

HAIGAZIAN UNIVERSITY

Lay Causal Beliefs, Help-seeking Behaviours and Coping Strategies for Depression and
PTSD among Syrian Refugees Living in Lebanon

Mirdza Abele

Beirut, Lebanon

May, 2021

HAIGAZIAN UNIVERSITY

Lay Causal Beliefs, Help-seeking Behaviours and Coping Strategies for Depression and
PTSD among Syrian Refugees Living in Lebanon

Mirdza Abele

Thesis submitted to the Faculty of Social and Behavioural Sciences in partial fulfilment of
the requirements for the Master of Arts in Psychology - Emphasis Clinical Psychology at
Haigazian University

Beirut, Lebanon

May, 2021

Thesis Release Form

I, Mirdza Abele,

authorize Haigazian University to supply copies of my thesis to libraries or individuals upon request.

do not authorize Haigazian University to supply copies of my thesis to libraries or individuals for a period of two years starting with the date of the thesis defence.

Signature

Date



A Thesis

Entitled

**Lay Causal Beliefs, Help-seeking Behaviours and Coping Strategies for Depression and PTSD
among Syrian Refugees Living in Lebanon**

By

Mirdza Abele

is accepted by the Graduate Thesis Committee as satisfying the thesis requirements for the
degree Master of Arts.

Date 11-05-2021

Signature of Thesis Committee Chairperson

Hanine Hout

Date 11-05-2021

Signature of Thesis Committee Member

Luzi Antonian

Date 11-05-2021

Signature of Thesis Committee Member

Hji

Haigazian University

June 2021

ACKNOWLEDGMENT

Throughout my thesis journey, I have received tremendous amount of support from souls near and far, so I take this opportunity to extend my thanks.

To begin with I would like to thank my Latvian family, your love, support, presence and guidance have been a beacon of light in my journey. My mom Anda, for everything you have sacrificed to give me this chance at life. My dad Leons, for embracing my differences. My grandmothers Māra and Aleksandra for being my guardian angels – I know you continue to be with me every step of the way. My grandfather Jāzeps for insisting to teach me the English language, despite my running and hiding from you. My sister Emīlija for uplifting me and cheering me up. My grandaunt Daila, for your unconditional love and warmth.

I would also like to thank my Lebanese family for being my rock, my support and for continuously believing in me. Thank you Fafi for being an amazing research assistant, a friend and a partner in this journey with me – I am so lucky and blessed to have you by my side. I also want to thank Soumy for being my bigger sister, for your unwavering support, loyalty and love throughout these years. To my non-biological parents – the Abou Jaoudeh and Annous families for adopting me and taking care of me like your own. To my four legged and fluffy children who remind me to love simply and to keep things down-to-earth.

I would like to express my sincere gratitude to my advisor Dr. Lucy Tavitian for the continuous support and for making this journey so much fun. Thanks also goes to Dr. Hanine Hout and Dr. Nizar Mehtar for their encouragement, insightful comments and fruitful discussions shared.

I also wish to extend my gratitude to CISP for supporting me in the data collection through the never ending lock-downs, road-blocks and restrictions. I could not have done this without your support.

Last, but not least, I wish to thank every single person that took part in my research study at the pilot and main data collection stages. Your courage, openness and willingness to share the most difficult parts of your journeys have been humbling and inspiring. I sincerely hope to be able to make your voices heard. May you find the healing and peace you are searching for.

Table of Contents

AKNOWLEDGMENT	v
Abstract.....	xii
CHAPTER I INTRODUCTION	1
Problem Statement.....	1
Rationale.....	5
Purpose Statement	9
Significance	9
CHAPTER II LITERATURE REVIEW	11
Refugees – an Overview.....	11
Prevalence of Mental Health Disorders Among Refugees.....	12
Refugee access to MHPSS	14
Culture and Mental Health	14
Perceptions of Aetiology of Disease	16
Culture and Help-Seeking Behaviours	19
Culture and Coping Mechanisms	21
The Current Study Aims.....	22
CHAPTER III METHODOLOGY	24
Research Design	24
Data Collection and Sampling.....	24
Instruments	29
Piloting the Instruments.....	33
Correcting for Validity Threats	34

Participants	35
Data Coding and Analysis	36
Ethical Considerations	36
CHAPTER IV RESULTS	38
Causal Beliefs	38
Help-seeking Behaviours.....	42
Stigma and Help-seeking Behaviours.....	48
Coping Mechanisms	51
Experience and Knowledge	53
CHAPTER V DISCUSSION.....	55
Causal Beliefs	56
Help-seeking Behaviours.....	60
Stigma and Help-seeking Behaviours.....	63
Coping	64
Bracketing Comparison	65
Recommendations	66
Strength and Limitations	68
References	71
Appendix A NGO Support Letter.....	83
Appendix B Depression Vignette	85
Appendix C PTSD Vignette	93
Appendix D Permission to Modify Tool	101
Appendix E Bracketing	103

Appendix F Ethics Clearance 105

Appendix G Ethics Clearance - Amendment 106

List of Tables

Table 1 - Coding Agenda for Causal Beliefs.....	25
Table 2 - Coding Agenda for Help-Seeking Avenues.....	26
Table 3 - Coding Agenda for Treatment Mechanisms	26
Table 4 - Coding Agenda for Coping Mechanisms.....	27
Table 5 Base Run Saturation	27
Table 6 First Run Saturation.....	28
Table 7 New Information Threshold - Run 1	28
Table 8 Results Pertaining to Causal Beliefs - Part 1.....	39
Table 9 Results Pertaining to Causal Beliefs - Part 2.....	40
Table 10 Disorder Comparison - Causal Beliefs.....	41
Table 11 Living Conditions Comparison - Causal Beliefs.....	41
Table 12 Area Comparison - Causal Beliefs	41
Table 13 Gender Comparison - Causal Beliefs	42
Table 14 Results Pertaining to Help-Seeking Avenues.....	43
Table 15 Results Pertaining to Treatment Mechanisms	44
Table 16 Disorder Comparison – Help-seeking Avenues	44
Table 17 Disorder Comparison – Treatment Mechanisms.....	44
Table 18 Living Conditions Comparison - Help-seeking Avenues.....	45
Table 19 Living Conditions Comparison - Treatment Mechanisms	45
Table 20 Area Comparison - Help-seeking Avenues	46
Table 21 Area Comparison - Treatment Mechanisms.....	46
Table 22 Gender Comparison - Help-seeking Avenues	47
Table 23 Gender Comparison - Treatment Mechanisms.....	47

Table 24 Results Pertaining to Stigma	48
Table 25 Disorder Comparison - Stigma	48
Table 26 Living Conditions Comparison - Stigma.....	49
Table 27 Area Comparison - Stigma	49
Table 28 Gender Comparison - Stigma	50
Table 29 Results Pertaining to Impact of Stigma	51
Table 30 Results Pertaining to Coping Mechanisms.....	51
Table 31 Disorder Comparison - Coping Mechanisms	52
Table 32 Living Conditions Comparison - Coping Mechanisms	52
Table 33 Area Comparison - Coping Mechanisms	53
Table 34 Gender Comparison - Coping Mechanisms	53
Table 35 Results Pertaining to Prevention	54

Abstract

A high prevalence of depression and posttraumatic stress disorder (PTSD), as well as low access and utilization rates of Mental Health and Psychosocial Support Services (MHPSS) have been widely confirmed among Syrian refugees residing in Lebanon. In order to suggest culturally appropriate and feasible mental health support programs, however, it must first be examined how Syrian refugees conceptualize mental health and illness. This study, therefore, aimed to explore how depression and PTSD are believed to be caused, and what are the subsequent help-seeking behaviours and coping mechanisms employed. Following the phenomenological qualitative research design, semi-structured interviews based on vignette instruments were conducted with Syrian refugee adults who have sought refuge in Lebanon since 2011. The interviews were audio-recorded, transcribed, and analysed using a priori coding agenda. Forty participants were interviewed, the average age was $M = 33.3$ ($SD = 11.8$), 47% ($n = 19$) of the participants were male and 53% ($n = 21$) were female. Current life conditions and past traumatic events, were the most frequently reported causes of depression and PTSD. Help and healing were typically sought from family members and friends, as well as mental health care providers, and the coping mechanisms employed most frequently were active and social coping. Mental health initiatives should focus on awareness and de-stigmatisation of mental health through experienced Syrian refugees. Community level MHPSS should be delivered through psychosocial programmes as opposed to psychiatric and clinical settings. MHPSS need to be provided along-side initiatives that address the difficult socio-economic conditions.

Keywords: Syrian Refugees; Lebanon; Mental Health; Depression; PTSD; Culture;

CHAPTER I INTRODUCTION

Lay causal beliefs, help-seeking behaviours and coping strategies for depression and PTSD among Syrian refugees living in Lebanon

Problem Statement

Lebanon has a long tradition of hosting refugees on its' soil, many of whom face mental health disorders such as Major Depressive Disorder (from here on referred to as depression) and Post-traumatic Stress Disorder (PTSD), mostly as a result of the stresses experienced before and throughout the displacement process. Despite the high prevalence rates of these disorders, Mental Health and Psychosocial Support Services (MHPSS) are accessible to an estimate of only 1% of the refugee population, that can partly be explained by the associated cost of such services. Nevertheless, other factors such as cultural perspectives, differences in opinion, knowledge, awareness and the presence of social stigma also likely play a key role. The present study will therefore focus on exploring the underlying beliefs on causes of depression and PTSD, as well as the subsequent help-seeking behaviours and coping mechanisms that Syrian refugees in Lebanon resort to.

Refugees represent only 10% of the global migrant population of 258 million individuals (IOM, 2018), nevertheless they are more often exposed to worse forms of stressful events (e.g. persecution, torture, exploitation) before departure, during the travel and possibly even after arrival to their hosting country (World Health Organization, 2018a). From the global refugee population of 25.9 million individuals, 26% (6.7 million) come from the Syrian Arab Republic (Syria) (UNHCR, 2019), and the vast majority (85%) are seeking refuge in the Middle Eastern region. Lebanon alone hosts an estimated 1.5 million Syrian refugees, representative of the highest concentration of refugees per capita in the world (Reliefweb, 2019). Having endured eight years in sub-standard living

conditions, with no access to livelihoods, living below the poverty line of USD 3.84/capita/day, and limited freedom of movement, (UNHCR et al., 2018), Syrian refugees face mental health issues (Al Ibraheem et al., 2017; Chu et al., 2013; Lindert et al., 2009).

