce psychological stress or anxiety in participants or those associated with the research, however unlikely you think that risk is?	☐ ✔	☐
Click here to read about how to deal with stress and anxiety caused by research procedures		
10. Will blood or tissue samples be obtained from participants?	☐	☑
Click here to read how the Human Tissue Act might affect your work		
11. Is your research governed by the Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000?	☐	☐ ✔
Click here to learn more about IRMER		
12. Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	☐ ✔
Click here to read about how participants need to be warned of potential risks in this kind of research		
13. Is pain or more than mild discomfort likely to result from the study? Please attach the pain assessment tool you will be using.	☐	☐ ✔

Click here to read how participants need to be warned of pain or mild discomfort resulting from the study and what do about it.		
14. Will the study involve prolonged or repetitive testing or does it include a physical intervention?	☐	✔
Click here to discover what constitutes a physical intervention and here to read how any prolonged or repetitive testing needs to managed for participant wellbeing and safety		
15. Will participants to take part in the study without their knowledge and informed consent? If yes, please include a justification.	☐	✔
Click here to read about situations where research may be carried out without informed consent		
16. Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	✔
Click here to read guidance on payment for participants		
17. Is there an existing relationship between the researcher(s) and the participant(s) that needs to be considered? For instance, a lecturer researching his/her students, or a manager interviewing her/his staff?	☐	✔
Click here to read guidance on how existing power relationships need to be dealt with in research procedures		
18. Have you undertaken Risk Assessments for each of the procedures that you are undertaking?	✔	☐
19. Is any of the research activity taking place outside of the UK?	✔	☐
20. Does your research fit into any of the following security sensitive categories: • commissioned by the military • commissioned under an EU security call • involve the acquisition of security clearances • concerns terrorist or extreme groups If Yes, please complete a Security Sensitive Information Form	☐	☐ ✔

I understand that if granted, this approval will apply to the current project protocol and timeframe stated. If there are any changes I will be required to review the ethical consideration(s) and this will include completion of a 'Request for Amendment' form.

☑ have attached a Risk Assessment

☐ ✔ have attached an Insurance Checklist

If the applicant has answered **YES** to **ANY** of the questions **5a – 17** then they must complete the MMU Application for Ethical Approval.

Signature of Applicant:_____ Date: 10/12/2017 (DD/MM/YY)

2 *Independent Approval for the above*

project is (please check the appropriate box):
Granted

☐ I confirm that there are no ethical issues requiring further consideration and the project can commence.

3 ***Not Granted***

☐ I confirm that there are ethical issues requiring further consideration and will refer the project protocol to the Faculty Research Group Officer.

Signature:_____Date:_
_____(DD/MM/YY)

Print Name:_____Position:_____ **App**
Independent Scrutiniser for UG and PG Taught/ PGRs RD1 Scrutiniser/ Faculty Head of Ethics for staff.

APPENDIX 3. APPROVAL THE NGO.

Subject: Gatekeeper permission

Dear Dr. Yaroup Ajlouni,

I am writing to ask your permission to conduct research at your practice for a study entitled, which has been given ethical EthOS Reference Number: 1174. This research is being conducted by from Manchester Metropolitan University as part of PhD Health Care and Social Work. The study has been approved by Manchester Metropolitan University Research Ethics Committee and, as part of that approval process, I am required to obtain gatekeeper permission from site where I recruit or interview participants. The aim of this study is to explore the adult male Syrian refugees mental health (more details can be found in the attached Participant Information Sheet.

The overall goal of this study is to hear the refugees voice and carry it to the outer world to give better understand of their situation. The data will be collected in the form of interview by set of questions and will be answered by participants within 30 to 90 minutes. If you are willing to be involved would you please sign the form below that acknowledges that you have read the Participant Information Sheet, you understand the nature of the study being conducted and the risks and likely benefits of participation in this study, and you give permission for the research to be conducted at the site.

Yours sincerely
Supervisor Dr. Ian Warwick
Student: Mousa Jawasreh

Dr. Yaroup Ajlouni as role title: CEO and president

of site name Jordan health Aid Society International at Za’atari camp in Jordan having been fully informed of the nature of the research to be conducted in Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health, give my permission for the study to be conducted in JHASi facilities. I reserve the right to withdraw this permission at any time.

Signature: Yaroup Ajlouni Date: 20th November 2018.

APPENDIX 4. ADVERTISING DETAILS, PARTICIPANT INFORMATION AND CONSENT FORM.

- **Advertising details**

To whom it may concern

I am a PhD student from Jordan, doing my degree in Manchester Metropolitan University in the United Kingdom. I will be doing interviews with Syrian adult males as a part of my study about the mental health statues and current quality of life among the Syrians in Jordan.

Study title **(Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health.)**

The interview will take between one hour to 90 minutes and will be held inside the clinic.

I will be available in the clinics between the dates (12th- 13th December 2018)

From this time (9:00am) To this time (6:00pm)

Please give me a call or come straight to meet me their

My contact number is +962xxxxxxxxxxxxxx

Mousa Jawasreh

PhD student at Manchester Metropolitan University

All Saints Building, All Saints,

Manchester M15 6BH

United Kingdom.

- **Participant Information**

- **Student name: Mousa Jawasreh**
- **+447588305577**
- **+9620**xxxxxxxxxx
- **Mjawasreh@hotmail.co.uk**
  xxxxxxxxxxxxxxxx
- **Irbid**, **Jordan.**

The study director's information:

- **Dr. Ian Warwick**
- **Faculty of Health, Psychology and Social Care**
  Brooks Building 53, Bonsall Street,
  Manchester, M15 6GX
- **+44-1612472545**
- **I.warwick@mmu.ac.uk**

EXPLORATION OF THE QUALITY OF LIFE AND THE IMPACT OF SETTLEMENT EXPERIENCES OF ADULT MALE SYRIAN REFUGEES LIVING IN JORDAN: FOCUSING ON THE MENTAL HEALTH.

I would like to invite you to take part in a research study. Before you accept or refuse take your time to read the research purpose and what involves you, if you can't read, I am happy to read for you. Ask any question if anything is not clear.

The purpose of the research is to understand the impact of displacement on Syrian refugees settling in Jordan on their quality of life and mental health.

Research Objectives

- **To explore the lifestyle and circumstances of Syrian refugees and how this relates to their quality of life and mental health living in Jordan.**

- **To look at their background and report the changes such as, culture, education, and work there they have engaged in since 2011 until the data collection date in 2018 to evaluate the effect on their mental health state throughout the years.**
- **To overview the effect of the services that they obtained via the NGOs throughout the years of being asylum seekers.**
- **To identify positive interventions for the Syrian refugees, who could be applied to world refugees, also any cases forcibly immigration that can happen in the future.**
- **To provide recommendations for the non-governmental organizations (NGOs), hosting communities and decision makers regarding the refugees in the Middle East and North Africa (MENA) and Europe.**

I have chosen you to participate in my study because; this study is only for the adult Syrian males who live in Jordan.

It's your own choice to participate in this study or not, after reading and understanding what this study is about. Then will have to sign consent form to show that you have agreed to take part in this study. Also, you have the right to withdraw from this study at any time, without giving a reason.

This interview will take between one-hour minutes and one 90 minutes, and you will be interviewed only once. No personal information or names will be taken. This interview will take place in the clinic. You will be asked an open-end questions and this will be audio-recorded.

The participant may feel discomfort or remember bad situations happened to them then gets emotional. If there any questions you are not happy to answer we can skip. If you feel you can't continuo also you can drop the whole interview. The audio-recording will be deleted once I analysed the data.

Benefits to participants

It is important to hear from people who survived and experienced war and living in a different life circumstances pre, during and post war. This is their chance to share experience and talk if they are willing to talk, to make their voice reach the concerned people and people in authorities in this regard.

Research results will be shared with the participants if they wish to have it and can have copy of summery. The research results will be published for the organizations and health professionals, to increase the understanding on the refugee's quality of life and mental health, to provide better support and services for the refugees.

If you are concern about the study or any part of the study this is my contact details, and I will answer your questions. Your information confidentiality will be safeguarded during and after the study, in a special place in Manchester Metropolitan University, during the study and the records will be destroyed after finishing the study. The information will be used to understand your current situation in Jordan and how it's developed throughout the years. People will access to view identifiable data, authorized persons such as researchers within

the team, supervisors, sponsors and for monitoring the quality, regulatory authorities /R&D audit.

If you have any complains regards the research be contact: +962xxxxxxxxxxxx

- **Consent Forms**

Manchester Metropolitan University

Centre Number:

Study Number:

Client Identification Number for this trial:

CONSENT FORM

Title of Project: **Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health.**

Name of Researcher: **Mousa Jawasreh**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **……**version **……**for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that this interview will be audio-taping. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

4. I agree to take part in the above study. ☐

5. I consent to use my pseudo name if needed. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent.	Date	Signature

APPENDIX 5. EXAMPLE TRANSCRIPTS

Interview (1) R means Researcher. P means Participant

R: How do you deal with daily challenges?

P: **"***Loan from others. Basics 100 JOD every month left with 10jod only. No money to cut my hair.*"

R: What made you leave Syria? What would you say was the main reason?

P: "I left Syria for the war, for the kids, I left Syria because the war reached my area (Nowa)."

R: What was your situation when you came over?

P: *"When I left Syria, the situation was a tragedy. The Free Army came to our area and expelled the regime forces which made them (the regime) attack the area in a very harsh way."*

R: How has your life been throughout the crisis? How has your life been affected during the 7 years?

P*: "I have been living in the camp for five years and these five years I have lived in debt. It is a very bad life and insecure life too Double prices, even the*

pharmacy prices are very expensive. I am worried about my kids' future and their education, no good education here."

"Between me and my neighbour only 2 meters, rain leakage from the roof."

"Area is clean."

*"Electric comes only for 12 hours, from 4:30pm to 5:00am". "*Sewerage and water are okay"

"When it rains, it gets very muddy and dirty everywhere which makes us unable to travel around."

R: How are you now? How do you feel now?

P: *"I feel very disappointed all the time."*

R: Did you see any health professionals during these 7 years?

P: *"The medical service has shortage of medicine."*

"There is always a long waiting time"

R: Were you diagnosed with any mental illness?

P: *"I can't say I have mental issues, because all the people will call us crazy. If you go around all the camp you will find everyone suffering from mental issues from poverty."*

R: Do you understand this diagnosis?

P: "*I am very tired mentally. Always depressed.*" "no, I haven't been tortured."

R: What help did you get from NGOs?

P: "*Debt."*

R: Was it helpful or unhelpful?

P: *"I was registered with NRC and RD for maintenance and never seen them and never did any help." " I used to make 2000 JOD every month in Syria, after one year I spent all my savings." "I take medication for diarrhoea as I always have it."*

R: What do you think would help you with your issues?

P: *"Increase the visa card amount, jobs, ease the immigration process."*

"Life is too expensive in Jordan."

"I feel so good when I leave the camp for few hours."

"I can't go back to Syria, very scared from the regime, they will welcome you front of the tv and then they will take to jail."

APPENDIX 6. ANALYSIS TEMPLATE

FINAL TEMPLATE **Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health**			
Theoretical Strands	**Main theme**	**Sub-theme**	**Sub-sub theme**
1		1.Jobs and employment (lack of work) 1.Loss of income 2.Loss of purpose 3.Loss of status	1. Anxiety 2. Depression 3. Frustration 4. Stress
		Education and schools 3. Concern for children's future **4.** Failure as father	1.Worthlessness 2. Pessimism 3. Shame

THE IMPACT OF SOCIAL CONTEXT AND STRUCTURAL INEQUALITIES (Reported in Chapter3 & 6)	*1.Social Environment: Daily life stressors and barriers*	4. Financial issues and very low income	1.Hopelessness 2.Anxiety 3.Shame 4. Stress
		5. Long-term Housing problems 4. Loss of privacy 5. Poor conditions	1.Pessimism 2.Shame
		6. Wasta, Discrimination, Exploitation and Stigma	4. Worthlessness 5. Powerlessness 6. Anger

FINAL TEMPLATE

Exploration of the quality of Life and the Impact of Settlement Experiences of adult male Syrian refugees living in Jordan: Focusing on the Mental Health

Theoretical Strands	Main theme	Sub-theme	Sub-sub theme
2 **MENTAL ILL HEALTH** (Reported in chapters 4 &6)	1. Anxiety, Depression and Post-Traumatic Stress Disorder	1. Lack of safety 2. Violence in the camp 3. Lack of trust – neighbours/NGOs	6. Anxious mood 7. Fear 8. Distrust 9. Isolation 10. PTSD /paranoia
		6. Loss of family 7. Loss status 8. Fears for future of children's education 9. Poor access to health care **10.** Memories of a better life before	5. Powerlessness 6. Hopelessness 7. Pessimism 8. Frustration
		Trauma	1.Nightmares

	(PTSD)	6. Witnessing abuse and rape 7. Torture 8. Traumatic migration 9. Bombing 10. Theft of property	2.Flashbacks 3.Intrusive memories
	2.Stigma and mental ill health	4. Poor take up of services 5. Poor service delivery in Arabic countries	2. Poor symptom control – anxiety, depression, PTSD
		6. Religion and jinn Punishments from God. Distrust of western medicine	3. Increased fear 4. Increased Anxiety
		5. Negative Community response 6. Fear of being identified as crazy	3. Increased Anxiety 4. Increased paranoia

References

Abo-Hilal, M. and Hoogstad, M. (2013) 'Syrian mental health professionals as refugees in Jordan: establishing mental health services for fellow refugees.' *Intervention*, *11*(1) pp. 89-93.