The most common mental health disorders that have been recorded among migrant and refugee communities are depression and PTSD (Turrini et al., 2017; Close et al., 2016). When it comes to the prevalence of depression and PTSD rates among Syrian refugees, they vary greatly from country to country, nevertheless the overall rates are significantly higher than the hosting populations (Naja et al., 2016; Kazour et al., 2016; Karam et al., 2008; Farhood & Dimassi, 2012). Despite the high depression and PTSD prevalence rates among the Syrian refugee population, an estimate of only 1% utilize the available MHPSS when compared to 10% of the Lebanese general population (El Chammy et al., 2013; El Chammy et al., 2016; Kerbage et al., 2016). Lack of access is partly explained by the high cost and the limited availability of community-based service providers (El Chammy et al., 2013; El Chammy et al., 2016; Kerbage et al., 2016). MHPSS access and utilization may also be impacted by the cultural perspectives and preferences, differences in opinion, knowledge, awareness and the presence of social stigma towards such services among the Syrian refugee population (Hader, 2017; Satinsky et al., 2019; Hassan et al., 2015).

Culture is a multi-layered concept which encompasses a broad range of issues, that contribute to a person's view of themselves as an individual and as a member of a group (Gopalkrishnan, 2018). Concepts such as mind, mental health and illness are derived from meanings people have accorded to these terms based on their experiences and culturally determined beliefs about the nature of the human condition (Fernando, 2014). Majority of the current day mental health theory and practice have emerged from the Western cultural

and world-view, largely influenced by reductionism, positivism and the Cartesian dualism of mind and body as separate entities (Gopalkrishnan, 2018). Whilst the Western understanding of mental health is backed up by a significant body of empirically tested conceptual tools and frameworks that have been documented to help alleviate mental health concerns, this does not mean that the Western model is cross-culturally applicable, and the most appropriate mode of intervention in non-Western cultures (Fernando, 2014; Gopalkrishnan, 2018).

One conceptual framework is known as mental health literacy (MHL), and as a Western concept, it largely tests people's ability to recognize symptoms of different mental disorders (Jorm et al., 1997) in line with standardized diagnostic manuals – such as the Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM - 5). Aside from reliance on knowledge of symptomology, the MHL model incorporates three other aspects: perceptions of aetiology of disease, help-seeking behaviours, and coping and resilience (Jorm et al., 1997). The latter three aspects are likely to be much more informative of an individual's understanding of mental health in a given context, than pure reliance of knowledge and recognition of symptoms (Gopalkrishnan, 2018).

Understanding the culturally-specific aetiology of mental health disorders, also known as lay causal theories, is an essential starting point, which if ignored has been shown to result in higher frequency of misdiagnosis of refugees and migrants compared to the local population (Markova & Sandal, 2016; World Health Organization, 2018a). For example, Somali refugees in Norway understand depression to be caused by spiritual or religious influences (e.g. being a bad Muslim) or it is seen as an illness of thoughts caused by difficult life situations (Markova & Sandal, 2016). It is not considered a physical or a medical disease and as such, treatment is sought from family, friends, religious and

traditional healers instead of medical doctors and psychologists (Markova & Sandal, 2016).

Help-seeking is defined as any form of communication concerning a problem, with the aim to obtain support, assistance or advice (Slewa-Younan et al., 2017). The following cultural factors have been shown to impact help-seeking behaviours: emotional expression, shame, spirituality and religion (Hechanova & Waelde, 2017). For example, in the Chinese culture excessive, unbalanced and undisciplined expression of emotions is believed to be the cause of mental illnesses, and as such talk therapy is discouraged and believed to cause further pain and illness (Hechanova & Waelde, 2017). Furthermore, stigma is a significant problem especially in collectivistic cultures where government safety nets are minimal or non-existent, as individuals rely heavily on family and close social networks for survival and support (Gopalkrishnan, 2018). In Lebanon, where social safety net is not extended to refugees, the population is still largely reliant upon collectivist, family and social support networks for survival (UNHCR et al., 2018), stigma and shame therefore likely impact help-seeking behaviours of this population group. Furthermore, in many cultures, including among Syrians, illness and suffering are seen as a normal parts of life which are directly linked to the concept of fate within their religion (Gopalkrishnan, 2018; Hassan et al., 2015). Medical and psychiatric interventions may thus not be solicited, except in severe forms, and support from religious leaders and reading of the Quran may be sought after instead (Hassan et al., 2015).

Understanding the way a certain cultural group copes with adversity can directly affect the way mental health is promoted and mental health issues prevented (Gopalkrishnan, 2018). Although some Syrian refugees will seek support from mental health service providers, many will resort to culturally acceptable coping mechanisms such

as praying, seeking community support, distracting oneself in activities (Hassan et al., 2015). Many Syrian refugees have spent more than 8 years living in difficult conditions with uncertainty about their future (UNHCR et al., 2018), and consequently turned to negative coping mechanisms such as drug use and alcohol consumption, which in turn worsen the psychological distress they experience (Hassan et al., 2015). Furthermore, the process of acculturation and the fact that so many Syrian refugees are experiencing mental health issues, is expected to influence their perception about mental health, and subsequently the coping mechanisms employed.

Prior to determining the best means of supporting the vast Syrian refugee population in Lebanon, in tackling the high depression and PTSD prevalence rates, it is imperative to explore how mental health and illness are conceptualized by this population group. In order to do this, the present study will move beyond looking at presence or absence of MHL type of symptom knowledge, and instead focus on exploring how depression and PTSD are believed to be caused, the subsequent help-seeking behaviours and coping mechanisms employed.

Rationale

Although some of the culturally specific models of mental health used in the Syrian culture have been documented (Hader, 2017; Hassan et al., 2015), many Syrian refugees residing in Lebanon have spent more than 8 years living in a new set of circumstances, which are likely impacting the way mental health is experienced, understood and handled. As documented by humanitarian aid agencies who operate in Lebanon (UNHCR et al., 2018), majority of the Syrian refugee population live in sub-standard conditions, with no access to livelihoods, surviving below the poverty line of USD 3.84/capita/day, and enduring limited freedom of movement. Officially, the Lebanese government has not

ratified the 1951 Convention relating to the Status of Refugees, and as such they are under no legal obligation to provide Syrian refugees with essential rights and services that refugee status holders would ordinarily be entitled to (Janmyr, 2016). As a result, many refugees do not have a legal residency status in Lebanon, and thus live in daily fear of arrest or, at the very least, extortion (UNHCR et al., 2018). Syrian refugees also face severe discrimination, they are perceived to be undesirable foreigners that are draining local resources and destabilizing the security, economic, socio-cultural, demographic and political arenas of the country (Janmyr, 2016). Although the government has not imposed an official camp confinement upon Syrian refugees, they do find themselves systemically segregated from the Lebanese community on multiple levels including the educational system, access to socio-economic opportunities, to legal status and rights, and to healthcare and welfare (UNHCR et al., 2018). Syrian refugee children study in separate classrooms from Lebanese children, whilst Syrian men and women are required to obtain a work permit in order to legally seek employment in Lebanon (UNHCR et al., 2018). The discriminatory perceptions and systemically divisive policies are partially in place to prevent the Syrian refugee population from settling in Lebanon permanently, and thus avoid altering the demographic balance and the political order in the country (Care International in Lebanon, 2018). Not surprisingly therefore, most refugees intend to return back to Syria once they deem that it is safe to do so (Care International in Lebanon, 2018), which indicates that in terms of the acculturation spectrum, this population group is pivoting between the separation and marginalization end (El Khoury, 2019).

The acculturation model as proposed by Berry in 1974, consists of two dimensions in relation to acculturation: the extent to which the host culture is adopted or rejected, and the extent to which the culture of origin is maintained or rejected (El Khoury, 2019).

Separation and marginalization are acculturation strategies which are derived from the crossover of the two dimensions of Barry's model, and are concerned with rejecting the host culture whilst trying to hold onto the culture of origin (El Khoury, 2019). When the separation strategy is employed, this is correlated with low psychological well-being and low sociocultural adjustment (Abou-Rayya, 2007; El Khoury, 2019). Combining the trauma experienced by refugees pre-migration, the stresses of the current living conditions, and the acculturation strategies being adapted by this population group, it is anticipated that the subject of mental health is experienced, understood and engaged with differently than before migration. Aside from exposure to chronic stress, uncertainty and traumatic events, the Syrian refugee population has also been exposed to the Western-driven psychological treatment methods through the programs run by the international humanitarian aid community (UNHCR et al., 2018). Collectively, these new experiences are expected to alter the pre-existing culturally specific models of mental health used by the Syrian refugee community in Lebanon, and this study therefore aims to understand what these models of mental health look like currently. The sampling methodology of this study takes into consideration the duration of refuge in Lebanon, allowing for it to be factored into the overall analysis of the information gathered. The study findings will in turn help determine the most culturally appropriate and affordable means of mental-health support for this population group, as the Western-driven psychological and psychiatric treatment methods may not be the most effective.

The recent crises that have impacted Lebanon are also likely affect the mental health outcomes for the Syrian refugee population. On the 17th of October 2019, the Lebanese protests broke out, caused by peaking public frustration due to the lack of accountability by the Lebanese Government, and resulting in mass and targeted

demonstrations and civil uprisings nationally (World Food Programme, 2020). The protests were quickly followed by an economic crisis, which has affected the local currency and caused the value of the Lebanese Lira to become extremely volatile. The currency rate on the black market reaching up to 15,000 LL for one USD, while the official bank rate remains at 1,500 LL. Simultaneously, restrictions continue to be imposed by banks on people's access to their funds, and operation times remain intermittent. Further to the Lebanese protests, on 20th February 2020, COVID-19 virus started spreading in Lebanon. Initial measures included safety procedures such as washing hands, but quickly evolved to a general lockdown of all private and public institutions and mandated physical distancing of the whole population of Lebanon since 15th March 2020. Since then, the closure of the country has been mandated by the government in an unpredictable manner, with often a very short notice period of 1 – 2 days maximum (World Food Programme, 2020).

The Lebanese protests, the economic crisis and the COVID-19 outbreak, have resulted in drastically increasing rates of unemployment across the Lebanese population as well as the Syrian refugees. Cost of items and services has increased significantly, impacting people's, especially the most vulnerable Syrian refugees' ability to meet their basic survival needs (e.g. food, rent, medication) even more so than before October 2019 (World Food Programme, 2020). These drastic changes in the socio-economic status of refugees as well as Lebanese individuals is likely to exacerbate the separation and marginalization experienced by the refugee community as access to healthcare, economic opportunities and education will likely be prioritized for the Lebanese community in light of this multi-layered crisis. This in turn is likely to affect the mental health outcomes for the refugee population even further.

The main aim of this study is therefore to explore the underlying beliefs on causes of depression and PTSD, as well as the subsequent help-seeking behaviours and coping mechanisms that Syrian refugees in Lebanon resort to. Once this exploration has been completed, the study then aims to suggest culturally appropriate, and feasible mental health support programs, derived from knowledge of depression and PTSD through the Syrian refugee cultural lens. In order to do this, the present study will move beyond looking at presence or absence of MHL type of symptom knowledge, and instead focus on exploring how depression and PTSD are believed to be caused, the subsequent help-seeking behaviours and coping mechanisms employed.