Abu Suhaiban, H., Grasser, L.R. and Javanbakht, A. (2019) 'Mental health of refugees and torture survivors: a critical review of prevalence, predictors, and integrated care.' *International journal of environmental research and public health*, *16*(13) pp. 2309.

Abubakar A., Fischer R. (2012) 'The factor structure of the 12-item general health questionnaire in a literate Kenyan population.' *Stress Health*. 28 (3) pp. 248–254. [Online] [Accessed o 27th July 2018] DOI: 10.1002/smi.1420

Adams, W. L., McIlvain, H. E., Lacy, N. L., Magsi, H., Crabtree, B. F., Yenny, S. K. and Sitorius, M. A. (2002) 'Primary care for elderly people: why do doctors find it so hard?' *The Gerontologist*, 42(6) pp. 835-842. [Online] [Accessed on 11th April 2018]. https://doi.org/10.1093/geront/42.6.835

Aggarwal, A. N., Agarwal, R. and Gupta, D. (2014) 'Abbreviated World Health Organization Quality of Life questionnaire (WHOQOL-Bref) in north Indian patients with bronchial asthma: an evaluation using Rasch analysis.' *NPJ primary care respiratory medicine*, 24(1), pp. 1-6.

Aggarwal, A., Agarwal, R. and Gupta, D. (2014) 'Abbreviated World Health Organization Quality of Life questionnaire (WHOQOL-Bref) in north Indian patients with bronchial asthma: an evaluation using Rasch analysis.' *npj Prim Care Resp Med,* 24 (14001) pp. 1-6. [Online] [Accessed 28th December 2019] https://doi.org/10.1038/npjpcrm.2014.1

Akinyemi, O. O., Owoaje, E.T., Ige, O. K. and Popoola, O. A. (2012) Comparative study of mental health and quality of life in long term refugees and host populations in Oru-Ijebu, Southwest Nigeria, *BMC research notes,* 5 (1) pp. 394-394.

Al Subeh, Z. Y. and Alzoubi, K. H. (2019) 'Cultural and Religious Barriers Influencing the Participation of Women in Research: A Study from Jordan.' *Gender Issues*, (37) June, pp.1-14

Alduraidi, H. and Waters, C. M. (2018) 'Depression, Perceived Health, and Right-of-Return Hopefulness of Palestinian Refugees. *Journal of Nursing Scholarship*, *50*(2) pp. 163-171.

Al-Krenawi, A., Graham, J. R., Dean, Y. Z. and Eltaiba, N. (2004) 'Cross-national study of attitudes towards seeking professional help: Jordan, United Arab Emirates (UAE) and Arabs in Israel.' *International journal of social psychiatry*, *50*(2), pp. 102-114.

Allen, M. (ed.) (2017) *The SAGE encyclopedia of communication research methods*. Sage Publications.

Allen, T. (ed.) (1996) In search of cool ground: war, flight & homecoming in Northeast Africa. Africa World Press

Almoshmosh, N., Jefee Bahloul, H., Barkil-Oteo, A., Hassan, G. and Kirmayer, L.J. (2019) 'Mental health of resettled Syrian refugees: a practical cross-cultural guide for practitioners.' *The journal of mental health training, education, and practice,* 15 (1) pp. 20-32.

Almoshmosh, N., Mobayed, M. and Aljendi, M. (2016) 'Mental health and psychosocial needs of Syrian refugees and the role of Syrian non-governmental organizations.' *BJPsych international,* 13 (4) pp. 81-83.

Aloud, N. (2004) *'Factors affecting attitudes toward seeking and using normal mental health and psychological services among Arab-Muslims population.'* Ph.D. The Ohio State University.

Al-Shamari, N. (2011) 'The corruption perception of the employee in the public and private sector in KSA.' Pp. 174-203.

Alvesson, M. and Deetz, S. (2000) *Doing critical management research*. Sage Publications Ltd.

Alwerthan, T. (2016) 'Investigating favouritism from a psychological lens'. *The Journal of Values-Based Leadership*, 9(2), pp. 158–168

Alwerthan, T. A., Swanson, D. P. and Rogge, R.D. (2018) 'It's better to give than to receive: Psychological need satisfaction mediating links between wasta (favouritism) and individuals' psychological distress.' *International journal of psychology,* 53, May, pp. 11-20. [Online] [Accessed on 15th August 2020] DOI: 10.1002/ijop.12419

Amawi, N., Mollica, R. F., Lavelle, J., Osman, O. and Nasir, L. (2014) 'Overview of research on the mental health impact of violence in the Middle East in light of the Arab Spring.' *The Journal of nervous and mental disease*, 202(9), pp.625-629. [Online] [Accessed on 13th August 2020]. doi: 10.1097/NMD.0000000000000174

American Psychiatric Association. (1980) DSM History. *American Psychiatric Association.* [Online] [Accessed on 11th August 2020] https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm

American Psychiatric Association. (no date) Trauma. *American Psychiatric Association.* [Online] [Accessed on 10th August 2020] https://www.apa.org/topics/trauma

Amnesty International. (2016) *Syria's Refugee Crisis in Numbers*. 5th February. [online] [Accessed on 10th December 2018] https://www.amnesty.org.nz/syrias-refugee-crisis-numbers-0

Andersen, S. H. (2009) *Dealing with unemployment: program effects on psychological and labour market outcomes*. Ph.D. University of Copenhagen.

Andrews, G. and Peters, L. (1998) 'The psychometric properties of the composite international diagnostic interview.' *Social psychiatry and psychiatric epidemiology*, *33*(2), pp. 80-88.

Arasli, H. and Tumer, M. (2008) 'Nepotism, favouritism and cronyism: A study of their effects on job stress and job satisfaction in the banking industry of north Cyprus'. *Social Behaviour and Personality: An International Journal,* 36(9) pp. 1237–1250 [Online] [Accessed on 11th August 2020] https://doi.org/10.2224/sbp.2008.36.9.1237

Asgary, R., Charpentier, B. and Burnett, D. C. (2013) 'Socio-medical challenges of asylum seekers prior and after coming to the US.' *Journal of immigrant and minority health*, *15*(5) pp.961-968.

Asmundson, G.J. and Katz, J. (2009) 'Understanding the co-occurrence of anxiety disorders and chronic pain: state-of-the-art.' *Depression and anxiety*, *26*(10) pp.888-901.

Aydogan, I. (2009) 'Favouritism in the Turkish educational system: Nepotism, cronyism and patronage.' *Educational Policy Analysis and Strategic Research*, 4(1) pp. 19–35

Bandeira, M., Higson-Smith, C., Bantjes, M. and Polatin, P. (2010) 'The land of milk and honey: a picture of refugee torture survivors presenting for treatment in a South African trauma centre.' *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, *20*(2) pp. 92-103

BBC News. (2013*) Syria Crisis: Cameron loses commons vote on Syria action*. 30th August. BBC News. [Online] [Accessed on 20th March 2019] https://www.bbc.co.uk/news/uk-politics-23892783

BBC News. (2015) *Syria air strikes: RAF Tornado jets carry out bombing*. 3rd December. BBC News. [Online] [Accessed on 20th March 2019] https://www.bbc.co.uk/news/uk-34992032

BBC News. (2016) *Syria: The story of the conflict*. 11th March. BBC News. [Online] [Accessed on 2nd April 2019] https://www.bbc.co.uk/news/world-middle-east-26116868

BBC News. (2019) *Syria Country Profile*. 14th January. BBC News. [Online] [Accessed 13th February 2019] https://www.bbc.co.uk/news/world-middle-east-14703856

Bellingcat Investigation Team. (2016) *Reaper Drones Revealed to Be Operating from Jordan*. 25TH February. Bellingcat. [Online] [Accessed on 30th March 2019]

https://www.bellingcat.com/news/mena/2016/02/25/reaper-drones-revealed-operating-jordan/

Ben Farhat, J., Blanchet, K., Juul Bjertrup, P., Veizis, A., Perrin, C., Coulborn, R.M., Mayaud, P. and Cohuet, S. (2018) 'Syrian refugees in Greece: experience with violence, mental health status, and access to information during the journey and while in Greece.' *BMC medicine,* 16 (1) pp. 1-12.

Bener A, Ghuloum S. (2011) 'Ethnic differences in the knowledge, attitude and beliefs towards mental illness in a traditional fast developing country.' *Psychiatria Danubina.* 23(2) pp. 157-164.

Berns, J. (2014) *Syrian refugee access to care study: medical service need among post-emergency Syrian refugees in Dohuk Governorate, Kurdistan Region, Iraq*. Erbil: World Health Organization and Ministry of Health, Kurdistan Regional Government, Iraq. [Online] [Accessed on 20th August 2020] https://data2.unhcr.org/en/documents/details/40166

Betancourt, T. S., Newnham, E. A., Layne, C. M., Kim, S., Steinberg, A. M., Ellis, H. and Birman, D. (2012) 'Trauma History and Psychopathology in War-Affected Refugee Children Referred for Trauma-Related Mental Health Services in the United States.' *Journal of traumatic stress*, 25(6) pp. 682-690.

Billington, R. (2003) *Living philosophy: an introduction to moral thought,* 3rd ed. London: Routledge.

Black, I. (2015*) France more active than rest of the west in tackling Syria*. 14th November. The Guardian. [Online] [Accessed on 7th March 2019] https://www.theguardian.com/world/2015/nov/14/france-active-policy-syria-assad-isis-paris-attacks-air-strikes

Blackmon, K. and Maylor, H. (2005) *Researching business and management.* HM Blackmon, Researching Business and Management. China: Palgrave MacMillan.

Bless, C., Higson-Smith, C. and Kagee, A. (2006) *Fundamentals of social research methods: An African perspective*. Juta and Company Ltd.

Bloch A. (ed) (1999) *Refugees in the job market: a case of unused skills in the British economy.* Refugees, Citizenship and Social Policy in Europe. Palgrave Macmillan, London. [Online] [Accessed on 11th July 2020] https://doi.org/10.1057/9780230371248_10

Bloch, A. (1999) *Refugees in the job market: a case of unused skills in the British economy.* Refugees, citizenship and social policy in Europe. Palgrave Macmillan, London.

Bogdan, R., and Taylor, S. J. (1975). *Introduction to qualitative research methods: a phenomenological approach to the social sciences*. New York, Wiley.

Bogic, M., Njoku, A. and Priebe, S. (2015) 'Long-term mental health of war-refugees: a systematic literature review.' *BMC international health and human rights*, *15*(1), p. 1-41

Bola, J. R., Kao, D., Soydan, H. and Adams, C.E. (2011) Antipsychotic medication for early episode schizophrenia. *Cochrane Database of Systematic Reviews*, (6). [Online] [Accessed on 20th August 2020] https://doi.org/10.1002/14651858.CD006374.pub2

Bonanno, G. A. (2009) *Other side of sadness: what the new science of bereavement tells us about life after loss,* Basic Books, New York.

Bosch, A. M. (2005) *Adolescents' reproductive health in rural Bangladesh: the impact of early childhood nutritional anthropometry*. Rozenberg Publishers.

Bowman, M.L., (1999) 'Individual differences in posttraumatic distress: problems with the DSM-IV model.' *The Canadian Journal of Psychiatry*, 44(1) pp. 21-33.

Bradbury-Jones, C., Irvine, F. and Sambrook, S. (2010) 'Empowerment of nursing students in clinical practice: spheres of influence.' *Journal of advanced nursing*, 66(9) pp. 2061-2070. [Online] [Accessed on 14th April] **https://doi.org/10.1111/j.1365-2648.2010.05351.x**

Bradley, R., Greene, J., Russ, E., Dutra, L. and Westen, D. (2005) 'A multidimensional meta-analysis of psychotherapy for PTSD.' *American journal of Psychiatry*, 162(2), pp. 214-227.[Online] [Accessed on 2nd August 2020] https://doi.org/10.1176/appi.ajp.162.2.214

Brannick, T. and Coghlan, D. (2007) In defense of being "native": The case for insider academic research. *Organizational research methods*, 10(1), pp. 59-74.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative research in psychology*, *3*(2), pp.77-101. [Online] [Accessed on 11th May 2018] https://doi.org/10.1191/1478088706qp063oa

Brewer, M. B. (1996) 'When contact is not enough: Social identity and intergroup cooperation'. *International journal of Intercultural relations*, *20* (3-4), pp. 291-303.

Brewin, C. R., Andrews, B. and Valentine, J.D., (2000) 'Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults.' *Journal of consulting and clinical psychology*, *68*(5) pp. 748-766.

British Library. (no date). The Escape from Egypt. British Library. [Online] [Accessed on 13th October 2020]. https://www.bl.uk/learning/cult/inside/goldhaggadahstories/escapeegypt/escapeegypt.html#:~:text=Escape%20across%20the%20Red%20Sea&text=But%20Moses%20told%20them%20that,by%20charging%20into%20the%20sea.

Bryant, R. A., Edwards, B., Creamer, M., O'Donnell, M., Forbes, D., Felmingham, K.L., Silove, D., Steel, Z., Nickerson, A., McFarlane, A.C. and Van Hooff, M. (2018) 'The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study.' *The Lancet Public Health*, *3*(5), pp. 249-258.

Bryman, A. (2012) *Social research methods*. 4th ed; OUP Oxford.

Cadmus, E., Owoaje, E., Akinyemi, O. and Nwachukwu, C. (2011) 'P2-377 A rural-urban comparison of the prevalence and patterns of elder abuse in Oyo state.' south western Nigeria. *Journal of epidemiology and community health (1979),* 65(1) pp. 327-327.

Caelli, K., Ray, L., and Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. International Journal of Qualitative Methods, 2(2), 1–24.

Cambridge Dictionary. (no date: online) epistemology. Cambridge Dictionary. [Accessed 1st May 2021] https://dictionary.cambridge.org/dictionary/english/epistemology

Campbell, T.A. (2007) 'Psychological assessment, diagnosis, and treatment of torture survivors: a review. *Clinical psychology review*, 27(5) pp. 628-641.

Canetti, D., Snider, K.L., Pedersen, A. and Hall, B.J. (2016) 'Threatened or threatening? How ideology shapes asylum seekers' immigration policy attitudes in Israel and Australia.' *Journal of refugee studies*, *29*(4), pp.583-606.
Carlson, E.B. and Dalenberg, C. J. (2000) A conceptual framework for the impact of traumatic experiences. *Trauma, violence, & abuse*, 1(1) pp. 4-28.

Carta, M. G., Bernal, M., Hardoy, M. C. and Haro-Abad, J. M. (2005) 'Migration and mental health in Europe (the state of the mental health in Europe working group: appendix 1).' *Clinical practice and epidemiology in mental health*, 1(1) pp. 13

Central Intelligence Agency. (No date) *The World Facebook, Middle East: Syria.* [Online] [Accessed 14th February 2019] https://www.cia.gov/library/publications/the-world-factbook/geos/sy.html

Cheung, P. (1994) 'Posttraumatic stress disorder among Cambodian refugees in New Zealand.' *International Journal of Social Psychiatry*, 40(1) pp. 17-26

Chirban, J.T. (1996) *Interviewing in depth: the interactive-relational approach*. London. SAGE.

Christianson, S. and Marren, J. (2012) 'The impact of event scale-revised (IES-R).' *Medsurg Nurs*, 21(5), pp. 321-322.

Chu, T., Keller, A. S. and Rasmussen, A. (2013) 'Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence'. *Journal of immigrant and minority health*. 15 (5) pp. 890-897
Chung, M.C., AlQarni, N., Al Muhairi, S. and Mitchell, B. (2017) 'The relationship between trauma centrality, self-efficacy, posttraumatic stress and psychiatric co-morbidity among Syrian refugees: is gender a moderator?.' *Journal of psychiatric research*, 94, November, pp. 107-115.
Chung, M.C., AlQarni, N., AlMazrouei, M., Al Muhairi, S., Shakra, M., Mitchell, B., Al Mazrouei, S. and Al Hashmi, S. (2018) 'The impact of trauma exposure characteristics on post-traumatic stress disorder and psychiatric co-morbidity among Syrian refugees.' *Psychiatry research*, 259, January, pp. 310-315.

Clark, A.E. (2003) 'Unemployment as a social norm: Psychological evidence from panel data.' *Journal of labour economics*, 21(2), pp. 323-351.

Coffey, G. J., Kaplan, I., Sampson, R. C. and Tucci, M. M. (2010) 'The meaning and mental health consequences of long-term immigration detention for people seeking asylum.' *Social science & medicine*, 70 (12), pp. 2070-2079. [Online] [Accessed on 13th September 2019]. doi: 10.1016/j.socscimed.2010.02.042.
Cohen, E. (2005) *Call for chapters: Bias, misinformation and disinformation in informing systems.* Informing Science Press.

Coid, J., Yang, M., Tyrer, P., Roberts, A. and Ullrich, S. (2006) 'Prevalence and correlates of personality disorder in Great Britain.' *The British Journal of Psychiatry*, 188(5), pp. 423-431. [Online] [Accessed on 25th July 2020] DOI: https://doi.org/10.1192/bjp.188.5.423

Community Quality of Life. (no date) Community-Quality-of-Life Survey. *CQoL.* [Online] [Accessed on 4th May 2019] http://www.miqols.org/cqol/

Conrad, C. D. (2011). *The handbook of stress: Neuropsychological effects on the brain*. Oxford: Wiley-Blackwell.

Corrigan, P. W., River, L.P., Lundin, R.K., Penn, D. L., Uphoff-Wasowski, K., Campion, J., Mathisen, J., Gagnon, C., Bergman, M., Goldstein, H. and Kubiak, M. A. (2001) 'Three strategies for changing attributions about severe mental illness.' *Schizophrenia bulletin*, 27(2), pp.187-195. [Online] [Accessed on 13th August 2020] https://doi.org/10.1093/oxfordjournals.schbul.a006865

Coussey, M. (2000) *Framework of integration policies*. Council of Europe.

Creswell, J. W. (1998) 'Qualitative inquiry and research design: Choosing among five traditions.' *Thousand Oaks, CA: Sage Publications.*

Creswell, J. W. (2014) *Research design: qualitative, quantitative, and mixed methods approaches.* Fourth, international Student edn. Los Angeles, California. SAGE.

Crotty, M. (1998) The Foundations of Social Research: Meaning and Perspective in the

Crowe, M. (1998) 'The power of the word: some post-structural considerations of qualitative approaches in nursing research.' *Journal of Advanced Nursing*, *28*(2), pp.339-344. [Online] [Accessed on 15th September 2020] https://doi.org/10.1046/j.1365-2648.1998.00780.x

Crowe, M., Inder, M. and Porter, R. (2015) 'Conducting qualitative research in mental health: Thematic and content analyses.' *Australian & New Zealand Journal of Psychiatry*, 49(7), pp. 616-623. [Online] [Accessed on 11th March 2019] https://doi.org/10.1177/0004867415582053

Culbertson, S., Oliker, O., Baruch, B. and Blum, I. (2016) *Rethinking coordination of services to refugees in urban areas: Managing the crisis in Jordan and Lebanon*. Rand Corporation. [Online] [Accessed on 10th September 2020] https://www.rand.org/pubs/research_reports/RR1485.html

Cunningham, R., and Sarayrah, Y. K. (1993) ‘Wasta: The hidden force in Middle Eastern society.’ *Westport, CT: Praeger*

Dahl, S., Mutapcic, A. and Schei, B. (1998) ‘Traumatic events and predictive factors for posttraumatic symptoms in displaced Bosnian women in a war zone. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, 11(1), pp.137-145.

Darak, S. and Kulkarni, S. (2005) *People with HIV: Stigma, Coping and Support Systems: An Insider's Perspective*. NIMHANS.

Dardas, L. A. and Simmons, L. A. (2015) ‘The stigma of mental illness in Arab families: a concept analysis: Mental illness stigma: a concept analysis.’ *Journal of psychiatric and mental health nursing,* 22, (9) pp. 668-679.

Dator, W., Abunab, H. and Dao-ayen, N. (2018) ‘Health challenges and access to health care among Syrian refugees in Jordan: a review.’ *Eastern Mediterranean Health Journal*, *24*(7), pp. 680-686.
De Maio, J., Silbert, M., Jenkinson, R. and Smart, D. (2014) ‘Building a new life in Australia: introducing the longitudinal study of humanitarian migrants.’ *Family Matters*, (94) June, pp. 5-14.
De Sardan, J. O. (1999) ‘A moral economy of corruption in Africa?’ *Journal of modern African studies*, pp. 25-52.

decision trail. Journal of Advanced Nursing 19, 976–986.
decision trail. Journal of Advanced Nursing 19, 976–986.
Denzin, N. K., and Lincoln, Y. S. (2003) *The landscape of Qualitative Research*. 2nd ed., Thousand Oaks, CA: Sage.

Denzin, N. K., and Lincoln, Y. S. (2013) *Strategies of qualitative inquiry.* 4th ed., Los Angeles: SAGE.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H. and Covi, L. (1974) ‘The Hopkins Symptom Checklist (HSCL): A self-report symptom inventory.’ Behavioral science, 19 (1) pp. 1-15. [online] [accessed 13th May 2020] doi.org/10.1002/bs.3830190102

Descartes, R. and Gröber, G. (1905) *Discours de la méthode: 1637*. Heitz.

Dgani-Ratsaby, A. (2011) *The Effects of Cultural and Familial Factors on Severity of Trauma and Treatment Outcome among a Multicultural Population of Refugee Survivors of Torture*. Ph.D, Adelphi University.

DiCicco-Bloom, B. and Crabtree, B. F. (2006) ‘Making sense of qualitative research.’ *Medical Education*, *40* (4) pp. 314-321.

Diener, E. D., Emmons, R. A., Larsen, R. J. and Griffin, S. (1985) ‘The satisfaction with life scale.’ *Journal of personality assessment*, 49(1) pp. 71-75.

Dimitrova, R., Johnson, D.J. and van de Vijver, Fons J.R. (2018) ‘Ethnic socialization, ethnic identity, life satisfaction and school achievement of Roma

ethnic minority youth.' *Journal of adolescence (London, England.),* 62, January, pp. 175-183.

Dmitri, T .(2012) Russia's Line in the Sand on Syria: Why Moscow Wants To Halt the Arab Spring. 5th February. Foreign Affairs.com. [Online] [Accessed on 20th February 2019]. https://www.foreignaffairs.com/articles/syria/2012-02-05/russias-line-sand-syria

Doğan, N., Dikeç, G. and Uygun, E. (2019) 'Syrian refugees' experiences with mental health services in Turkey: I felt lonely because I wasn't able to speak to anyone.' *Perspectives in psychiatric care,* 55 (4), pp. 673-680.

Effarah, J. (2020) *Syria Stabilization Stabilizes*. AuthorHouse.

El Arnaout, N., Rutherford, S., Zreik, T., Nabulsi, D., Yassin, N., and Saleh, S. (2019) 'Assessment of the health needs of syrian refugees in lebanon and Syria's neighboring countries.' *Conflict and Health, 13*(1) pp. 31-31.

Epatko, L. (2012) *Syria and Turkey: A Complex Relationship*. 15th November. PBS News Hour. [Online] [Accessed on 26th March 2019] https://www.pbs.org/newshour/world/syria-and-turkey

European Commission. (2016) *European Civil Protection and Humanitarian Aid Operations: Syria.* [Online] [Accessed on 15th 2018] https://ec.europa.eu/echo/where/middle-east/syria_en

Farrugia, B. (2019) 'WASP (write a scientific paper): Sampling in qualitative research. *Early Human Development*, 133*,* June, pp. 69-71. [Online] [Accessed on 10th July 2020] https://doi.org/10.1016/j.earlhumdev.2019.03.016

Fazel, M., Wheeler, J., and Danesh, J. (2005) 'Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review.' *The Lancet,* 365(9467) pp. 1309-1314. doi:10.1016/S0140-6736(05)61027-6

Feeney, A. (2000) 'Refugee employment.' *Local economy*, *15*(4) pp. 343-349. [online] [Accessed on 30th July 2020] https://doi.org/10.1080/026909400750068086

Fernando, S. (2003) 'Cultural Diversity, Mental Health and Psychiatry The struggle against racism.' Hove: Brunner-Routledge pp. 89-145.

Fernando, S. (2010) '*Mental health, race and culture.'* 3rd ed., Palgrave Macmillan, Houndmills, Basingstoke, Hampshire, England; New York, New York.

Ferreira, M. (1988) A sociological analysis of medical encounters of aged persons at an outpatient centre: a qualitative approach. In M. Ferreira, J. Mouton, G. Puth., E. Schurink, W. Schurink, (Eds.). Introduction to qualitative research. Pretoria: Human Sciences Research Council.

Fine, M., Weis, L., Weseen, S. and Wong, L. (2000) 'Qualitative research, representations and social responsibilities.' *Handbook of qualitative research*, *2*, pp. 107-131

Firestone, W. A. (1990) ‘Accommodation: toward a paradigm-praxis dialectic.’ In: Guba, E. (Ed.), The Paradigm Dialog. *Sage, Newbury Park*, United States, pp. 105–124.