Purpose Statement

The primary purpose of this study is to explore, the lay causal theories of depression and PTSD, the subsequent help-seeking behaviours and coping mechanisms used among Syrian refugees residing in Lebanon. Through gaining an insight on these factors, this study also aims to suggest culturally appropriate, and feasible mental health support programs that could be adopted by the humanitarian aid community supporting this population group.

Significance

Insight into the lay causal models, help-seeking behaviours and coping mechanisms for depression and PTSD among the Syrian refugee population in Lebanon could help tailor mental health and psychosocial support interventions provided by Lebanese and the international aid practitioners. The findings of this study will produce culturally specific insight of mental health, including key beliefs and fears, which can be used to tailor the means of service delivery (e.g. via Syrian community leaders), type of intervention (e.g.

bio-medical model vs. expressive arts therapy), and content of the intervention (e.g. focusing on building a client –therapist rapport based on culturally accepted methods).

It would also help reduce rates of misdiagnosis among this population group, as research shows that migrant and refugee populations are more likely to be misdiagnosed when compared to their native counterparts (Markova & Sandal, 2016). Refugees from Arab origins are more-likely to present with a physical complaint for psychological disorders, due partly to the fact that Arab (including Syrian) idioms of distress do not separate between psychological and somatic experiences, since body and the soul are linked (Markova & Sandal, 2016; Hader, 2017). Furthermore, this population group might be using super-natural causes (e.g. Jinns and the evil eye) to explain the cause of their illness, which might be misunderstood as psychotic symptoms leading to a misdiagnosis (Markova & Sandal, 2016; Hader, 2017). Although the latter kind of misdiagnosis is more likely among mental health professionals foreign to the Middle Eastern culture, raising awareness of Syrian refugee explanatory models of depression and PTSD could benefit all practitioners working with this population group.

Noting the scarcity of MHPSS providers, and the lack of financial capacity among the refugee population to afford such services, the outcomes of this research could be used by Civil Society Organizations (CSOs) and Non-governmental Organisations (NGOs) in order to tailor affordable, subsidized and informal psycho-social support projects. Such initiatives could be tailored based on the help seeking and coping mechanism channels identified by this study. Increase in culturally appropriate and affordable MHPSS could help address the mental health access gap and thus high depression and PTSD prevalence rates among Syrian refugees in Lebanon.

CHAPTER II LITERATURE REVIEW

Refugees – an Overview

Refugees represent only 10% of the global migrant population of 258 million individuals (IOM, 2018), nevertheless they are more often exposed to worse forms of stressful events (e.g. persecution, torture, exploitation) before departure, during the travel and possibly even after arrival to their hosting country (World Health Organization, 2018a). Upon arrival, refugees face the difficult task of adapting to the new culture, environment, and often learning a new language (World Health Organization, 2018a). A great many will need to temporarily reside in several countries (countries of transit) before reaching their final destination, having to face the stressors in general and stressors of acculturation more than once, and living in conditions of uncertainty (World Health Organization, 2018a). As a result of the multiple stressors related to the migration process, refugees are twice as likely to face mental health issues (Al Ibraheem et al., 2017; Chu et al., 2013; Lindert et al., 2009), yet accessing the needed MHPSS is difficult for them (World Health Organization, 2018a).

From the global refugee population of 25.9 million individuals, 26% (6.7 million) come from Syria (UNHCR, 2019), and the vast majority (85%) have sought and continue to seek refuge in the Middle Eastern region. Lebanon alone hosts an estimated 1.5 million Syrian refugees, representative of the highest concentration of refugees per capita in the world (Reliefweb, 2019). Having endured eight years in sub-standard living conditions, with no access to livelihoods, and limited freedom of movement, 69% of all registered refugees find themselves living below the poverty line of USD 3.84/capita/day (UNHCR et al., 2018). They face severe discrimination, are treated as undesirable foreigners who drain local resources and destabilize the security, economic and political arenas of the country

(Janmyr, 2016). Since 2011, a number of Ministries in collaboration the United Nations (UN) and NGOs have made considerable efforts to improve the quality of life of Syrian refugees in Lebanon through programs aimed at improving access to education, water and sanitation, purchasing power and healthcare (Government of Lebanon & United Nations, 2020). However, the resources to meet the growing needs are limited. For example, two thirds of the refugee households have at least one family member with a chronic medical or mental health condition which affects their functionality and for which continuous support is needed (UNHCR et al., 2018).

Prevalence of Mental Health Disorders Among Refugees

The most common mental health disorders that have been recorder among migrant and refugee communities are depression and PTSD (Turrini et al., 2017; Close et al., 2016). When it comes to the point prevalence of mental health disorders across the refugee population globally, depression rates range from 5-44% and Post-Traumatic Stress Disorder (PTSD) from 9-36% (Turrini et al., 2017). These figures are significantly higher than the average estimated life-time prevalence rates for both disorders as follows: 1-16.9% for depression (Kessler & Bromet, 2013) and 1.3 – 8.8% for PTSD (Atwoli et al., 2015). It is important to highlight that prevalence rates for both disorders vary greatly between countries and cultures, due to differences in assessment instruments, languages, geographic, socio-demographic and political contexts (Hofmann & Hinton, 2014).

Mental health disorder prevalence rates among Syrian refugees appear to be similar to the global refugee figures, whilst also varying across different countries, for the same reasons as mentioned above. The recorded point-prevalence depression rates among Syrian refugees are as follows: 29.5% in Jordan (Gammouh et al., 2015), 44.1% in Netherland (Al Ibraheem et al., 2017) and 43.9% in Lebanon (Naja et al., 2016). When it comes to PTSD,

the rates are: 11.4% in Germany (Georgiadou et al., 2018), 32.2% in USA (Javanbakht et al., 2019), and 27.2% in Lebanon (Kazour et al., 2016). Hofmann and Hinton (2014) recommend to compare prevalence rates of culturally similar groups within a multicultural country, in order to yield more meaningful results. Lebanon can be described as a multicultural country, with 18 official religious denominations, and a significant presence of Syrian, Iraqi and Palestinian refugees (World Health Organization, 2010). As such, it is important to compare the prevalence rates for depression and PTSD among Syrian refugees who reside in Lebanon, and Lebanese nationals. For Lebanese nationals, the depression life-time prevalence rates are estimated at 9.9%, and PTSD at 3.4%, these percentages are expected to rise with any exposure to war-related traumatic events¹, noting the turbulent past and insecure future (Karam et al., 2008). In support of this point, Farhood and Dimassi (2012) demonstrate how depression and PTSD rates fluctuate depending on the location from where the study population sample was taken, and the extent to which the individuals within the sample has experienced one or more traumatic events. For example, 17.2% of the total sample of Lebanese civilians exposed to church explosions were symptomatic of PTSD, and 41.9% of depression (Farhood & Dimassi, 2012). As such, it is not surprising to see that the depression and PTSD rates are higher amongst the Syrian refugee population, noting that all of them are refugees and thus are experiencing at least one of the ten war-related traumatic events that are associated with increased risks of developing mental health disorders, particularly PTSD (Karam et al., 2008). Furthermore, PTSD and depression are highly co-morbid (Farhood & Dimassi,

¹ Kidnapping, being robbed or threatened at a gun-point, trauma experienced by a close person, death of a close person, witnessing atrocities, witnessing death or injury, doing rescue work, becoming a refugee, being a civilian in a war or terror region (Karam et al., 2008).

2012; Karam et al., 2008). Despite the high depression and PTSD prevalence rates among the Syrian refugee population, an estimate of only 1% utilize the available MHPSS when compared to 10% of the Lebanese general population (El Chammay et al., 2013; El Chammay et al., 2016; Kerbage et al., 2016).

Refugee access to MHPSS

MHPSS aim to protect and promote psychosocial wellbeing through professional (e.g. psychological counselling and psychiatric services) and lay (e.g. community activities, basic psychosocial interventions) healthcare providers (Satinsky et.al, 2019). When it comes to refugees from Syria who reside in Lebanon, the lack of MPHSS utilization is partly explained by the high cost and the limited availability of community-based service providers (El Chammy et al., 2013; El Chammay et al., 2016; Kerbage et al., 2016). Basic psychosocial support services and financial subsidies in order to access formal mental health services provided by the UN and NGOs are also scarce in the face of the scale of mental health disorder prevalence (UNHCR et al., 2018). However, MPHSS access and utilization may also be impacted by the cultural perspectives and preferences, differences in opinion, knowledge, awareness and the presence of social stigma towards such services among the Syrian refugee population (Hader, 2017; Satinsky et al., 2019; Hassan et al., 2015).

Culture and Mental Health

A person's view of themselves as an individual and as a member of a group is influenced by culture, a multi-layered concept which is governed by language, religion, gender, ethnic identity and race (Gopalkrishnan, 2018). The Western cultural world view has played and continues to play a large role in influencing the modern day mental health theory and practice (Gopalkrishnan, 2018), but it does not mean that it is representative of

different world cultures. When it comes to mental health, concepts such as mind, and psychological wellbeing are derived from meanings people have accorded to these terms based on their experiences and culturally determined beliefs about the nature of the human condition (Fernando, 2014). It is therefore essential to recognize that people from different cultures will understand mental health issues differently, and will likely take different steps when it comes to seeking help or engaging in a coping strategy (Fernando, 2014; Gopalkrishnan, 2018). As pointed out by Pickren (2014), it is the culture of the individual that teaches them the ways of living, including how one should take care of their health and wellbeing. Furthermore, culturally-specific practices and beliefs can be a source of strength, sustenance and resilience to refugee communities (Pickren, 2014), even if they are unknown to or disregarded by the Western medical model. In line with this perspective it is therefore argued that the Western-driven psychological and psychiatric interventions may not be cross-culturally applicable, nor most appropriate mode of intervention in non-Western cultures (Fernando, 2014; Gopalkrishnan, 2018).

One of many empirically tested, Western conceptual frameworks for investigating mental health is MHL, which encompasses individual's knowledge and beliefs about mental health disorders, that in turn impact the way they are recognized, managed and prevented from re-occurring (Jorm et.al., 1997). In line with standardized diagnostic manuals – such as the DSM – 5, MHL largely tests people's ability to recognize symptoms of different mental disorders (Jorm et al., 1997). Aside from reliance on knowledge of symptomology, the MHL model incorporates three other aspects: perceptions of aetiology of disease, help-seeking behaviours, and coping and resilience (Jorm et al., 1997). The latter three aspects are likely to be much more informative of an individual's understanding of mental health in a given context, than pure reliance of knowledge and recognition of

symptoms (Gopalkrishnan, 2018), and as such the study will largely focus on gathering information around these aspects as they apply to the Syrian refugee population in Lebanon.