Follain, J. and Leppard, D. (2012) *Syria rebels aided by UK intelligence.* 19th August. The Times. [Online] [Accessed on 7th March 2019] https://www.thetimes.co.uk/article/syria-rebels-aided-by-uk-intelligence-763hg5jbpf0

Fossey, E., Harvey, C., McDermott, F. and Davidson, L. (2002) ‘Understanding and evaluating qualitative research.’ *Australian & New Zealand Journal of Psychiatry*, 36(6) pp. 717-732. [Online] [Accessed on 3rd April 2018] https://doi.org/10.1046/j.1440-1614.2002.01100.x

Fox PG, Burns KR, Popovich JM, Ilg MM. (2001) ‘Depression among immigrant Mexican women and Southeast Asian refugee women in the U. S.’ The International Journal of Psychiatric Nursing Research. 7(1) pp. 778-792.
Fuhr, D.C., Acarturk, C., McGrath, M., Ilkkursun, Z., Sondorp, E., Sijbrandij, M., Ventevogel, P., Cuijpers, P., McKee, M. and Roberts, B. (2019) ‘Treatment gap and mental health service use among Syrian refugees in Sultanbeyli, Istanbul: a cross-sectional survey.’ *Epidemiology and psychiatric sciences*, 29, October, pp. 1-11.

Fullilove, M. T. (1996) ‘Psychiatric implications of displacement: Contributions from the psychology of place.’ *American Journal of Psychiatry*, 153(12) pp. 1516-1523.

Gearing, R. E., MacKenzie, M. J., Ibrahim, R. W., Brewer, K. B., Batayneh, J. S. and Schwalbe, C. S. (2015) ‘Stigma and mental health treatment of adolescents with depression in Jordan.’ *Community mental health journal*, 51(1) pp. 111-117

Geisser, M. E., Roth, R. S., Bachman, J. E. and Eckert, T. A. (1996) ‘The relationship between symptoms of post-traumatic stress disorder and pain, affective disturbance and disability among patients with accident and non-accident related pain. *PAIN®*, *66* (2-3), pp. 207-214.

George, U., Thomson, M.S., Chaze, F. and Guruge, S. (2015) ‘Immigrant Mental Health, A Public Health Issue: Looking Back and Moving Forward.’ *International journal of environmental research and public health.* 12(10), pp. 13624-13648.

Georgiadou, E., Zbidat, A., Schmitt, G.M. and Erim, Y. (2018) ‘Prevalence of Mental Distress Among Syrian Refugees with Residence Permission in Germany: A Registry-Based Study.’ *Frontiers in psychiatry,* 9, August, pp. 393-393

Getanda, E. M., Papadopoulos, C., and Evans, H. (2015) ‘The mental health, quality of life and life satisfaction of internally displaced persons living in nakuru county, Kenya.’ BMC Public Health, 15(1), pp. 1-9. [Online] [Accessed on 30th May 2018]. doi:10.1186/s12889-015-2085

Getnet, B., Medhin, G. and Alem, A. (2019) ‘Symptoms of post-traumatic stress disorder and depression among Eritrean refugees in Ethiopia: identifying direct,

meditating and moderating predictors from path analysis.' *BMJ open*, *9*(1) pp. 1-12.

Giacco, D., Laxhman, N. and Priebe, S., 2018, May. Prevalence of and risk factors for mental disorders in refugees. In *Seminars in cell & developmental biology*. 77, (May) pp. 144-152. [Online] Accessed 13th October 2019] doi.org/10.1016/j.semcdb.2017.11.030

Gibelman, M. and Gelman, S. R. (2004) 'A loss of credibility: Patterns of wrongdoing among nongovernmental organizations.' *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, *15*(4) pp. 355-381.

Given, L. M. (2012) *Neutrality in Qualitative Research In: The SAGE Encyclopedia of Qualitative Research Methods.* Sage publications, Inc. [online] [Accessed on 14th October 2020] https://dx.doi.org/10.4135/9781412963909

GL Assessment. (2017) 'Hospital Anxiety and Depression Scale (HADS).' GL Assessment. [Online] [Accessed 12th August 2018] https://www.gl-assessment.co.uk/products/hospital-anxiety-and-depression-scale-hads/

Glaser, B. G. and Strauss, A. L. (1967) *The discovery of grounded theory: strategies for qualitative research.* Aldine de Gruyter, New York.

Goffman, E. (1986) *Stigma: notes on the management of spoiled identity.* ProQuest Ebook Central]. Touchstone, New York.

Gøtzsche, P. C., Young, A. H. and Crace, J. (2015) 'Does long term use of psychiatric drugs cause more harm than good?' *BMJ*, 350, May, pp. 2435. [Online] [Accessed on 15th August 2020] https://doi.org/10.1136/bmj.h2435

Greenbaum, P. E., Dedrick, R. F., and Lipien, L. (2004) *The Child Behaviour Checklist/4-18 (CBCL/4-18).* In M. J. Hilsenroth and D. L. Segal (Eds.), *Comprehensive handbook of psychological assessment, Personality assessment*, John Wiley & Sons Inc. 2, pp. 179-191.
Guest, G., Namey, E. E., and Mitchell, M. L. (2013) Qualitative research: Defining and designing. *Collecting qualitative data: A field manual for applied research*, pp.1-40.

Haagen, J. F., ter Heide, F.J. J., Mooren, T. M., Knipscheer, J. W. and Kleber, R. J. (2017) 'Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis.' *British Journal of Clinical Psychology*, *56*(1) pp. 69-83.

Hakim, C. (1995) 'Five feminist myths about women's employment.' *British journal of sociology*, *46*(3) pp. 429-455. [Online] [accessed on 7th October 2020]. DOI: 10.2307/591850

Hallebone, E. and Priest, J., (2008) *Business and management research: paradigms and practices*. Macmillan International Higher Education

Hamid, A. (2018) *Mental health care for Syrian refugees: shared realities in the context of conflict and forced displacement*. Ph.D. (University College London).

Harlacher, U., Nordin, L. and Polatin, P. B. (2016) 'Torture survivors' symptom load compared to chronic pain and psychiatric in-patients.' *Torture Journal*, 26(2), pp. 11-11.

Harvard Program in Refugees Trauma. (no date, a) Harvard Trauma Questionnaire (HTQ). *HPRT.* [Online] [Accessed on 30th June 2019] http://hprt-cambridge.org/screening/harvard-trauma-questionnaire/

Harvard Program in Refugees Trauma. (no date, b) Hopkins Symptoms Checklist (HSCL-25). *HPRT.* [Online] [Accessed on 30th June 2019] http://hprt-cambridge.org/screening/hopkins-symptom-checklist/

Hassan, G, Kirmayer, LJ, MekkiBerrada A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S. and Ventevogel, P. (2015) 'Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict.' *UNHCR*. [Online] [Accessed on 10th August 2019]. https://www.unhcr.org/55f6b90f9.pdf
Hassan, G, Kirmayer, LJ, MekkiBerrada A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B., Youssef, A., Jefee-Bahloul, H., Barkeel-Oteo, A., Coutts, A., Song, S. and Ventevogel, P. (2015) 'Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict.' Geneva: *UNHCR.* [Online] [Accessed 25th December 2018] http://www.unhcr.org/55f6b90f9.pdf

Hayajenh, A., Maghrabi, A., and Al-Dabbagh, T. (1994) 'Research note: Assessing the effect of nepotism on human resource managers.' *International Journal of Manpower,* 15(1) pp. 60–67.

Hendrickx, M., Woodward, A., Fuhr, D.C., Sondorp, E. and Roberts, B. (2019) 'The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighboring countries: a systematic review,' *Journal of public health (Oxford, England),* 42(3) pp. 299-310.

Hennink, M.M., Hutter, I. and Bailey, A. (2011) *Qualitative research methods.* SAGE, London; Los Angeles.

Heritage, J. (1984) *Garfinkel and ethnomethodology*. Cambridge, United Kingdom: Polity Press.

Herman, J. L. (1992) *Trauma and recovery.* Basic Books. History. (2017) *Syria.* 10th July. History. [Online] [Accessed 15th February 2019] https://www.history.com/topics/middle-east/the-history-of-syria

Hollifield, M., Warner, T., Krakow, B. and Westermeyer, J. (2018) 'Mental Health Effects of Stress over the Life Span of Refugees.' *Journal of clinical medicine.* 7(2)pp. 25.[Online] [Accessed on 1st September 2020] https://www.mdpi.com/2077-0383/7/2/25

Holloway, I. (1997) *Basic Concepts for Qualitative Research.* London: Blackwell Science.

Holloway, I., and Todres, L. (2003) 'The status of method: Flexibility, consistency and coherence.' *Qualitative Research,* 3(3) pp. 345–357. doi:10.1177/1468794103033004

Holloway, I., and Todres, L. (2003). The status of method: Flexibility, consistency and coherence. Qualitative Research, 3, 345–357. [Accessed 1st May 2021] doi:10.1177/1468794103033004

Homosonline. (no date) *Syria.* Homosonline. [Online] [Accessed on 11th February 2019] https://homsonline.com/EN/Syria/Syria.htm

Hooberman, J., Rosenfeld, B., Rasmussen, A. and Keller, A. (2010) 'Resilience in trauma-exposed refugees: The moderating effect of coping style on resilience variables.' *American Journal of Orthopsychiatry*, 80(4) pp. 557-563.

Hubbard, B. (2015*) A look at the Army of Conquest, a prominent rebel alliance in Syria*. 1st October. *The New York Times.* [Online] [Accessed on 21st February 2019] https://www.nytimes.com/2015/10/02/world/middleeast/syria-russia-airstrikes-rebels-army-conquest-jaish-al-fatah.html

Hutchings, K. and Weir, D. (2006) 'Guanxi and wasta: A comparison.' *Thunderbird International Business Review*, 48(1) pp. 141-156.

Hutchings, K. and Weir, D. (2006) 'Understanding networking in China and the Arab World: lessons for international managers.' *Journal of European Industrial Training,* 30 (4) pp. 272–290. [Online] [Accessed on 16th August 2020] https://doi.org/10.1108/03090590610673641

Hyland, P., Ceannt, R., Daccache, F., Abou Daher, R., Sleiman, J., Gilmore, B., Byrne, S., Shevlin, M., Murphy, J. and Vallières, F. (2018) 'Are posttraumatic stress disorder (PTSD) and complex-PTSD distinguishable within a treatment-seeking sample of Syrian refugees living in Lebanon?.' *Global Mental Health*, *5* (14) pp. 1-9. [Online] [Accessed 13th October 2020]. doi:10.1017/gmh.2018.2

Hynie, M. (2017) 'The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review.' *Canadian journal of psychiatry,* 63(5) pp. 297-303.

Ibrahim, H. and Hassan, C.Q. (2017) 'Post-traumatic stress disorder symptoms resulting from torture and other traumatic events among Syrian Kurdish refugees in Kurdistan Region, Iraq.' *Frontiers in psychology*, *8*,February, p. 1-8.

Internal Displacement Monitoring Centre. (2020) Global Report on Internal Displacement 2020. Internal Displacement Monitoring Centre. [Online] [Accessed on 10th October 2020] https://www.internal-displacement.org/global-report/grid2020/

International Labour Organization. (2015) *Access to work for Syrian refugees in Jordan: a discussion paper on labour and refugee laws and policies*. International Labour Organization. 30th March. [Online] [Accessed on 28th July 2020] https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/publication/wcms_357950.pdf

Ireton, C. and Posetti, J. (2018) *Journalism, fake news & disinformation: handbook for journalism education and training*. UNESCO Publishing.

Isbouts. J. (2019) Ten Plagues and a Betrayal- How Moses Saved the Hebrew Slaves. National Geographic. (22nd January 2019). [Online] [Accessed on 13th October 2020]. https://www.nationalgeographic.com/culture/people-in-the-bible/moses-plagues-miracles-prophet/

Islam. (2014) *Social Identity Theory.* Springer, New York, NY. [Online] [Accessed on 13th August 2020] https://doi.org/10.1007/978-1-4614-5583-7_289

Javanbakht, A., Amirsadri, A., Suhaiban, H.A., Alsaud, M.I., Alobaidi, Z., Rawi, Z. and Arfken, C.L. (2019) 'Prevalence of possible mental disorders in Syrian refugees resettling in the United States screened at primary care.' *Journal of immigrant and minority health*, 21(3), pp. 664-667.
Jensen, P. S., Arnold, L. E., Swanson, J. M., Vitiello, B., Abikoff, H. B., Greenhill, L. L., Hechtman, L., Hinshaw, S. P., Pelham, W. E., Wells, K. C. and Conners, C. K. (2007) '3-year follow-up of the NIMH MTA study.' *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(8) pp. 989-1002 [Online] [Accessed on 16th August 2020] https://doi.org/10.1097/CHI.0b013e3180686d48

Joly, D. (1996) *Reception and Settlement Policies: A Comparative Study.* In Haven or Hell?. Palgrave Macmillan, London.
https://doi.org/10.1057/9780230373969_4

Joly, D. (2016) *Haven or hell?: asylum policies and refugees in Europe*. Springer.