Perceptions of Aetiology of Disease

Causality of disorders can be viewed at an individual, social or natural world levels (Gopalkrishnan, 2018), further to this, the attribution theory provides a means to understand and evaluate causal beliefs across the following three dimensions: control (internal or external), controllability (controllable or uncontrollable) and stability (stable of variable) (Weiner, 1985). Using the attribution theory alongside the causal one allows for the examination of the frame used by the individual to explain the aetiology of the disorder (Zimmermann & Papa, 2019). For example, the individual who believes that their depression is a result of a chemical imbalance in the brain is likely to evaluate it as internal, stable and uncontrollable (Zimmermann & Papa, 2019). In contrast, someone who recognises that depression is caused by an interaction between multiple external and internal factors (e.g. learned cognitive patterns, socio-cultural pressures etc.) will more likely attribute the causes as unstable but controllable (Zimmermann & Papa, 2019). The way in which disorders are understood to be caused and attributed have important consequences on the individual's affective response but also their subsequent behaviour (Zimmermann & Papa, 2019). For example, correlation studies show that individuals who attribute depression to neurobiological causes, are more likely to seek pharmacological treatment, whilst those attributing the disorder to psychological causes will seek psychotherapy (Beshai et al., 2019; Jorm et al., 1997; Zimmermann & Papa, 2019).

The sociocultural context and subjective experiences play a significant role in shaping the causal explanations of illness and health, and vary significantly across time,

living environments, demographic characteristics and lifespan events (Kuittinen et al., 2017). For this reason, studies demonstrate that the way people understand and explain what is causing illness varies across cultures (Gopalkrishnan, 2018), and are often referred to as lay causal theories (Markova & Sandal, 2016). In the Western culture, mental illnesses are primarily thought to originate in the human mind, as a result of interaction between biological, psychological and social factors (Fernando, 2014). In contrast, for example, Somali refugees in Norway understand depression to be caused by spiritual or religious influences (e.g. being a bad Muslim) or it is seen as an illness of thoughts caused by difficult life situations (Markova & Sandal, 2016). It is not considered a physical or a medical disease and as such, treatment is sought from family, friends, religious and traditional healers instead of medical doctors and psychologists (Markova & Sandal, 2016). Similarly, Somali refugees in Finland primarily attribute mental health problems to evil spiritual influences (a.k.a jinns), life experiences (e.g. fleeing from war) and jealousy from polygamous relationships (Kuittinen et al., 2017). Some refugees from Arab origins have been recorded to present with a physical complaint for psychological disorders, and expect medical professionals to prescribe medication, not psychotherapy (Markova & Sandal, 2016; Hassan et al., 2015). This can partly be explained by the fact that most Arabic and Syrian idioms of distress do not separate between psychological and somatic experiences, as body and the soul are thought to be linked (Hassan et al., 2015).

Studies of Syrian nationals displaced inside Syria (Hassan et al., 2015) and Syrian refugees residing in Greece (Ben Farhat et al., 2018) and Germany (Zbidat et al., 2020) shown that causes of mental disorders are believed to emanate from losses, violence and socio-economic pressures, as well as religious beliefs. The subsequent help-seeking behaviour include turning to social circles for help, advice and distraction and turning to

religious and traditional healers as a more culturally acceptable, and less stigmatising healing avenue (Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020).

When it comes to Syrian refugees in Lebanon, only one study has been published which examines the causal beliefs of this population group in Wadi Khaled, North area of Lebanon (Al Laham et al., 2020). The study reported that stigma, fear and shame are heavily associated with mental health and among one of the bigger barriers to seeking mental health services (Al Laham et al., 2020). Causal beliefs of mental disorders were closely linked to religious beliefs, particularly the influence of the Jinn, as well as socio-economic life circumstances in the area (Al Laham et al., 2020). People of Wadi Kahlaed, including Syrian refugees residing in this area, preferred to turn to religious healers as the first line of help, as they were perceived to be culturally acceptable in comparison to mental health providers in the area (e.g. NGOs) (Al Laham et al., 2020). Individuals who did turn to psychopharmacology or psychotherapy for help did so discretely and secretively (Al Laham et al., 2020).

A study of the causal beliefs of mental health clinicians' in America found that mental health disorders are conceptualized along a continuum between nonbiological disorders and highly biological (e.g. autism), and thus pharmacological interventions were believed to be more effective for biological causes, whilst psychotherapy for non-biological (Ahn et al., 2009). The causal beliefs and subsequent preferred treatment options may contrast sharply with those of a client, especially when they come from a starkly different cultural background. This can lead to a client's dissatisfaction with the mental health professional or the system as a whole, and lead the client to seek alternative treatment options that are more culturally acceptable to them. This has been evidenced in

Finland, where Somali refugees reported dissatisfaction with the mental health services offered to them, and would in some cases return to Somalia in order to get treatment (Kuittinen et al., 2017). Studies also show that a higher frequency of misdiagnosis is recorded among refugees and migrant communities when compared to the local population (Markova & Sandal, 2016; World Health Organization, 2018a). Understanding the culturally-specific aetiology of mental health disorders, is therefore an essential starting point to providing efficient mental health services to people of different cultural origins (Kuittinen et al., 2017).

Culture and Help-Seeking Behaviours

Help-seeking is defined as any form of communication concerning a problem, with the aim to obtain support, assistance or advice (Slewa-Younan et al., 2017). Help-seeking can be aimed at obtaining professional assistance (e.g. qualified and legitimately recognized professionals in the relevant field), and/or non-professional support (e.g. help from informal social networks, or any non-qualified specialists) (Slewa-Younan et al., 2017). The way in which people decide to seek help has been proven to vary across cultures (Gopalkrishnan, 2018). Examining Southeast Asian culture Hechanova and Waelde (2017) present a number of factors impacting help-seeking behaviours, such as: emotional expression, shame, spirituality and religion.

In certain cultures, such as the Chinese, excessive, unbalanced and undisciplined expression of emotions is believed to be the cause of mental illnesses, and as such talk therapy is discouraged and believed to cause further pain and illness (Hechanova & Waelde, 2017). Similarly, and as part of their socialization process Syrian men are culturally socialized to suppress emotions, as display of emotions is associated with weakness (Hassan et al., 2015). For this reason, Syrian men might avoid seeking help from

mental health professionals that encourage expression of emotions, and resort instead to more culturally-acceptable coping strategies such as praying or seeking community support (Hassan et al., 2015).

Multiple studies of refugee and migrant populations residing in high income countries report a consistent trend of significantly delayed help-seeking behaviour for mental health disorders, with majority of cases only reaching out for professional help at severe stages of mental distress (Hagmayer & Engelmann, 2014; Markova & Sandal, 2016; Nguyen & Bornheimer, 2014). One of the key reasons behind this pattern is thought to be shame and stigma that surround the matter of mental-health among different refugee and migrant cultural groups (Gopalkrishnan, 2018). In the Asian culture, shame stems from the fear of damaging one's own or family's reputation as a result of being labelled as crazy by a mental-health professional (Hechanova & Waelde, 2017). Stigma is a mark of disapproval, disgrace or shame, which leads to discrimination, rejection and/or exclusion of an individual from their family and participation in different aspect of society (Gopalkrishnan, 2018). This is a significant problem especially in collectivistic cultures where government safety nets are minimal or non-existent, as individuals rely heavily on family and close social networks for survival and support (Gopalkrishnan, 2018). When seen in this context, it is not difficult to understand why individuals from such cultures would hide their symptoms, as being cast-out from the only support network available could be a matter of life or death (Gopalkrishnan, 2018). For example, in Syria, before the 2011 war begun the need for mental health, clinical psychology and psychiatry services was not visible, as psychological disorders were heavily stigmatized and not well understood by the general population (Hader, 2017). In Lebanon, where social safety net is not extended to refugees, the population is still largely reliant upon collectivist, family and

social support networks for survival (UNHCR et al., 2018), stigma and shame therefore likely impact help-seeking behaviours of this population group and will be explored as a sub-factor impacting help-seeking behaviour and coping mechanisms.

In many cultures, including among Syrians, illness and suffering are seen as a normal parts of life which are directly linked to the concept of fate within their religion (Gopalkrishnan, 2018; Hassan et al., 2015). Islam, practiced by an estimated 87% of the total Syrian population, is understood as obedience to God's will, and thus mental health disorders are seen as a test of faith and a chance to prove oneself (Hassan et al., 2015). Medical and psychiatric interventions may thus not be solicited, except in severe forms, and religious leaders and reading of the Quran may be sought after instead (Hassan et al., 2015).

Culture and Coping Mechanisms

Coping mechanisms are defined as the different actions taken by individuals in order to cope with every-day and acute, infrequent stressors in their lives – including stressors that affect their mental health (Gopalkrishnan, 2018). Understanding the way a certain cultural group copes with adversity can directly affect the way mental health is promoted and mental health issues prevented (Gopalkrishnan, 2018). Different cultures will normalize different stressors depending on their frequency or level of acceptance (e.g. coming-of age rituals considered by Western cultures to be sadistic or harmful) (Gopalkrishnan, 2018). Similarly, assessment of what is considered a stressor, and the subsequent resource allocation by a specific cultural group has been shown to vary significantly (Gopalkrishnan, 2018).

Although some Syrian refugees will seek support from mental health services providers, many will result to culturally acceptable coping mechanisms such as praying,

seeking community support, distracting oneself in activities (Hassan et al., 2015). Many Syrian refugees residing in Lebanon have spent more than 8 years living in difficult conditions with uncertainty about their future (UNHCR et al., 2018). As such, many refugees feel hopeless and turn to negative coping mechanisms such as drug use and alcohol consumption, which in turn worsens the psychological distress they experience (Hassan et al., 2015). It can safely be assumed that majority of Syrian refugees in Lebanon are going through a process acculturation, albeit mostly adapting strategies such as separation and marginalization as a direct result of discriminatory perceptions and systemically divisive governmental policies (UNHCR et al., 2018), as described in the sections above. Separation and marginalization are in turn linked to negative mental health and social adjustment outcomes (El Khoury, 2019). This process and the fact that so many Syrian refugees are experiencing mental health issues, is expected to influence their perception about mental health, and subsequently coping mechanisms employed. As part of the acculturation process, many Syrian refugees and their children may have benefited from basic psychosocial support services (e.g. child friendly spaces), or psychological first aid (UNHCR et al., 2018), which may have affected their perceptions about mental-health.