Jones, E. and Wessely, S. (2001) 'The origins of British military psychiatry before the First World War.' *War & society*, 19(2) pp. 91-108.

Jones, E. and Wessely, S. (2005) '*Shell shock to PTSD: Military psychiatry from 1900 to the Gulf War*.' Psychology Press.

Kane, J. C. and Greene, M. C. (2018) Addressing alcohol and substance use disorders among refugees: a desk review of intervention approaches. Geneva: *United Nations High Commissioner for Refugees.* [Online] [Accessed on 2nd September 2020] https://www.unhcr.org/5c064a8d4.pdf

Kassem, S. (2011) *Rise up and salute the sun: The writings of Suzy Kassem*. Awakened Press.

Kathryn Reid. (2020) *Syrian Refugees Crisis: Facts, FAQs, and How to Help*. World Vision. [online] [accessed on 23rd June 2020] https://libguides.mmu.ac.uk/ld.php?content_id=33171991

Kawakibi, S. (2013) *The Syrian crisis and its repercussions: internally displaced persons and refugees.* Migration Policy Centre (MPC) Research Report, MPC Research Report 2013/03. [Online] [Accessed on 12th December 2018] https://cadmus.eui.eu/bitstream/handle/1814/29453/MPC-RR-2013%2003.pdf?sequence=1

Kenya Human Rights Commission and the National Network for IDPs in Kenya. (2011) 'Out in the cold: the fate of internally displaced persons in Kenya 2008-

2010.'Kenya Human Rights Commission. [online] [Accessed on 2nd June 2018]. http://www.khrc.or.ke/publications/23-gains-and-gaps-a-status-report-on-idps-in-kenya-2008-2010/file.html

Kenya Human Rights Commission. (2011) *Silenced Minds: The Systemic Neglect of the Mental Health System in Kenya.* [online] [Accessed on 10th December 2019] https://www.knchr.org/Portals/0/EcosocReports/THE_%20MENTAL_HEALTH_REPORT.pdf

Kerbage, H., Marranconi, F., Chamoun, Y., Brunet, A., Richa, S. and Zaman, S., (2020) 'Mental health services for Syrian refugees in Lebanon: perceptions and experiences of professionals and refugees.' *Qualitative Health Research*, 30(6), pp. 849-864.

Keyes, E. F. (2000) 'Mental health status in refugees: an integrative review of current research.' *Issues in Mental Health Nursing*, *21*(4) pp. 397-410.

Khalaf, R. and Smith, F. (2013) *Qatar bankrolls Syrian revolt with cash and arms*. 16th May. Financial Times. [Online] [Accessed on 25th March 2019] http://ig-legacy.ft.com/content/86e3f28e-be3a-11e2-bb35-00144feab7de#axzz64VrjAsMb

Khan, M. M. (1998) 'Suicide and attempted suicide in Pakistan.' *Crisis*, 19(4) pp. 172-176. [Online] [Accessed on 11th August 2020] https://doi.org/10.1027/0227-5910.19.4.172.

Khatri, N., Tsang, E.W. and Begley, T.M. (2006) 'Cronyism: A cross-cultural analysis. *Journal of International Business Studies*, 37(1) pp. 61-75

Kheirallah, K. A., Cobb, C. O., Alsulaiman, J. W., Alzoubi, A., Hoetger, C., Kliewer, W. and Mzayek, F. (2019) 'Trauma exposure, mental health and tobacco use among vulnerable Syrian refugee youth in Jordan.' *Journal of Public Health*. *Oxford, England,* 42(3) pp. 343-351. [online] [Accessed on 12th October 2020] https://doi-org.mmu.idm.oclc.org/10.1093/pubmed/fdz128

Khin, N. A., Chen, Y. F., Yang, Y., Yang, P. and Laughren, T. P. (2012) 'Exploratory analyses of efficacy data from schizophrenia trials in support of new drug applications submitted to the US Food and Drug Administration.' *The Journal of clinical psychiatry*, 73(6) pp. 856-864. [Online] [Accessed on 13th August 2020] https://www.psychiatrist.com/JCP/article/Pages/exploratory-analyses-efficacy-data-schizophrenia-trials.aspx

Kim J., Suh W., Kim S., Gopalan H. (2012) 'Coping strategies to manage acculturative stress: Meaningful activity participation, social support, and positive emotion among Korean immigrant adolescents in the USA'. *International Journal of Qualitative Studies on Health and Well-being*, 7(1) pp. 1-11 [Online] [Accessed on 11th August 2020] https://doi.org/10.3402/qhw.v7i0.18870

King, N. (2004) 'Using templates in the thematic analysis of text.' In C. Cassell & G. Symon (Ed), *Essential guide to qualitative methods in organizational research.* London, UK*. Sage*

KingHussaien. Gov. Jo. (No date) *Biographical Information: Muhmmed, the Messenger of God.* KingHussaien. Gov. Jo. [online] [Accessed 13th October 2020]. http://www.kinghussein.gov.jo/prophet_muhammad.html

Kira, I. A., Alawneh, A. W. N., Aboumediene, S., Lewandowski, L. and Laddis, A. (2014) 'Dynamics of oppression and coping from traumatology perspective: The example of Palestinian adolescents.' *Peace and Conflict: Journal of Peace Psychology*, 20(4) pp.385.

Kiselev, N., Pfaltz, M., Haas, F., Schick, M., Kappen, M., Sijbrandij, M., De Graaff, A.M., Bird, M., Hansen, P., Ventevogel, P., Fuhr, D.C., Schnyder, U. and Morina, N. (2020) 'Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland,' *European journal of psychotraumatology,* 11 (1) pp. 1-17.

Kleinman, A. (1980) *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press

Knifton, L. (2012) 'Understanding and addressing the stigma of mental illness with ethnic minority communities.' *Health Sociology Review*, *21*(3) pp. 287-298. [Online] [Accessed on 6th October 2020]. https://doi.org/10.5172/hesr.2012.21.3.287

Koch T. (1994) Establishing rigour in qualitative research: the
Koch T. (1994) Establishing rigour in qualitative research: the
Koch, T. (1994) 'Establishing rigour in qualitative research: the decision trail.' *Journal of advanced nursing*, *19*(5) pp. 976-986

Koch, T. (1994) 'Establishing rigour in qualitative research: the decision trail.' *Journal of advanced nursing*, 19(5) pp. 976-986. [Online] [Accessed on 11th September 2020] https://doi.org/10.1111/j.1365-2648.1994.tb01177.x

Kostaras, P., Bergiannaki, J.D., Psarros, C., Ploumbidis, D. and Papageorgiou, C. (2017) 'Posttraumatic stress disorder in outpatients with depression: Still a missed diagnosis.' *Journal of Trauma & Dissociation*, 18(2) pp.233-247

Kulwicki, A. and Ballout, S. (2015) '*Post Traumatic Stress Disorder (PTSD) in Arab American refugee and recent immigrant women.*' 22(10) pp. 9-12.

Kvale, S. and Brinkmann, S. (2009) *Interviews: Learning the craft of qualitative research interviewing*. Sage.

Kwan, J., Jones, M., Somaini, G., Hull, L., Wessely, S., Fear, N.T. and MacManus, D. (2018) 'Post-deployment family violence among UK military personnel,' *Psychological medicine,* 48 (13) pp. 2202-2212.

Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, B. A. and De Jong, J. T., (2004) 'Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands.' *The Journal of nervous and mental disease*, 192(12) pp. 843-851.

Lea, D. and Rowe, A. (2001) *A political chronology of the Middle East*. Psychology Press.

Leaman, S. C. and Gee, C. B. (2012) 'Religious coping and risk factors for psychological distress among African torture survivors.' *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(5) p. 457-465.

Lee, Y. J. G., Jun, J. Y., Lee, Y. J., Park, J., Kim, S., Lee, S. H., Yu, S. Y. and Kim, S. J. (016) 'Insomnia in North Korean refugees: association with depression and post-traumatic stress symptoms. *Psychiatry investigation*, 13(1) p. 73-67.

Leff, J. and Warner, R. (2006) *Social inclusion of people with mental illness*. Cambridge University Press. [Online] [Accessed on 22nd August 2020] https://doi.org/10.1017/CBO9780511543937

Legislation. Gov. (no date) Data Protection Act 2018. *Legislation. Gov.* [Online] [Accessed on 5th March 2018] https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Lester, D. (2006) 'Suicide and Islam.' *Archives of suicide research.* 10(1) pp. 77-97. [Online] [Accessed on 11th August 2020] doi/full/10.1080/13811110500318489

Levav, I., Greenfeld, H. and Baruch, E. (1979) 'Psychiatric combat reactions during the Yom Kippur War.' *The American journal of psychiatry*. 136(5) pp. 637–641 [Online] [Accessed on 11th August 2019] https://doi.org/10.1176/ajp.136.5.637

Li, S. S., Liddell, B. J. and Nickerson, A. (2016) 'The relationship between post-migration stress and psychological disorders in refugees and asylum seekers.' *Current psychiatry reports*, *18*(9) pp. 1-9

Lichtman, M. (2017) *Qualitative research for the social sciences,* London. SAGE Publications Ltd.

Lim, A., Hoek, H.W., Ghane, S., Deen, M. and Blom, J.D. (2018) 'The Attribution of Mental Health Problems to Jinn: An Explorative Study in a Transcultural Psychiatric Outpatient Clinic.' *Frontiers in psychiatry,* 9(89) pp. 89-89.[Online] [Accessed on 30th September 2020] DOI https://doi.org/10.3389/fpsyt.2018.00089

Lincoln, YS. and Guba, EG. (1985) *Naturalistic Inquiry.* Newbury Park, CA: Sage Publications.

Link, B.G. and Phelan, J.C. (2013) *Labeling and stigma*. In Handbook of the sociology of mental health. Springer, Dordrecht.

Loewe, M., Blume, J. and Speer, J. (2008) 'How Favoritism Affects the Business Climate: Empirical Evidence from Jordan.' *The Middle East Journal,* 62 (2) pp. 259-276. [Online] [Accessed on 15th August 2020] https://doi.org/10.3751/62.2.14

Lopez, G. I., Figueroa, M., Connor, S. E. and Maliski, S. L. (2008) 'Translation barriers in conducting qualitative research with Spanish speakers.' *Qualitative health research*, 18(12) pp. 1729-1737. [Online] [accessed 13th October 2020]. https://doi.org/10.1177/1049732308325857

Luitel, N. P., Jordans, M. J., Sapkota, R. P., Tol, W. A., Kohrt, B. A., Thapa, S. B., Komproe, I. H. and Sharma, B. (2013) 'Conflict and mental health: a cross-sectional epidemiological study in Nepal. *Social psychiatry and psychiatric,* 48, July, pp. 183-193.

Maguire, M. and Delahunt, B. (2017) 'Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars.' *All Ireland Journal of Higher Education*, 9(3) pp. 3351-3514

Malterud, K. (2001) 'Qualitative research: standards, challenges, and guidelines.' *The lancet*, 358(9280) pp. 483-488. [Online] [Accessed on 17th September 2020] https://doi.org/10.1016/S0140-6736(01)05627-6

Manna, H. (2012) *Syria's opposition has been led astray by violence*. 22nd January. The Guardian. [Online] [Accessed on 25th March 2019] https://www.theguardian.com/commentisfree/2012/jun/22/syria-opposition-led-astray-by-violence

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M. and Chun, C. A. (2005) 'Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Jama*, 294(5) pp. 571-579

Mayo Clinic Organization. (2019) Stress symptoms: Effects on your body and behaviour. *Mayo Clinic Organization*. [Online] [Accessed on 10th September 2020] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/stress-symptoms/art-20050987

McKee-Ryan, F., Song, Z., Wanberg, R.C. and Kinicki, A.J. (2005) 'Psychological and physical wellbeing during unemployment: a meta-analytic study.' Journal of Applied Psychology, 90(1) pp. 53–76.

McKernan, B. (2018) *Syria Conflict: 34% rise in civilian death caused by Russians airstrikes, report finds.* 25th July. *The Independent*. [online] [Accessed on 27th February 2019] https://www.independent.co.uk/news/world/middle-east/syria-rise-civilian-deaths-russian-bombing-a8463776.html

McLaughlin, K. (2020) *The changing nature of stigma in the 21st century*. The Routledge International Handbook of Global Therapeutic Cultures.

McInnis, k. (2016) *Coalition Contributions to Countering the Islamic State.* Congressional Research Service. [online] [Accessed on 29th March 2019] https://fas.org/sgp/crs/natsec/R44135.pdf

Megheirkouni, M. (2016) 'Factors influencing leadership development in an uncertain environment.' *Journal of Management Development*, 35(10) pp. 1232–1254. doi:10.1108/JMD-07-2016-0128

Megheirkouni, M. and Weir, D. (2019) 'Insights into informal practices of sport leadership in the middle east: the impact of positive and negative wasta.' *International journal of sport policy and politics,* 11(4) pp. 639-656.