The Current Study Aims

Prior to determining the best means of supporting the vast Syrian refugee population in Lebanon, in tackling the high depression and PTSD prevalence rates, it is imperative to explore how mental health and illness are conceptualized by this population group. In order to do this, the present study will move beyond looking at presence or absence of MHL type of symptom knowledge, and instead focus on exploring how depression and PTSD are believed to be caused, and the subsequent help-seeking behaviours and coping mechanisms employed. As demonstrated by the body of literature

discussed earlier, Western-driven psychological and psychiatric treatment methods may not be the most appropriate, nor affordable means of mental-health support for Syrian refugees residing in Lebanon. The main aim of this study is therefore to explore the underlying beliefs on causes of depression and PTSD, as well as the subsequent help-seeking behaviours and coping mechanisms that Syrian refugees in Lebanon resort to. Once this insight has been established, the study then aims to suggest culturally appropriate, and feasible mental health support programs, derived from knowledge of depression and PTSD through the Syrian refugee cultural lens. Due to the exploratory nature of this study, no hypothesis is set at this point in time, and the research design adapted will be phenomenological, which is reflective of this point.

CHAPTER III METHODOLOGY

Research Design

In order to study the lay causal theories of depression and PTSD, the subsequent help-seeking behaviours and coping mechanisms used among Syrian refugees residing in Lebanon, a phenomenological qualitative research design has been employed. A qualitative research approach was chosen, as a means to generate an initial body of knowledge, which is currently largely absent for Syrian nationals who are seeking refuge from war by having fled to Lebanon. Following the philosophical approach of constructivism, the aim of this research study was to begin the knowledge gathering by an in-depth exploration (Christensen et al., 2014) of how depression and PTSD are experienced by a number of individuals from the target population group. In doing so, this study hoped to contribute to the existing body of knowledge on causal beliefs among refugee populations worldwide and to encourage further research into the subject matter in a larger, more representative and generalizable manner.

Data Collection and Sampling

The participants of the study were identified through an international non-governmental organization that work with Syrian refugees in different areas of Lebanon. The organizations was approached by the researcher, the details about the study were provided, and a letter of support was obtained (see Appendix A). The organization agreed to identify potential participants that meet the study inclusion criteria, and make this initial contact with them. During the initial contact, the organization representative explained the study details, asked whether the individual is interested to participate and sought permission for their contact details to be shared with the researcher. Following this, the researcher contacted the potential participants in order to set a time for the interview. The

organisation premises were used to conduct some of the interviews, whilst others were done over the internet, using the Zoom application.

Data was gathered in a semi-structured interview format, using vignette instruments (see Instruments section below). The duration of each interview ranged between 20 to 30 minutes. The researcher was supported by a research assistant who has multiple years of experience in working with refugee populations, understands the culture and is able to speak in the Syrian Arabic dialect. All interviews were recorded after seeking permission from participants. All interviews were transcribed and translated from Arabic to English by the research assistant.

Snowball and thematic saturation sampling were used to identify participants and to ensure that all concepts, patterns and key themes have been captured (O'Reilly, 2012). At the end of each interviews, participants identified through the NGO were asked whether they knew of anybody else that would also be willing to participate in line with the inclusion criteria. In this way, snowball sampling was employed. In terms of thematic

Table 1 - Coding Agenda for Causal Beliefs

Causal Categories	Examples	Coding Rules
Religious	Layla/Louai's symptoms are caused by: - the will of God/it is their destiny; - being a "bad Muslim"/not following the religious faith properly	Rel_01_God/Destiny Rel_02_Religious Disobedience
Supernatural	Layla/Louai's symptoms are caused by the Jinn/Evil Eye/other magical creature/source	Sup_Jinn/Evil Eye/Magic
Biological	Layla/Louai's symptoms are caused by: - hormone imbalance; - change in brain/mind chemistry; - change in bodily function; - inherited illness from parents/grandparents; - use of mind or body altering drugs/alcohol/medication;	Bio_01_Hormones; Bio_02_Brain Chemistry; Bio_03_Body Function; Bio_04_Inherited; Bio_05_Drugs/Alcohol/Medication;
Cognitive	Layla/Louai's symptoms are caused by: - thinking too much/in a wrong way; - change of perspective/outlook on life;	Cog_01_Thinking Wrong; Cog_02_Change in Perspective;
Experiential	Layla/Louai's symptoms are caused by the past experience memories of incident/trauma that happened;	Exp_Past Incident;
Social	Layla/Louai's symptoms are caused by: - loss and/or separation from family; - not married/lack of spouse/loss of spouse; - discrimination and stigma from the society and/or family; - feeling of not being understood by family/society;	Soc_01_Loss/Separation from family; Soc_02_Not Married/separated/lost spouse; Soc_03_Discrimination/Stigma; Soc_04_Not Understood
Psychological	Layla/Louai's symptoms are caused by a mental disorder;	Psy_Mental Disorder

saturation sampling, a priory coding agenda was established (see Tables 1-4) at the outset of data collection, based on the existing body of knowledge on refugees worldwide, and findings of studies specific to Syrian refugees (Al Laham et al., 2020; Hagmayer & Engelmann, 2014; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat, Georgiadou, Borho, Erim, & Morawa, 2020).

Table 2 - Coding Agenda for Help-Seeking Avenues

Coding Agenda for Help-Seeking Avenues

Help-Seeking Categories	Examples	Coding Rules
Religious Leaders	Imams/Priests/Local Religious Leaders	Rel_Help
Traditional Healers	Al-fataha/ Darwish/ Moalj bel-koran	Trad_Healers
Medical Doctors	General practitioner/family doctor (psychiatrist is not included in this category)	Med_Doctor
Mental Health Specialist	Psychiatrist/psychologist/therapist/counsellor	MH_Psy
Social Support	Family/friends/colleagues/neighbours/community	Soc_Help
Isolation	Avoid seeing people/spending time with friends or spending more time alone.	Isol_Alone
UN/NGOs/Social Support Services	Turning to Civil Society Organisations for financial/medical/schooling aid	UN_Aid

Table 3 - Coding Agenda for Treatment Mechanisms

Coding Agenda for Treatment Mechanisms

Treatment Categories	Examples	Coding Rules
Religious Practices	Praying, reading the Quran, making religious vows, visiting a holy place	Rel_Practices
Traditional Healing	Obtain an amulet from a traditional healer to ward off evil spirits etc.	Trad_Healing
Bio-medical Treatment	Going to a medical doctor to seek a medical solution to symptoms (e.g. nightmares, lack of appetite. *Psychiatrists are not considered inside this category;	Med_Doctor
Psychological Treatment	Seeking treatment from a psychiatrist/psychologist/therapist or counsellor (e.g. anti-depressants/therapy etc).	Psy_Treatment
Social Support as Treatment	Talking with friends/attending family gatherings/talking to a neighbours about depression etc.	Soc_Support
Recreational Activities	Sports, walking, watching TV, painting etc.	Rec_Activities
UN/NGOs/Social Services Support	Seeking financial or in kind aid from Civil Society Organisations to support with paying rent/affording medical bills etc.	UN_Aid

Table 4 - Coding Agenda for Coping Mechanisms

Coding Agenda for Coping Mechanisms

Coping Categories	Examples	Coding Rules
Cognitive	Making/having plans, finding strength; Change perspective/self-talk/motivation	Cog_Cope
Social	Making new friends/taking to friends Talking to family/friends/spouse/partner	Social_Cope
Religious	Praying and reading Holy Scripts	Rel_Cope
Avoidance	Avoiding people/places/activities/reminders of past; Leaving work/country/family;	Avoid_Cope
Emotional	Crying/Laughing/Screaming etc;	Emo_Cope
Activity	Listening or playing music; Meeting friends/going out; Sports; Watching TV/movie; Cooking; Shopping	Act_Coping

Saturation, for the purposes of this study, is defined as the point during the data collection process, at which little or no new themes emerge in relation to the research purpose. The definition of the word “themes” refers to causal, help-seeking avenue, treatment methods, and coping strategies categories. The method proposed by Guest, Namey and Chen (2020), which calculates the base size, run length and new information threshold, was used to determine when the saturation of themes was reached. The base size refers to the minimum number of interviews that need to be analysed in order to determine the amount of information gathered (Guest et al., 2020). In this study the base size was set at 5 interviews, and the total base themes identified were 21 (see Table 5). Run length is defined as the number of interviews considered in order to search for and calculate new

Table 5 Base Run Saturation

Base Run - Saturation

Saturation Theme	1	2	3	4	5	Number of base themes
Causality	4	4	0	1	1	10
Help-seeking Avenues	2	0	0	0	0	2
Treatment Methods	2	0	0	0	1	3
Coping Mechanisms	3	2	1	0	0	6
Total Base Themes						21

information (Guest et al., 2020). In this study the base size was set at 3 interviews, and for example, the total number of new themes identified after the first run were 8 (see Table 6).

New information threshold is the limit expressed in percentage which is used to indicate

Table 6 First Run Saturation

First Run - Saturation

Saturation Theme	6	7	8	Number of new themes in a run
Causality	1	0	3	4
Help-seeking Avenues	1	0	2	3
Treatment Methods	0	1	0	1
Coping Mechanisms	0	0	0	0
Total First Run Themes				8

that saturation has been reached (Guest et al., 2020). For this study, the new information threshold was set at 0% - in other words, when no new information is derived across the thematic areas (causality, help seeking avenues, treatment methods and coping mechanisms). As an example, refer to Table 7 in order to see how the new information threshold ratio was calculated after the first run of 3 interview. A decision was taken to only stop when the new information threshold reached 0% across all four categories simultaneously, due to the fact that the study aimed at exploring and identifying potentially

Table 7 New Information Threshold - Run 1

New Information Threshold

Saturation Theme	Run 1	Base Run	New Information Threshold
Causality	4	10	40%
Help-seeking Avenues	3	2	150%
Treatment Methods	1	3	33%
Coping Mechanisms	0	6	0%
Overall Threshold	8	21	38%

new and previously unreported themes (outside of the priory coding agenda). Although, due to the use of priory coding agenda, this research study appears to be largely deductive in nature, it does aim also to search for any new, previously unidentified themes. To this extent, sampling will not be terminated when all the existing themes, in line with the priory coding agenda have been identified, but rather when there are no new themes emerging in general, irrespective of whether they form part of the existing coding agenda or are new in the sense that they have not been captured inside the priory. In doing so, this study hopes to overcome the shortcomings of the purely a priory thematic saturation (Saunders et al., 2018), which requires the data collection to stop when themes have been identified in line with findings of previous and well established research studies.

Purposeful maximum variation was used, in order to gather and analyse data from a wide range of Syrian refugees (e.g. both genders, different age ranges, different duration of refuge in Lebanon etc.), whilst ensuring the following inclusion criteria are observed: the participant must be a Syrian refugee who has sought refuge in Lebanon as a result of the 2011 war; and must be 18 years or older. The reason for setting these inclusion criteria is that they directly speak to the purpose of the study, which is to examine how depression and PTSD are understood, and explained by this specific group of people. As such it is imperative that the participants are Syrian nationals who came to Lebanon seeking refuge as of 2011, when the war in Syria begun. Furthermore, since this study is concerned with adult mental health, no participants under the age of 18 years will be recruited.