Mental Health Foundation. (2016) *Refugees, Mental health and Stigma in Scotland*. August 2016. [online] [accessed on 13 August 20200]. https://www.mentalhealth.org.uk/sites/default/files/Anti-stigma%20briefing.pdf

Merriam, S. B. (1998) '*Qualitative Research and Case Study Applications in Education. Revised and Expanded from" Case Study Research in Education."*.' Jossey-Bass Publishers, 350 Sansome St, San Francisco, CA 94104.

Michaels, J. and Bacon, J. (2015) *Jordan executes two in response to pilot's slaying*. USA Today News. [online] [Accessed on 27th March 2019] https://eu.usatoday.com/story/news/world/2015/02/03/islamic-state-jordanian-pilot/22798055/

Miller, A., Hess, J. M., Bybee, D. and Goodkind, J. R. (2018) 'Understanding the Mental Health Consequences of Family Separation for Refugees: Implications for Policy and Practice.' *American journal of orthopsychiatry,* 88(1) pp. 26-37.

Miller, K. E. and Rasmussen, A. (2010) 'War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks.' *Social science & medicine*, 70(1), pp. 7-16.

Miller, K. E. and Rasmussen, A. (2017) The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and psychiatric sciences*, 26(2) pp. 129-138.

Mind Organization. (2017) Post-traumatic stress disorder (PTSD). *Mind Organization.* [Online] [Accessed on 2nd June 2020] https://www.mind.org.uk/information-support/types-of-mental-health-problems/post-traumatic-stress-disorder-ptsd/symptoms-of-ptsd/#WhatAreFlashbacks

Ministry of Labour. (2020) *Syrian Refugee Unit Work Permit Progress Report December 2019*. Relief Web. [Online] [Accessed on 13th July 2020] https://reliefweb.int/sites/reliefweb.int/files/resources/73629.pdf

Misco, T. (2007) 'The frustrations of reader generalizability and grounded theory: Alternative considerations for transferability.' *Journal of Research Practice*, 3(1) pp. 10-10. [Online] [Accessed on 29th June 2020] https://files.eric.ed.gov/fulltext/EJ800358.pdf

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., and Lavelle, J. (1992) 'The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees.' *Journal of Nervous and Mental Disease, 180*(2), 111–116. [Online] [Accessed 28th September 2019]. doi.org/10.1097/00005053-199202000-00008

Mollica, R. F., Poole, C., Son, L., Murray, C. C. and Tor, S. (1997) 'Effects of war trauma on Cambodian refugee adolescents' functional health and mental health

status.' *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(8), pp.1098-1106.

Momartin, S., Silove, D., Manicavasagar, V. and Steel, Z. (2004) 'Complicated grief in Bosnian refugees: Associations with posttraumatic stress disorder and depression.' *Comprehensive psychiatry*, *45*(6), pp. 475-482.

Moncrieff, J., Wessely, S. and Hardy, R. (2004) 'Active placebos versus antidepressants for depression.' *Cochrane database of systematic reviews,* (1) January, pp. 1-23. [Online] [Accessed on 20th August 2020] https://doi.org/10.1002/14651858.CD003012.pub2

Morasco, B. J., Lovejoy, T. I., Lu, M., Turk, D. C., Lewis, L. and Dobscha, S. K. (2013) 'The relationship between PTSD and chronic pain: mediating role of coping strategies and depression.' *Pain*, *154*(4) pp. 609-616.

Morse, J. M. (1999) *Silent debates in qualitative inquiry*. Sage Publications, Inc.

Morse, J. M. and Johnson, J. L. (1991) *The illness experience.* Newbury Park. Sage.

Muhtz, C., Wittekind, C., Godemann, K., Von Alm, C., Jelinek, L., Yassouridis, A. and Kellner, M. (2016) 'Mental health in offspring of traumatized refugees with and without post-traumatic stress disorder. *Stress and Health*, *32*(4) pp. 367-373.

Murakami, N. and Schechter, A. (2016) 'Healthcare-based human rights monitoring in the acutely displaced: lessons from a community hospital by the eastern Democratic Republic of the Congo'. *Annals of global health,* 82(3) pp. 397-436.

Murshidi, M.M. (2016) 'Syrian refugees constitute 20% of Jordan's population.' *American journal of public health*, 106(5), pp. 18.

Musisi, S. (2004) 'Mass trauma and mental health in Africa.' *African Health Sciences*, 4(2), pp.80-82.

Musisi, S. and Kinyanda, E. (2020) 'Long-Term Impact of War, Civil War, and Persecution in Civilian Populations-Conflict and Post-Traumatic Stress in African Communities.' Frontiers *in psychiatry,* 11, Ferbruary, pp. 20-20. [Online] [Accessed on 4th September 2020] doi: 10.3389/fpsyt.2020.00020

Naja, W. J., Aoun, M. P., El Khoury, E. L., Abdallah, F. J. B. and Haddad, R. S. (2016) 'Prevalence of depression in Syrian refugees and the influence of religiosity.' *Comprehensive psychiatry*, *68*(July) pp. 78-85. [online] [accessed on 17th July 2019]. doi: 10.1016/j.comppsych.2016.04.002

Nasir, L. S. and Al-Qutob, R. (2005) 'Barriers to the diagnosis and treatment of depression in Jordan. A nationwide qualitative study.' *The Journal of the American Board of Family Practice*, *18*(2), pp. 125-131.
Nasıroğlu, S. and Çeri, V. (2016) 'Posttraumatic stress and depression in Yazidi refugees.' *Neuropsychiatric disease and treatment*, 2016(12) pp. 2941-2948

Nickerson, A., Byrow, Y., O'Donnell, M., Mau, V., McMahon, T., Pajak, R., Li, S., Hamilton, A., Minihan, S., Liu, C. and Bryant, R.A. (2019) 'The association between visa insecurity and mental health, disability and social engagement in refugees living in Australia.' *European journal of psychotraumatology*, 10, December, pp. 1-15.

Nordin, L. and Perrin, S. (2019) 'Pain and posttraumatic stress disorder in refugees who survived torture: The role of pain catastrophizing and trauma-related beliefs.' *European journal of pain*, 23(8) pp. 1497-1506. [online] [Accessed on 15th June 2020] DOI: 10.1002/ejp.1415

Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., Priebe, S. and Barbui, C. (2017) 'Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis.' *PloS one*, 7(12), pp. 251-264 [Online] [Accessed on 4th June 2019] https://doi.org/10.1177/2045125317721662

Nyboe, L., Bentholm, A. and Gyllensten, A.L. (2017) 'Bodily symptoms in patients with post-traumatic stress disorder: A comparative study of traumatized refugees, Danish war veterans, and healthy controls.' *Journal of bodywork and movement therapies*, 21(3) pp. 523-527.

Nygaard, M., Sonne, C. and Carlsson, J. (2017) Secondary psychotic features in refugees diagnosed with post-traumatic stress disorder: a retrospective cohort study. *BMC psychiatry*, *17*(1), pp. 1-11.

Ochieng, P. A. (2009) 'An analysis of the strengths and limitation of qualitative and quantitative research paradigms.' *Problems of Education in the 21st Century*, *13*, p.13-18.

Odenat, L. (2012) *Means of Survival as Moderator of the Relationship between Cumulative Torture Experiences and Posttraumatic Stress Disorder among Refugees*. Ph.D. Georgia State University. [Online] [Accessed on 26th July 2020]. https://scholarworks.gsu.edu/cgi/viewcontent.cgi?article=1090&context=cps_diss

O'Hara, P. and Neutel, C. I. (2002) 'Maintaining confidentiality in research data.' *Pharmacoepidemiology and drug safety*, 11(1), pp. 75-78. [Online] [Accessed on 15th February 2019] https://onlinelibrary.wiley.com/doi/abs/10.1002/pds.680

Oliver, D. G., Serovich, J. M. and Mason, T. L. (2005) 'Constraints and opportunities with interview transcription: Towards reflection in qualitative research.' *Social forces*, 84(2), pp. 1273-1289. [Online] [Accessed on 22nd October 2020] https://doi.org/10.1353/sof.2006.0023

Onwuegbuzie, A. J. and Leech, N. L. (2006) 'Linking research questions to mixed methods data analysis procedures.' *The qualitative report*, 11(3), pp. 474-498

Orozobekova, C. (2016) Russia loses seat in the UN human rights Council. 31st October. The Diplomat. [Online] [Accessed on 26th February 2019]

https://thediplomat.com/2016/10/russia-loses-seat-at-the-un-human-rights-council/

Oxford English Dictionary (2nd ed.). (1989) *C. Soanes & A. Stevenson.* (2nd Ed). Oxford University Press.

Ozer, E. J., Best, S. R., Lipsey, T. L. and Weiss, D. S. (2003) 'Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological bulletin*, 129(1), pp.52-73.

Panter-Brick, C., Hadfield, K., Dajani, R., Eggerman, M., Ager, A. and Ungar, M. (2018) 'Resilience in Context: A Brief and Culturally Grounded Measure for Syrian Refugee and Jordanian Host-Community Adolescents,' *Child development,* 89(5) pp. 1803-1820.

Patton, M. Q. (1990) *Qualitative evaluation and research methods*. SAGE Publications, inc.

Patton, MQ. (2001) *Qualitative Evaluation and Research Methods.* (2nd Ed). Thousand oaks, CA: Sage Publications.

Peel, E., Parry, O., Douglas, M. and Lawton, J. (2006) '"It's no skin off my nose": why people take part in qualitative research.' *Qualitative Health Research*, *16*(10), pp.1335-1349. [Online] [Accessed on 20th February 2019] https://doi.org/10.1177/1049732306294511

Percy, W. H., Kostere, K. and Kostere, S. (2015) Generic qualitative research in psychology. *The qualitative report*, *20*(2), pp.76-85.

Plotner, C. (2014) '*If Israel accepted Syrian refugees and IDPs in the Golan Heights*.' Forced Migration Review, pp. 33-34. [Online] [Accessed on 20th July 2020] https://www.fmreview.org/sites/fmr/files/FMRdownloads/en/syria/plotner.pdf

Polit, D.F. and Beck, C.T. (2010) 'Generalization in quantitative and qualitative research: Myths and strategies.' *International journal of nursing studies*, 47(11), pp.1451-1458. [Online] [Accessed on 11th September 2020] https://doi.org/10.1016/j.ijnurstu.2010.06.004

Popay, J., Rogers, A. and Williams, G. (1998) 'Rationale and standards for the systematic review of qualitative literature in health services research.' *Qualitative health research*, 8(3), pp. 341-351.

Porter, M. and Haslam, N., (2005) 'Predisplacement and Postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis.' *Jama*, 294(5) pp. 602-612.

Prugsamatz, R. (2010) 'Factors that influence organization learning sustainability in non-profit organizations.' *The Learning Organization*, 17(3) pp. 243-267 https://doi.org/10.1108/09696471011034937

Pynoos, R. S., Goenjian, A., Tashjian, M., Karakashian, M., Manjikian, R., Manoukian, G., Steinberg, A. M. and Fairbanks, L. A. (1993) Post-traumatic stress reactions in children after the 1988 Armenian earthquake. *The British Journal of Psychiatry*, 163(2), pp. 239-247.

Raghavan, S., Rasmussen, A., Rosenfeld, B. and Keller, A.S. (2013) 'Correlates of symptom reduction in treatment-seeking survivors of torture.' *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(4), pp. 377-383 https://doi.org/10.1037/a0028118

RAND Health Care. (No Date) 36-Item Short Form Survey (SF-36). [Online] [Accessed 14th April 2018]. https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form.html

Refugee Action. (no date) *Facts About Refugees, Claiming Asylum is a Human Right.* [Online] [Accessed on 19th September 2020). https://www.refugee-action.org.uk/about/facts-about-refugees/

Reitmanova, S. and Gustafson, D. L. (2009) 'Primary mental health care information and services for St. John's visible minority immigrants: Gaps and opportunities.' Issues Ment. Health Nurs. 30(10) pp. 615–623 10.1080/01612840903033733

Renner, A., Hoffmann, R., Nagl, M., Roehr, S., Jung, F., Grochtdreis, T., König, H., Riedel-Heller, S. and Kersting, A. (2020) 'Syrian refugees in Germany: Perspectives on mental health and coping strategies.' *Journal of psychosomatic research,* 129, February, pp. 1-9.

Research Process. London: Sage.

Reyes, H. (2007) 'The worst scars are in the mind: psychological torture.' *International review of the Red Cross (2005),* 89(867) pp. 591-617.

Richards, K. (2003) Qualitative Inquiry in TESOL. Basingstoke: Palgrave Macmillan.

Richters, J.E. and Saltzman, W. (1990) 'Survey of exposure to community violence: Self-report version.' *JE Richters.*

Rizkalla, N. and Segal, S. P. (2018) 'Well-Being and Posttraumatic Growth Among Syrian Refugees in Jordan.' *Journal of traumatic stress,* 31(2) pp. 213-222.