Instruments

Data was gathered using two vignette instruments (see Appendices B and C), that tell a story of Layla or Louai with either symptoms of depression or PTSD. The vignette instruments were used in order to explore how both disorders are perceived to be caused,

and consequently what help seeking behaviours and coping mechanisms are adopted. This form of interview schedule was first developed by Jorm et al., (1997) in order to assess MHL among different population groups. Depression and schizophrenia were the focus of the original vignette, aiming to examine how well could a given individual recognize symptoms of the disorders and the associated help-seeking behaviours (Jorm et al., 1997). The vignette instrument also allowed researchers to make inferences about how knowledge and belief impact help-seeking practices and coping mechanisms (Jorm et al., 1997). Although several measures of similar nature have since been elaborated, formal examination of the psychometric properties of such measures has been scarce (O'Connor et al., 2014). Using the Census-based Standards for the Selection of Health Measurement Instruments (COSMIN) guidelines, O'Conner et al., (2014) assessed the quality, scope and psychometric properties of the available, peer-reviewed scale-based measures of MHL. They found that the majority of the MHL instruments address only one domain out of the nine of COSMIN and overall there is limited evidence of appropriate validity assessments (O'Conner et al., 2014). Nevertheless, the vignette instrument and its' adaptations have been used extensively to assess MHL across different population groups and cultures (Chen et al., 2017; Erfanian et al., 2000; O'Conner et al., 2014;). Furthermore, adaptations of vignette instruments for measuring of beliefs and explanatory causal models of specific mental disorders have been used with refugee populations (Markova & Sandal, 2016; Hagmayer & Engelmann, 2014). Vignette instruments have been attempted to be adapted for use in the Lebanese context (Naal, 2018), however non to date have been used in published studies. Nevertheless, an adapted version of Jorm et al., (1997) vignette instrument appears to be the most appropriate measurement instrument for this study.

The original vignette begins with a story, which describes a person who presents with ICD-10 and DSM-IV criteria for major depression (Jorm et al., 1997). Following this, the reader is asked to answer multiple choice questions intended to probe for the respondent's knowledge about: a) this specific mental disorder; b) assess for the help-seeking behaviour and sources of help; c) assess for treatment options including use of medication, and other coping mechanisms (e.g. physical activity or relaxation) (Jorm et al., 1997). In addition to this, the respondents are asked to rate how helpful or harmful the different help-seeking behaviours and treatment options are (Jorm et al., 1997). Considering that the original vignette focuses primarily on whether or not knowledge of a specific disorder is present, a modification of the tool was made in order to broaden its focus on the explanatory causal models, help-seeking behaviours and coping mechanisms associated with depression and PTSD, and not just the presence/ absence of knowledge. The tool was adapted based on the available body of knowledge (Al Laham et al., 2020; Hassan et al., 2015; Zbidat et al., 2020) about mental health disorder causal theories among the Syrian nationals, and similar vignette adaptations used with other refugee populations (Markova & Sandal, 2016; Erdal et al., 2011; Lee et al., 2017), and best practice guidelines for cross-cultural adaptation of tools (Beaton et al., 2000). Furthermore, during the adaptation process, care was taken to ensure that the vignette text and the subsequent prompts are relatable to the reality of the Syrian refugee experience. One of the main reported drawbacks of the vignette approach is that they can sometimes be on the hypothetical side, eliciting only hypothetical answers from the participants that do not represent reality (Erfanian et al., 2020). To overcome this drawback, the adapted instrument begins by asking the participant to share their own experience where they have encountered something similar to the story read out to them. If the participant had no prior

experience of similar nature, they were then asked to recall if they knew anybody in their circle of friends, family or acquaintances that had passed through an experience similar to Louai/Layla. Only in the event that they themselves had no prior experience, and they did not know anyone else who had, the participants were asked to engage hypothetically with the vignette story. Finally, permission to modify and translate the original tool was obtained from the author – Anthony Jorm (see Appendix D).

The modified instrument has been adjusted to be more reflective of the culture of a Syrian refugee residing in Lebanon (e.g. use of culture-specific idioms to describe depression and trauma symptomology in line with Hassan et al., (2015)). In the original vignette developed by Jorm et al., (1997), the readers were asked to explain what is happening to the character of the vignette in order to measure their knowledge of depression. Since this study is more concerned with exploration of causal models of depression and PTSD than presence or absence of knowledge, the vignette informs the reader that the main character (Louai/Layla) is exhibiting symptoms of depression/PTSD. Following the vignette story, several open-ended questions were posed to the participant about the causes of the disorder, and potential associated help seeking behaviours and coping mechanisms. For example: “what do you think is causing Louai’s depression?” and “if you were Layla, who would you turn to in order to get help and why?” The main vignette characters (Layla and Louai) were assigned to participants randomly, in order to assess for any gender-based assumptions as they relate to causes, treatment options and coping mechanisms across both depression and PTSD. Once the modifications were made, the instrument was translated into the Arabic dialect used by Syrian nationals, and the construct and cross-cultural validity of the tool was tested during the pilot phase of data collection and reviewed by the researcher, the research assistant and the thesis advisor.

Piloting the Instruments

During the pilot testing phase, the researcher and the research assistant interviewed a total of six individuals. The average age was $M = 46.3$ ($SD = 19.1$) years (range = 29 - 72), 50% ($n = 3$) of the participants were male and 50% ($n = 3$) were female. During the pilot phase, it became clear that certain questions were written from a technical perspective, and people who are not familiar with terminology used in the field of psychology would struggle to understand what is being asked of them. For example, the majority of the pilot-phase participants were not familiar with the term stigma, especially the Arabic translation of it “wassme”. To overcome this, a question was added to introduce the subject of stigma in an indirect way: “What do you think people would think about Layla/Louai if they knew she/he is experiencing depression/PTSD?” Furthermore, the definition of the term was added in order to make sure that all participants had a clear understanding of what stigma means. Finally, other colloquial terms used to mean stigma were added, for example “mou3ayara”.

Aside from adjusting the instrument, the pilot interviews were very helpful in the practice of asking questions in a way that is not leading or forcing an answer out of the participants. Whilst transcribing the pilot interviews, the research team (the researcher and the research assistant) became aware of instances where leading was taking place. To avoid this and to make sure that the protocol and the content of the interview adhere to the approved ethics guidelines, the language and terminology are clear, context appropriate and non-leading, a trial interview was conducted between the research team and the thesis advisor. This practice run also allowed for preparation in addressing typical challenges that might arise during data collection (e.g. social desirability, re-directing of difficult participants etc).

Correcting for Validity Threats

One of the key threats to validity in qualitative research is researcher bias, which is defined as the tendency for the person leading the study to only confirm and look for one's own preconceived notions on the subject matter (Christensen et al., 2014). In order to correct for this bias, purposive sampling strategy was opted for which aimed to gather a sample representing maximum population variation (e.g. variation across genders, age groups, albeit from age 18 and above, socio-economic status and duration of refuge in Lebanon) (Christensen et al., 2014). In doing so, the researcher bias was reduced as varying target population sub-groups were anticipated to have varying opinions and ideas, that do not necessarily conform to the views and beliefs of the researcher. Furthermore, the researcher used bracketing by writing down their own opinions and expectations (see Appendix E) and thus setting these aside temporarily in order to minimise their impact on the data collection and analysis (Fischer, 2009).

In order to ensure descriptive validity, investigator triangulation was used (Christensen et al., 2014), where the researcher and the research assistant both worked on collecting, transcribing, and translating the data in order to ensure its' accuracy. The researcher ensured that the assistant fully understands the purpose of the study, including the possible study biases and the impact that these could have on the results generated. By involving a Lebanese research assistant, the researcher aimed to correct for potential language and cross-cultural biases. By recording the interviews, the research assistant was able to transcribe the participant's accounts as close to the original description and phrasing as possible, using direct quotations and verbatims where appropriate. Research assistant's support in this matter was of high value in order to ensure correct representation

and translation of the original phrasing, thus ensuring low-inference descriptor inclusion, and working towards strengthening interpretive validity.

The findings were also be cross-checked against studies of similar nature through the established priory coding agenda (see Tables 1- 4) in order to conduct theory triangulation. Furthermore, the researcher aims to submit this study to a journal for peer review, which will allow for the quality of the findings to be critically analysed by individuals who are experts in this field of study, thus strengthening the theoretical validity of the research.

Due to the limitations in terms of the scope of this research study, the time and resource availability, it will not be possible to use additional research methods (e.g. participant feedback gathering, quantitative data gathering), which would allow for further data triangulation and validation of the results.

Participants

A total of 40 participants of Syrian nationality were interviewed. The average age was $M = 33.3$ ($SD = 11.8$) years old (range = 18 - 67), 47% ($n = 19$) of the participants were male and 53% ($n = 21$) were female. The majority of participants resided in South Lebanon 43% ($n = 17$), 25% ($n = 10$) in Beirut and Mt. Lebanon area, another 25% ($n = 10$) in North Lebanon, and 8% ($n = 3$) in the Bekaa. On average, participants reported having lived in Lebanon for 7.9 years (range = 1-10 years, $SD = 1.9$), with the majority of the sample – 65% ($n = 26$) currently living in Sub-standard living conditions².

² Sub-standard refers to living in a structure that is not built for long-term residential purposes (e.g. garage, warehouse, tented settlement, shop, farm, school etc.) (Government of Lebanon, & United Nations, 2020).

Data Coding and Analysis

Maximum variation sampling was used, with a priori coding agenda (see Tables 1-4) established at the outset of data collection, based on the existing body of knowledge on refugees worldwide and finding of studies specific to Syrian refugees (Al Laham et al., 2020; Hagmayer & Engelmann, 2014; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020). Coding took place in parallel to data collection, in order to continuously monitor for the maximum saturation in themes. In doing so, the coding followed a deductive category application approach (Mayring, 2000), whilst making sure to note down and add any new emerging themes not captured within the a-priority coding agenda.

Ethical Considerations

This study was approved by the Ethics Committee of Haigazian University on 08.02.202, protocol number TA.11.20 (see Appendix F), with an amendment to the original approval issued on 09.04.2021 (see Appendix G).

Upon arrival to the interview, all participants were briefed once more on the purpose of the study, including the expected duration of the interview, the participant inclusion criteria were cross checked, and written participation consent was sought. For the interviews conducted online, the consent forms were emailed to participants and signed digitally. All participants were verbally assured that they have the right to quit at any time, and to refuse to answer any and all question if they so wish. Furthermore, participant anonymity was assured, and that they were to be provided with information about how the data they provided would be used. Consent to use a voice recording device was obtained from all participants, and all were assured that the voice recordings are only gathered for transcribing purposes.

In order to avoid causing harm to the participants, the following potential risks and their respective mitigation strategies have been identified.