Robert Wood Johnson Foundation. (2008) Lincoln and Guba's Evaluative Criteria. *Robert Wood Johnson Foundation*. [Online] [Accessed on 11th August 2020] http://www.qualres.org/HomeLinc-3684.html

Robinson, V. (1998) 'The importance of information in the resettlement of refugees in the UK.' *Journal of Refugee Studies*, 11(2), pp. 146-160. [Online] [Accessed 20th July 2020] https://doi.org/10.1093/jrs/11.2.146

Robjant, K., Hassan, R. and Katona, C. (2009) Mental health implications of detaining asylum seekers: systematic review. *The British journal of psychiatry*, 194(4), pp. 306-312.

Rousseau, C., Hassan, G., Moreau, N. and Thombs, B.D. (2011) Perceived discrimination and its association with psychological distress among newly arrived immigrants before and after September 11, 2001. *American journal of public health*, 101(5), pp. 909-915.

Ruiz-Párraga, G.T. and López-Martínez, A.E. (2014) 'The contribution of posttraumatic stress symptoms to chronic pain adjustment.' *Health Psychology*, 33(9) p. 958-967.

Rustemli, A., Mertan, B. and Ciftci, O. (2000) 'In-group favouritism among native and immigrant Turkish Cypriots: Trait evaluations of in-group and out-group targets.' *The Journal of Social Psychology*, 140(1), pp. 26-34. [Online] [Accessed on 15th August 2020] https://doi.org/10.1080/00224540009600443

Sagaltici, E., Alpak, G. and Altindag, A. (2020) 'Traumatic life events and severity of posttraumatic stress disorder among Syrian refugees residing in a camp in Turkey.' *Journal of loss and trauma*, 25(1), pp.47-60.

Salazar, M., West, B., Raj, A., Torreblanca, M. and Reed, E. (2016) 'Contraceptive use and risk perceptions for STI and unintended pregnancy among adolescent females in San Diego County at the US-Mexico Border.' *Annals of Global Health*, 82(3), pp.434.

Saleh, A., Aydin, S. and Koçak, O. (2018). A comparative study of Syrian refugees in Turkey, Lebanon, and Jordan: healthcare access and delivery. OPUS Uluslararası Toplum Araştırmaları Dergisi, 8(14) pp.448-464.

Sandahl, H., Vindbjerg, E. and Carlsson, J. (2017) 'Treatment of sleep disturbances in refugees suffering from post-traumatic stress disorder.' *Transcultural Psychiatry*, *54*(5-6), pp. 806-823.

Sandelowski, M. (1993) 'Rigor or rigor mortis: the problem of rigor in qualitative research.' *Advances in nursing science*, 16(2), pp .1-8.

Sandelowski, M. (1993) 'Rigor or rigor mortis: The problem of rigor in qualitative research revisited.' *Advances in Nursing Science*. 16(2) pp1-8.

Sands, P. and Maayeh, S. (2013) *Syrian rebels get arms and advice through secret command centre in Amman*. 28th December. The National News. [Online] [Accessed on 1st April 2019] https://www.thenational.ae/world/syrian-rebels-get-arms-and-advice-through-secret-command-centre-in-amman-1.455590

Sayce, L. (2000) *From psychiatric patient to citizen: Overcoming discrimination and social exclusion.* St Martin's Press

Sayed. F. (2015) A few surprising facts about the Arabic language. British Council. [Accessed on 10th May 2021] https://www.britishcouncil.org/voices-magazine/surprising-facts-about-arabic-language

Schon, J. (2018) 'Motivation and opportunity for conflict-induced migration: An analysis of Syrian migration timing.' *Journal of Peace Research*, 56(1), pp. 12-27. [Online] [Accessed on 21st July 2020] https://doi.org/10.1177/0022343318806044

Schubert, C. C. and Punamäki, R. L. (2011) ‘Mental health among torture survivors: cultural background, refugee status and gender.’ *Nordic journal of psychiatry*, 65(3), pp. 175-182

Schutz, K., Leshner, A., Foy, D. and Kelly, C. (2012) *Retraumatization*. Encyclopaedia of trauma: an interdisciplinary guide. SAGE Publications, Inc.

Schwarz, R. (2008) ‘The political economy of state-formation in the Arab Middle East: Rentier states, economic reform, and democratization’. *Review of International Political Economy,* 15(4) pp. 599-621. [Online] [Accessed on 13th August 2020] https://doi.org/10.1080/09692290802260662

Segal, D. L. (2010) Diagnostic and statistical manual of mental disorders (DSM-IV-TR). *The Corsini Encyclopedia of Psychology*, pp. 1-3.

Şeker, B. D., and Sirkeci, I. (2015) ‘Challenges for Refugee Children at School in Eastern Turkey.’ *Economics & Sociology*, 8(4) pp. 122–133 [Online] [Accessed on 5th June 2018] https://doi.org/10.14254/2071-789X.2015/8-4/

Sexual Violence Research Initiative. (no date) Hospital Anxiety and Depression Scale (HADS). *SVRI.* [Online] [Accessed on 24th November 2020] https://www.svri.org/sites/default/files/attachments/2016-01-13/HADS.pdf

Shannon, P. J., Vinson, G. A., Wieling, E., Cook, T. and Letts, J. (2015) ‘Torture, war trauma, and mental health symptoms of newly arrived Karen refugees. *Journal of Loss and Trauma*, 20(6), pp. 577-590.

Sheehan, D. V., and Lecrubier, Y. (1997) Mini-International Neuropsychiatric Interview (MINI). *Mapi Research Trust.* [Online] [Accessed on 3rd May 2019] https://eprovide.mapi-trust.org/instruments/mini-international-neuropsychiatric-interview

Shin, Y. A., Yeo, J. and Jung, K. (2018) ‘The Effectiveness of International Non-Governmental Organizations’ Response Operations during Public Health Emergency: Lessons Learned from the 2014 Ebola Outbreak in Sierra Leone.’ *International journal of environmental research and public health*, 15(4), p. 1-13 [Online] [Accessed on 13th October 2020]. https://doi.org/10.3390/ijerph15040650

Shinnar, R. S. (2008) ‘Coping with negative social identity: The case of Mexican immigrants.’ *The Journal of Social Psychology*, 148(5), pp. 553-576. [Online] [Accessed on 10th August 2020] https://doi.org/10.3200/SOCP.148.5.553-576

Short, K.H. and Johnston, C. (1997) ‘Stress, maternal distress, and children’s adjustment following immigration: The buffering role of social support.’ J. Consult. Clin. Psychol. 65(3) pp. 494–503.
Shulman, D. (2005) *Labelling Theory*. Encyclopaedia of Social Theory. SAGE Publications, Inc. [Online] [Accessed on 22nd August 2020] DOI: http://dx.doi.org/10.4135/9781412952552.n161

Sifaki-Pistolla, D., Chatzea, V.E., Vlachaki, S.A., Melidoniotis, E. and Pistolla, G. (2017) 'Who is going to rescue the rescuers? Post-traumatic stress disorder among rescue workers operating in Greece during the European refugee crisis.' *Social psychiatry and psychiatric epidemiology*, 52(1) pp. 45-54. [Online] [Accessed on 5th June 2019]. doi.org/10.1007/s00127-016-1302-8

Silove, D., Tay, A.K., Kareth, M. and Rees, S. (2017) 'The relationship of complex post-traumatic stress disorder and post-traumatic stress disorder in a culturally distinct, conflict-affected population: A study among West Papuan refugees displaced to Papua New Guinea.' *Frontiers in psychiatry*, 8(73) pp. 1-9 [Online] [Accessed on 1st July 2019]. doi.org/10.3389/fpsyt.2017.00073

Smeekes, A., Verkuyten, M., Çelebi, E., Acartürk, C. and Onkun, S. (2017) 'Social identity continuity and mental health among Syrian refugees in Turkey'. *Social psychiatry and psychiatric epidemiology,* 52(10) pp. 1317-1324.

Snape, D., and Spencer, L. (2003) The foundations of qualitative research In J. Richie & J. Lewis (Eds.), Qualitative Research Practice (pp. 1-23). Los Angeles: Sage.

Song, S. J., Kaplan, C., Tol, W. A., Subica, A. and de Jong, J. (2015) 'Psychological distress in torture survivors: pre-and post-migration risk factors in a US sample.' *Social psychiatry and psychiatric epidemiology*, 50(4), pp. 549-560.

Soykoek, S., Mall, V., Nehring, I., Henningsen, P. and Aberl, S. (2017) 'Post-traumatic stress disorder in Syrian children of a German refugee camp.' *The Lancet*, 389(10072) pp. 903-90. [Online] [Accessed on 3rd June 2019]. DOI: https://doi.org/10.1016/S0140-6736(17)30595-0

Srinivasan, S. (1994) An overview of research into refugee groups in Britain during the 1990s, paper presented at the fourth International Research and Advisory Panel Conference. Oxford.

Startfor. (2017) *Russia looks for an exit in Syrian*. 4th January. World View. [Online] [Accessed on 25th March 2019] https://worldview.stratfor.com/article/russia-looks-exit-syria

Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A. and Van Ommeren, M. (2009) 'Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis.' *Jama*, 302(5), pp. 537-549.

Stevens, J., Ressler, K. and Jovanovic, T. (2018) 'T22. PTSD Symptom Profiles and Amygdala Function Vary as a Function of Repeated Trauma Exposure: Numbing as a Specific Neurobiological Phenotype.' *Biological Psychiatry*, 83(9), p. S137. [Online] [Accessed on 29th November 2020] doi.org/10.1016/j.biopsych.2018.02.358

Strandh, M., Hammarström, A., Nilsson, K., Nordenmark, M. and Russel, H. (2013) 'Unemployment, Gender and Mental Health: The Role of the Gender

Regime.' *Sociology of Health & Illness*, 35(5), pp. 649-665 [Online] [Accessed on 8th October 2020] https://doi.org/10.1111/j.1467-9566.2012.01517.x

Strauss, A. and Corbin, J. (1990) *Basics of qualitative research.* Sage publications.

Streubert H. J. and Carpenter D. R. (1999) *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. Lippincott, Williams & Wilkins, Philadelphia.

Syam, H., Venables, E., Sousse, B., Severy, N., Saavedra, L. and Kazour, F. (2019) 'With every passing day I feel like a candle, melting little by little.' 'experiences of long-term displacement amongst Syrian refugees in Shatila, Lebanon'. *Conflict and health,* 13(1) pp. 1-12.

Syrian Observatory for Human Rights. (2018) *Syria: 560,000 killed in seven yrs of war, SOHR.* 12th December. [Online] [Accessed on 20th February 2019] https://www.syriahr.com/en/108829/

Tabur, S., Tufan, A. E., Çeri, V. and Semerci, B. (2019) 'Syrian Civil War's effects on Turkish school children: prevalence and predictors of psychopathology.' *Psychiatry and Clinical Psychopharmacology*, 29(4) pp. 811-816.

Taher, R. and Allan, T. (2020) 'Posttraumatic Growth in Displaced Syrians in the UK: A Mixed-Methods Approach.' *Journal of Loss and Trauma*, 25(4) pp. 333-347. [Online] [Accessed on 3rd June 2019]. doi.org/10.1080/15325024.2019.1688022

Tajifel H., Turner J. C. Worchel S., Austin W. (1986) The social identity theory of intergroup behaviour. The psychology of intergroup relations. (2nd Ed), Chicago, IL: *Nelson-Hall*. 7–24.

Tashakkori, A., Teddlie, C. and Teddlie, C. B. (1998) *Mixed Methodology: Combining Qualitative and Quantitative Approaches: 46 (Applied Social Research Methods).* Sage Publication Inc.

Tay, A. K., Rees, S., Chen, J., Kareth, M. and Silove, D. (2015) 'The structure of post-traumatic stress disorder and complex post-traumatic stress disorder amongst West Papuan refugees.' *BMC psychiatry*, *15*(1), pp. 1-17.

Tedeschi, R. G., and Calhoun, L. G. (1995) *Trauma and transformation: Growing in the aftermath of suffering*. United States: Sage. [Online] [Accessed on 11th October 2019]/ doi.org/10.4135/9781483326931.

The International Trauma Consortium. (no date) International Trauma Questionnaire. *The International Trauma Consortium.* [Online] [Accessed on 24th November 2020] https://www.traumameasuresglobal.com/itq

The World Bank. (2012) FAQs about development. The World Bank. [Online] [Accessed 14th April 2019]

http://web.worldbank.org/WBSITE/EXTERNAL/EXTSITETOOLS/0,,contentMDK:20147486~menuPK:344190~pagePK:98400~piPK:98424~theSitePK:95474,00.html

The World Bank. (2018) Refugees crisis. *The World Bank*. [Online] [Accessed on 11th April 2020] https://blogs.worldbank.org/taxonomy/term/14528

Thompson, C.T., Vidgen, A. and Roberts, N.P. (2018) 'Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis.' *Clinical Psychology Review*, 63, July, pp. 66-79.