Psychological Risk. Through the interview participants were expected to recall potentially unpleasant feelings or experiences, and as such a very mild distress was anticipated, albeit not greater than that experienced by a Syrian refugee in their daily lives. During the data collection process, no instances of actual distress caused were recorded.

Relationship. No direct relationship was present between the researcher (and research assistant) and the participants. The data collection process was tailored in a manner in which the researcher does not have influence over a) who is identified as a potential participant, and b) is willing to participate. The data collection and participant selection process did not alter existing dynamics between participants and participant relatives or friends;

Legal. The study did not require the participant to disclose any instances of law violation, or to provide any demographic data that may disclose their identity or legal status in Lebanon;

Economic/professional. During the initial phone conversation between the researcher and the potential participants, care was taken to ensure that the agreed upon timing of the interview did not impact the participants economic or professional commitments. The researcher was flexible with participants in order not to negatively affect their daily schedules and thus income generating activities. All interested participants were assured, that their participation does not in any way impact their eligibility for any form of assistance from the organization through which they have been identified.

Physical. No risk of physical injury occurred as a result of this study;

CHAPTER IV RESULTS

The main themes identified in this study were participants' beliefs pertaining to causality of depression and PTSD, as well as the subsequent help-seeking behaviours and coping mechanisms that Syrian refugees in Lebanon resort to. Observations were made relating to the way in which stigma is believed to affect help-seeking behaviours. Furthermore, participants' previous experiences and knowledge about depression and PTSD were recorded.

Causal Beliefs

The majority of participants believed depression and PTSD to be caused by current life conditions, with financial difficulties and poor living circumstances being the top two most frequently mentioned subcategories (see Tables 8 and 9). Past incidents and traumatic events captured under experiential category, were the second largest reported causes for depression and PTSD. Difficulties in the social aspects of life, such as loss of or separation from one's family, friends and country of origin, as well as discrimination, stigma and social isolation were the third most frequently mentioned causes for mental illness.

The majority of the participants who were given the depression vignette, reported current life conditions as the main cause for depression, whereas the majority exposed to the PTSD vignette believed the cause of the disorder to be related to experiential circumstances (i.e. the car accident) (see Table 10). The majority of the participants who reside in sub-standard living environments attributed the presented disorders to their current life conditions, whereas those residing in standard surroundings believed the disorders to be caused by experiential circumstances (see Table 11).

Table 8 Results Pertaining to Causal Beliefs - Part 1

Results Pertaining to Causal Beliefs - Part 1

Causal Categories	Category Total Score	Subcategories	Subcategory Total Score	Examples
Current life conditions	27	Financial difficulties/no employment	9	"My son asks me for a biscuit, I can't afford a biscuit. To let them eat I would take things from the mini market and tell them I will pay back later, and sometimes the minimarket owner would shame me in front of my family" (ID027)
		Living conditions	8	"Our tent is 7x7 meters, our living conditions are terrible, we are 15 people living in this space. This is depression and bitterness" (ID030) "I live in a house that even goats would not accept to live in" (ID028)
		Lack of medical support/sickness	4	"If we want to get medical treatment, we can't here. We go down to Syria for treatment and come back. Here me and my husband have been trying to do some tests for two days, but we financially we are not able to do so" (ID008)
		Lack of food	3	"I cannot buy meat for my children, they ask me for it everyday and I lie to them telling them that the shop is closed" (ID030)
		Lack of education	2	"The thing that is bothering us the most in the current situation is that the kids cannot continue their studies" (ID008)
		Crises in Lebanon	1	"The crises in Lebanon is affecting us all badly" (ID034)
Experiential	26	Past Incident/Traumatic Event	25	"Trauma that could be caused by external things like war, death threat, etc..." (ID001)
		Power and Frequency of the shocks	1	"Power and frequency of the shock also affect PTSD" (ID004)
Social	17	Loss of /separation from family, friends, country	9	"My mother passed away back in Syria. I could not go back to see her and this affected me greatly. I will die before being able to get over this." (ID028)
		Discrimination, stigma and social isolation	5	"Humiliation from people. We always felt like we're worthless, some people make as feel like we're bugs. I mean, they say hurtful things." (ID035)
		Marital difficulties	1	"If the husband and his wife have a bad communication and problems" (ID029)
		No children	1	"My son has been married for 4 years, and still does not have any children. This is affecting him very badly." (ID026)
		Upbringing	1	"How one was taught to deal with things, how they interact with others, with oneself"(ID002)

Note: Multiple answers possible under category and subcategory total scores

Table 9 Results Pertaining to Causal Beliefs - Part 2

Results Pertaining to Causal Beliefs - Part 2

Causal Categories	Category Total Score	Subcategories	Subcategory Total Score	Examples
Psychological	4	Mental disorder	1	"Being mentally unstable causes depression" (ID023)
		Personal/personality differences	3	"Some people get depressed by not getting what they want whilst others do not" (ID002)
Biological	3	Change in bodily function;	2	"Person's nervous system cannot process this trauma" (ID001) "I am psychologically tired because I have an infection in my leg" (ID023)
		Change in brain/mind chemistry;	1	"You have imbalances in your neurotransmitters so you do not have enough serotonin or dopamine to make you happy" (ID017)
Cognitive	3	Thinking too much/in a wrong way;	2	"Taking up the role of a victim drives them to become depressed" (ID002)
		Fear of tomorrow	1	"We are living in a constant fear of tomorrow" (ID030)
Emotional	3	Facing overwhelming emotions	3	"Not understanding own feelings/facing overwhelming emotions" (ID001)
Religious	1	The will of God/it is their destiny	1	"His God wrote this for him" (ID005)

Note: Multiple answers possible under category and subcategory total scores

Table 10 Disorder Comparison - Causal Beliefs

Disorder Comparison - Causal Beliefs

Causal Categories	Depression	PTSD
Current life conditions	15	12
Experiential	10	16
Social	12	5
Psychological	3	1
Biological	2	1
Cognitive	2	1
Emotional	1	2
Religious	0	1

Table 11 Living Conditions Comparison - Causal Beliefs

Living Conditions Comparison - Causal Beliefs

Causal Categories	Standard	Sub-standard
Current life conditions	3	24
Experiential	11	15
Social	4	13
Psychological	2	2
Biological	2	1
Cognitive	2	1
Emotional	2	1
Religious	0	1

Majority of the participants from South and Beirut Mount Lebanon areas attributed the causes of depression and PTSD to current life conditions, whereas the participants from North Lebanon reported experiential circumstances to be the main reason (see Table 12).

Table 12 Area Comparison - Causal Beliefs

Area Comparison - Causal Beliefs

Causal Categories	North	Beirut Mt Lebanon	Bekaa	South
Current life conditions	1	8	1	17
Experiential	10	6	1	9
Social	3	1	1	12
Psychological	2	0	0	2
Biological	0	2	0	1
Cognitive	2	0	0	1
Emotional	0	2	0	1
Religious	1	0	0	0

In terms of gender differences, the majority of the female participants attributed depression and PTSD to current life condition causes, whereas the majority of males believed the disorders to be caused by experiential circumstances (see Table 13). Only two participants in total held gender specific beliefs with regards to causes of depression and PTSD. A male participant ID007 stated: “I feel like they [women] have a weakness a little bit more than men because they have worries, they have problems”. Whereas a female participant ID002 stated: “Males from Syria face more depression than females, because men are targeted and harassed more at the borders, check-points by armed groups and police representing various political and governmental entities. It is less safe to move around and live as a male Syrian refugee”.

Table 13 Gender Comparison - Causal Beliefs

Gender Comparison - Causal Beliefs

Causal Categories	Females	Males
Current life conditions	17	10
Experiential	11	15
Social	7	10
Psychological	3	1
Biological	2	1
Cognitive	2	1
Emotional	0	3
Religious	1	0

Help-seeking Behaviours

Overwhelming majority of the participants reported that they would seek help from their family members, friends and acquaintances, all grouped under the category of social support (see Table 14). The second most popular choice was the category of mental health

professionals (i.e. psychologists, psychiatrists etc.), whilst religion, and God specifically, was the third most reported help-seeking avenue.

Table 14 Results Pertaining to Help-Seeking Avenues

Results Pertaining to Help-Seeking Avenues

Help-seeking Categories	Category Total Score	Examples
Social Support (family, friends, acquaintances)	29	"I have a father and a mother. I have my friend, he talks to me, and just like he talks to me I talk to him" (ID006)
Mental Health Professional	9	"If my surroundings can't help me, I would go to a psychologist. I mean I would let people say I'm crazy, but not get crazy for real." (ID022)
Religion	8	"I don't refer to anyone but God" (ID010)
No-one	4	"Nobody can help, we tried a lot but nobody helped us. All people are in the same situation, so nobody can help" (ID037)
Self-Help	4	"I wouldn't seek help, I'd help myself" (ID021)
Medical Doctor	3	"I had some shoulder problems so I did osteopathy sessions and I discovered that they also helped me mentally a lot. It helped me reduce my crying related to Syria and the car accident" (ID016)
Aid from UN/NGOs/Civil Society	3	"In Lebanon we try to seek help from the UN" (ID030)

Note: Multiple answers possible under category total scores

Similarly, when asked how would they go about treating depression or PTSD, majority of the participants elected to talk to, spend time with or seek advice from their social support networks (see Table 15). Almost the same number of participants would not attempt any treatment at all, instead choosing to "get used to it and just let it pass" (ID013) or "accept the idea of it all" (ID008). Seeking treatment from mental health professionals was the third most frequently mentioned option.

Table 15 Results Pertaining to Treatment Mechanisms

Results Pertaining to Treatment Mechanisms

Treatment Categories	Category Total Score	Examples
Social Support (family, friends, acquaintances)	12	"But what helped me the most was my cell phone or technology, since I can talk to my parents and see them over a simple phone call even if they are distant." (ID020)
No treatment	11	"We stayed for a while like this until we got used to everything" (ID013)
Mental health professional	10	"I tried Cognitive Behavioural Therapy (CBT) which did not work out for me, so I went to a psychiatrist that prescribed me antidepressants which I took for almost two years" (ID011)
Religion	7	"I pray to my God and read the Quran. " (ID029)
Work/recreational activities	6	"Find something to get your mind off of it, to get out of this thing. For example go to the gym, go do some exercises, go learn music, start in a conservatory for arts for example" (ID006)
Aid from UN/NGOs/Civil Society	3	"Louai needs to have his needs met, to receive something in order to be okay. It is not just about talking, he needs to get his needs met. " (ID037)
Facing fear	2	"I guess a friend that knows how to drive... I would go with that person for a drive, ask him to drive me around and teach me how to drive to overcome my fear" (ID014)
Immigrating	1	"What helped me was leaving the war in Syria and coming to Lebanon" (ID027)
Medical doctor	1	"I went to osteopathy sessions" (ID016)

Note: Multiple answers possible under category total scores

The majority of participants would turn to their family members, friends and acquaintances (i.e. social support) for help and to try to treat disorders (e.g. in the form of talking, advice seeking and doing activities together), irrespective of whether they were given the depression or the PTSD vignette (see Tables 16 and 17). Although many of those presented with the depression vignette also reported seeking no treatment (see Table 17).