Tinghög, P., Al-Saffar, S., Carstensen, J. and Nordenfelt, L. (2010) 'The association of immigrant-and non-immigrant-specific factors with mental ill health among immigrants in Sweden. *International Journal of Social Psychiatry*, 56(1), pp. 74-93

Tinghög, P., Malm, A., Arwidson, C., Sigvardsdotter, E., Lundin, A. and Saboonchi, F. (2017) 'Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: a population-based survey.' *BMJ open*, 7(12), pp.e018899

Tlaiss, H., and Kauser, S. (2011) 'The importance of wasta in the career success of Middle Eastern managers.' *Journal of European Industrial Training,* 35(5) pp. 467–486

Tobin, G. A. and Begley, C. M. (2004) 'Methodological rigour within a qualitative framework.' *Journal of advanced nursing*, 48(4), pp. 388-396 [Online] [Accessed on 30 September 2020] https://doi.org/10.1111/j.1365-2648.2004.03207.x

Treisman, D. (2000) 'The causes of corruption: a cross' national study'. *Journal of Public Economics* 76(3) pp. 399-457 {Online] [Accessed on 14th August 2020] https://doi.org/10.1016/S0047-2727(99)00092-4

Tsai, J. H. C., Choe, J. H., Lim, J. M. C., Acorda, E., Chan, N. L., Taylor, V. and Tu, S. P. (2004) 'Developing culturally competent health knowledge: Issues of data analysis of cross-cultural, cross-language qualitative research.' *International Journal of Qualitative Methods*, 3(4) pp. 16-27.

Tuckett, A.G. (2004) 'Qualitative research sampling: the very real complexities.' *Nurse researcher*, 12(1), pp. 47-61.

Tufan, A. E., Alkin, M. and Bosgelmez, S. (2013) 'Post-traumatic stress disorder among asylum seekers and refugees in Istanbul may be predicted by torture and loss due to violence.' *Nordic journal of psychiatry*, 67(3) pp. 219-224.

Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G. and Barbui, C. (2017) 'Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies.' *International journal of mental health systems*, 11(1) p. 51.

Twinn, D. S. (1998) ‘An analysis of the effectiveness of focus groups as a method of qualitative data collection with Chinese populations in nursing research.’ *Journal of advanced nursing, 28(*3) pp. 654-661

Twinn, S. (1997) ‘An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research.’ *Journal of advanced nursing*, 26(2), pp. 418-423

U.S. Department of Veterans Affairs. (2020) PTSD Checklist for DSM-5 (PCL-5). *U.S. Department of Veterans Affairs.* [Online] [Accessed on 10th November 2020] https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

U.S. Dept of Defense. (2018) *5 Thing to know about the fight against ISIS in Syria.* 20th December. *U.S. Dept of Defense. [*Online] [Accessed on 3rd March 2019]. https://www.defense.gov/explore/story/Article/1718356/5-things-to-know-about-the-fight-against-isis-in-syria/

Ugurlu, N., Akca, L. and Acarturk, C. (2016) ‘An art therapy intervention for symptoms of post-traumatic stress, depression and anxiety among Syrian refugee children.’ *Vulnerable children and youth studies*, 11(2) pp. 89-102.

UN General Assembly. (1951) ‘*Convention Relating to the Status of Refugees*, 28 July 1951’, United Nations, Treaty Series, 189 p. 137, [Online] [Accessed on 24th January 2019] https://www.refworld.org/docid/3be01b964.html

UNHCR the UN Refugee Agency. (2013) *Syrian Refugees: Crossing The Border To Jordan.* [Online] [Accessed on 27th July 2020] https://www.youtube.com/watch?v=Z0SgBM2yMtY

UNHCR. (2019) Global Trends, Forced Displacement in 2018. United Nation High Commissioner of Refugees. [Online] [Accessed on 25th May 2020]. https://www.unhcr.org/globaltrends2018/#:~:text=Asylum%2Dseekers%20submitted%201.7%20million,)%20and%20Turkey%20(83%2C800).

UNHCR. (2019). Syria Regional Refugee Response. *United Nations High Commissioner for Refugees.* [Online] [Accessed 20th December 2019] https://data2.unhcr.org/en/situations/syria/location/53

United Nations Commissioner High for Refugees. (2020a) *Jordan-Zaatari Refugee Camp*. UNHCR. [Online] [Accessed on 10th September 2020] file:///C:/Users/mousa%20J/Downloads/Jordan%20Zaatari%20UNHCR%20Update%20January%202020%20Final.pdf

United Nations Educational, Scientific and Cultural Organization. (n.d.) Geneva Convention (1951) Refugee. Article 1A (2). United Nations Educational, Scientific and Cultural Organization [Online] [accessed on 12th May 2018]. http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/refugee/

United Nations for High Commissioner of Refugees. (2014h) Flowing Across Borders. *UNHCR.* [Online] [Accessed on 10th April 2018]. http://www.unhcr.org/pages/49c3646c125.html

United Nations for High Commissioner of Refugees. (2015a) *UNHCR global trends: forced displacement in 2014*. 2nd July. [Online] http://www.unhcr.org.uk/about-us/key-facts-and-figures.html

United Nations High Commissioner for Refugees (2020) Figures at a Glance. UNHCR [Online] [Accessed on 13th October 2020]. https://www.unhcr.org/uk/figures-at-a-glance.html

United Nations High Commissioner for Refugees. (2010) Convention and Protocol Relating to the Status of Refugees. United Nations High Commissioner for Refugees. [Online] [Accessed on 28th February 2018]. file:///D:/MMU%20UNI/New%20work%20Sep/MMU%20UNI/3b66c2aa10%20(1).pdf

United Nations High Commissioner for Refugees. (2015) Worldwide Displacement Hits All-time High as War and Persecution Increase. United Nations High Commissioner for Refugees. [Online] [Accessed on 15th April 2019]. https://www.unhcr.org/uk/news/latest/2015/6/558193896/worldwide-displacement-hits-all-time-high-war-persecution-increase.html

United Nations High Commissioner for Refugees. (2019) Syrian Arab Republic. Working Environment. United Nations High Commissioner of Refugees. [Online] [Accessed on 10th September 2019] https://reporting.unhcr.org/node/2530?y=2020#year

United Nations High Commissioner for Refugees. (2020) 2019 Year-End report. United Nations High Commissioner of Refugees. Operation: Syrian Arab Republic [Online] [Accessed 12th October 2020] https://reporting.unhcr.org/sites/default/files/pdfsummaries/GR2019-SyrianArabRepublic-eng.pdf

United Nations Human Rights. (1984) *United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.* 10th December 1984/26th June 1987/ 27(1).

United Nations International Children's Emergency Fund. (2019). Syria Crisis April 2019 Humanitarian Results. United Nations International Children's Emergency Fund. [Online] [Accessed on 5th January]. https://www.unicef.org/media/77246/file/Syria-Crisis-SitRep-April-2019.pdf

USA for the United Nations Commissioner High for Refugees. (no date). Syria Refugees Crisis. [online] [accessed on 11th March 2020] https://www.unrefugees.org/emergencies/syria/

Vaismoradi, M. and Snelgrove, S. (2019) 'Theme in qualitative content analysis and thematic analysis.' In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*. 20(3) pp. 1-14 [Online] [Accessed on 11th October 2019] http://dx.doi.org/10.17169/fqs-20.3.3376

Van Etten, M. L. and Taylor, S. (1998) 'Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis.' *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, 5(3), pp. 126-144. [Online] [Accessed on 3rd August 2020] https://doi.org/10.1002/(SICI)1099-0879(199809)5:3<126::AID-CPP153>3.0.CO;2-H

Vangen, S. and Huxham, C. (2003) 'Nurturing collaborative relations: Building trust in interorganizational collaboration.' *The Journal of applied behavioural science*, 39(1) pp. 5-31

Ventevogel, P., De Vries, G., Scholte, W.F., Shinwari, N.R., Faiz, H., Nassery, R., van den Brink, W. and Olff, M. (2007) 'Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self-Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan.' *Social psychiatry and psychiatric epidemiology*, 42(4), pp. 328-335. [Online] [accessed on 17th January 2020]. DOI: 10.1007/s00127-007-0161-8

Wagner, P. S. (1946) 'Psychiatric activities during the Normandy offensive, June 20-August 20, 1944: An experience with 5,203 neuropsychiatric casualties.' *Psychiatry*, 9(4) pp. 341-364.

Warren, C. (2001). Qualitative interviewing. In Gubrium, J. F., and Holstein, J. A. (Eds.), *Handbook of interview research* (pp. 83-102). SAGE Publications, Inc.,

Weatherhead, S. and Daiches, A. (2010) 'Muslim views on mental health and psychotherapy.' *Psychology and Psychotherapy: Theory, Research and Practice*, 83(1), pp. 75-89.

Webb, C. (1992) 'The use of the first person in academic writing: objectivity, language and gatekeeping.' *Journal of advanced nursing*, 17(6) pp. 747-752.

Wells, R., Steel, Z., Abo-Hilal, M., Hassan, A.H. and Lawsin, C. (2016) 'Psychosocial concerns reported by Syrian refugees living in Jordan: Systematic review of unpublished needs assessments.' *The British journal of psychiatry*, 209(2), pp. 99-106.

Wengraf, T. (2001) *Qualitative research Interviewing: Biographic Narrative and Semi-structured Methods*. London: Sage Publications.

Wildschut, T., Sedikides, C. and Alowidy, D. (2019) 'Hanin: Nostalgia among Syrian refugees.' *European Journal of Social Psychology*, 49(7), pp. 1368-1384

Wiles, R., Crow G., Heath, S., Y. Charles, V. (2006) 'Anonymity and Confidentiality.' Conference ESRC Research Methods Festival. University of Oxford. [online] [Accessed on 13th February 2019] http://eprints.ncrm.ac.uk/423/1/0206_anonymity%2520and%2520confidentiality.pdf

Wolffers, I. (1996) 'Confidentiality in research.' *Lancet (London, England)*, 347(9001) p. 620. [Online] [Accessed on 11th February 2019] DOI: https://doi.org/10.1016/S0140-6736(96)91317-3

World Food Program USA. (2020) *10 Facts About the Syrian Refugee Crisis in Jordan.* 29th October. [Online] [Accessed on 11th November 2020] https://www.wfpusa.org/articles/10-facts-about-the-syrian-refugee-crisis-in-jordan/

World Health Organization (2014). Mental health: a state of well-being. World Health Organization. [Online] [Accessed 13th May 2019]. http://www.who.int/features/factfiles/mental_health/en/

World Health Organization (2015b). Polio Update in the Middle East- Update. [Online] [Accessed on 13th April 2019] http://www.who.int/csr/don/2014_3_21polio/en/

World Health Organization. (no date) ICD-11 International Classification of Diseases 11th Revision The global standard for diagnostic health information. *WHO*. [Online] [Accessed on 24th November 2020] https://icd.who.int/en

World Health Organization. (1997) *Measuring quality of life the world health organization quality of life instruments (The WHOQOL-100 and the WHOQOL-BREF).* WHO/MSA/MNH/PSF/97.4. World Health Organization. [Online] [Accessed 13th November 2019] https://www.who.int/mental_health/media/68.pdf

World Health Organization. (2004) The World Health Organization Quality of Life (WHOQOL) -BREF. *WHO.* [Online] [Accessed on 4th May 2019] https://www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf

Yalim, A.C. and Kim, I. (2018) 'Mental Health and Psychosocial Needs of Syrian Refugees: A Literature Review and Future Directions.' *Advances in Social Work*, 18(3) pp. 833-852.
Yaser, A., Slewa-Younan, S., Smith, C.A., Olson, R. E., Guajardo, M.G. U. and Mond, J. (2016) 'Beliefs and knowledge about post-traumatic stress disorder amongst resettled Afghan refugees in Australia.' *International journal of mental health systems*, 10(1) pp. 1-9.

Yayan, E.H., Düken, M.E., Özdemir, A.A. and Çelebioğlu, A. (2019) 'Mental health problems of Syrian refugee children: Post-traumatic stress, depression and anxiety.' *Journal of pediatric nursing*. 51, March-April, pp. e27-e32.

Youssef, N. (2014) *Syrian Rebels Describe U.S.-Backed Training in Qatar.* 26th May. PBS News Hour. [Online] [Accessed on 27th March 2019] https://www.pbs.org/wgbh/frontline/article/syrian-rebels-describe-u-s-backed-training-in-qatar/

Yurtsever, A., Konuk, E., Akyüz, T., Zat, Z., Tükel, F., Çetinkaya, M., Savran, C. and Shapiro, E. (2018) 'An eye movement desensitization and reprocessing (EMDR) group intervention for Syrian refugees with post-traumatic stress symptoms: Results of a randomized controlled trial.' *Frontiers in psychology*, 9, June, p. 493.[Online] [Accessed 16th June 2020] Doi.org/10.3389/fpsyg.2018.00493