Table 16 Disorder Comparison – Help-seeking Avenues

Disorder Comparison - Help-Seeking Avenues

Help-seeking Categories	Dep	PTSD
Social Support (family, friends, acquaintances)	13	16
Mental Health Professional	4	5
Religion	3	5
No-one	3	1
Self-Help	1	3
Medical Doctor	2	1
Aid from UN/NGOs/Civil Society	1	2

Table 17 Disorder Comparison – Treatment Mechanisms

Disorder Comparison - Treatment Mechanisms

Treatment Categories	Depression	PTSD
Social Support (family, friends, acquaintances)	6	6
No treatment	7	4
Mental health professional	5	5
Religion	2	5
Work/recreational activities	3	3
Aid from UN/NGOs/Civil Society	2	1
Facing fear	0	2
Immigrating	1	0
Medical doctor	0	1

The participants who reside in sub-standard living environments overwhelmingly chose to turn to their family members, friends and acquaintances (i.e. social support) for help. Whereas those living in standard living conditions would almost equally turn to social support or seek help from mental health professionals (see Table 18).

Table 18 Living Conditions Comparison - Help-seeking Avenues

Living Conditions Comparison - Help-Seeking Avenues

Help-seeking Categories	Standard	Sub-standard
Social Support (family, friends, acquaintances)	8	21
Mental Health Professional	7	2
Religion	2	6
No-one	2	2
Self-Help	1	3
Medical Doctor	2	1
Aid from UN/NGOs/Civil Society	0	3

Similarly, the participants residing in sub-standard living environments overwhelmingly chose not to treat depression or PTSD, or turn to the social support networks for treatment. In comparison, the individuals living in standard living conditions would seek treatment from mental health professionals as their first choice (see Table 19).

Table 19 Living Conditions Comparison - Treatment Mechanisms

Living Conditions Comparison - Treatment Mechanisms

Treatment Categories	Standard	Sub-standard
Social Support (family, friends, acquaintances)	3	9
No treatment	1	10
Mental health professional	8	2
Religion	2	5
Work/recreational activities	3	3
Aid from UN/NGOs/Civil Society	1	2
Facing fear	1	1
Immigrating	0	1
Medical doctor	1	0

The majority of the participants from South and Beirut Mount Lebanon areas would turn to their family members, friends and acquaintances (i.e. social support) for help with their depression and PTSD. Whereas participants from North Lebanon would turn to their social networks or a mental health professional (see Table 20).

Table 20 Area Comparison - Help-seeking Avenues

Area Comparison - Help-seeking Avenues

Help-seeking Categories	North	Beirut Mt Lebanon	Bekaa	South
Social Support (family, friends, acquaintances)	6	9	1	13
Mental Health Professional	4	3	0	2
Religion	1	2	1	4
No-one	0	1	1	2
Self-Help	2	0	0	2
Medical Doctor	0	3	0	0
Aid from UN/NGOs/Civil Society	0	1	0	2

In terms of treatment mechanisms, the participants from the South Lebanon area choose their social support networks as primary mode of treatment, or do not seek any treatment at all. Whereas the participants from North and Beirut Mount Lebanon areas primarily opt to see a mental health professional as a their primary treatment choice (see Table 21).

Table 21 Area Comparison - Treatment Mechanisms

Area Comparison - Treatment Mechanisms

Treatment Categories	North	Beirut Mt Lebanon	Bekaa	South
Social Support (family, friends, acquaintances)	1	3	1	7
No treatment	2	2	1	6
Mental health professional	4	4	0	2
Religion	1	1	1	4
Work/recreational activities	1	3	0	2
Aid from UN/NGOs/Civil Society	0	0	1	2
Facing fear	1	0	0	1
Immigrating	0	0	0	1
Medical doctor	0	1	0	0

There are almost no gender differences in terms of turning to the social support networks in pursuit of help, however more women than men would choose to see a mental health professional (see Table 22).

Table 22 Gender Comparison - Help-seeking Avenues

Gender Comparison - Help-Seeking Avenues

Help-seeking Categories	Females	Males
Social Support (family, friends, acquaintances)	14	15
Mental Health Professional	7	2
Religion	4	4
No-one	3	1
Self-Help	1	3
Medical Doctor	3	0
Aid from UN/NGOs/Civil Society	1	2

A similar trend can be observed in the reported treatment mechanisms for depression and PTSD, namely women’s preferred choice of treatment are the mental health services, followed closely by social support networks and no treatment. Whereas men primarily choose to treat mental disorders with the help of their social network, or do not have any treatment all together (see Table 23).

Table 23 Gender Comparison - Treatment Mechanisms

Gender Comparison - Treatment Mechanisms

Treatment Categories	Females	Males
Social Support (family, friends, acquaintances)	6	6
No treatment	6	5
Mental health professional	7	3
Religion	4	3
Work/recreational activities	2	4
Aid from UN/NGOs/Civil Society	0	3
Facing fear	0	2
Immigrating	1	0
Medical doctor	1	0

Only one participant reported a gender specific preference with regards to help-seeking avenues for depression and PTSD. A female participant ID012 stated that she prefers to seek help from: “my husband and my male siblings the most”.

Stigma and Help-seeking Behaviours

When asked what would people say about Layla/Louai if they knew that she/he has depression/PTSD, majority of the respondents felt that there would be no stigmatisation at all. For those who stated that Layla/Louai would be stigmatised, the majority felt that it would be the shaming or insulting type, followed by stigmatisation in relation to mental instability (see Table 24).

Table 24 Results Pertaining to Stigma

Results Pertaining to Stigma

Stigma Categories	Category Total Score	Examples
No Stigma	22	"We are all from Adam and Eve. Why stigmatize someone? We are all the same thing and we all are going back to the soil " (ID010) "No one would care, honestly" (ID015)
Shaming/insulting	17	He/she is: "crazy," "an animal," "possessed," "neglect and avoid her/him," "it is all her/his own fault."
Related to mental instability	13	He/she is: "mentally ill," "diseased," "retarded," "stupid," "lost his/her mind" "unstable," "depressed," "psychologically sick."
Light Criticism	8	He/she is: "tired," "sad," "going through pressure," "dumped by someone she/he loves," "angry at someone," "attached to Syria," "moody."
Related to faking/pretending	7	He/she is: "overreacting," "being dramatic," "acting," "exaggerating," "lying," "attention seeker."
Weakness related	7	He/she is: "weak personality," "weak faith," "unsuitable for marriage," "pathetic," "underdeveloped," "complicated," "sensitive personality."

Note: Multiple answers possible under category total scores

The distribution of answers pertaining to stigma did not vary much based on the type of vignette presented to the participants (i.e. depression or PTSD) (see Table 25).

Table 25 Disorder Comparison - Stigma

Disorder Comparison - Stigma

Stigma Categories	Dep	PTSD
No Stigma	11	11
Shaming/insulting	9	8
Related to mentall instability	8	5
Light Criticism	5	3
Related to faking/pretending	4	3
Weakness related	3	4

More participants residing in sub-standard living conditions responded that there would be no stigma than those living in standard living circumstances. Furthermore, in the event that stigma was present, those residing in sub-standard living conditions reported more instances of using shaming or insulting type of stigmatisation, and mental instability related stigma than participants from standard living environments (see Table 26).

Table 26 Living Conditions Comparison - Stigma

Living Conditions Comparison - Stigma

Stigma Categories	Standard	Sub-standard
No Stigma	8	14
Shaming/insulting	5	12
Related to mental instability	3	10
Light Criticism	4	4
Related to faking/pretending	5	2
Weakness related	2	5

The majority of the participants from Bekaa, South, and Beirut Mount Lebanon areas reported that Layla/Louai would not be stigmatised for experiencing depression/PTSD. In the event that stigmatisation would take place, the majority of participants from South Lebanon believed it would be related to shaming or insulting. The majority of Beirut and Mount Lebanon participants also believed it would be related to shaming or insulting. Whereas the majority of participants from North Lebanon stated the weakness related stigma would be present (see Table 27).

Table 27 Area Comparison - Stigma

Area Comparison - Stigma

Stigma Categories	North	Beirut Mt Lebanon	Bekaa	South
No Stigma	3	8	2	9
Shaming/insulting	4	5	0	8
Related to mental instability	4	2	1	6
Light Criticism	4	1	0	3
Related to faking/pretending	4	2	0	1
Weakness related	5	1	0	1

In terms of gender differences, there were more female participants who reported that Layla/Louai would not be stigmatised for experiencing depression/PTSD. Similarly, female participants believed that the type of stigma to be present would be the shaming or insulting type, faking or pretending type, and weakness related. Male participants stated that the most common type of stigmatizing would be shaming and insulting, as well mental instability related (see Table 28).

Table 28 Gender Comparison - Stigma

Stigma Categories	Females	Males
No Stigma	14	8
Shaming/insulting	9	8
Related to mentall instability	5	8
Light Criticism	4	4
Related to faking/pretending	6	1
Weakness related	5	2

Only two participants in total reported a gender specific stigmatisation as a result of experiencing depression and PTSD. A male participant ID006 stated: “Poor her! Who would take her?” implying that women with depression become undesirable for marriage. A female participant ID012 stated: “Louai is not a girl to go through stereotype of shame” implying that only women can be stigmatised.

In terms of how stigma affects help-seeking behaviour, the majority of participants stated that depression or PTSD experienced by Layla/Louai would get worse. The second most reported impact was that Layla/Louai would refuse to seek help and isolate her/himself from the community. The third most frequently mentioned impact was that

stigma would negatively affect or completely put a stop to the treatment process (see Table 29).

Table 29 Results Pertaining to Impact of Stigma

Results Pertaining to Impact of Stigma

Stigma Impact Categories	Category Total Score	Examples
Get worse	27	He/she will: "never get well," "will commit suicide," "fall apart," "add pressure".
Not seek help/isolate	22	He/she will: "not trust people," "refuse to seek help," "avoid people".
Impact treatment	12	He/she will: "stop/delay/prolong treatment," "take medication without prescription," "seek help in secrecy".
Positive impact	7	"I think we have to let these words make us stronger, to face people and show them that it's true that I'm unhappy but I'm not crazy, I'm just hurt but I want to get over it" (ID020)
No impact	5	"Stigma would not affect, because there is nobody to turn to for help except for family who will not stigmatise" (ID026)
Other	2	"She resorted to other things, like smoking, drugs, and these kinds of things" (ID011); "Maybe if she became a mom, she would transmit her disorder to her children" (ID014)

Note: Multiple answers possible under category total scores

Coping Mechanisms

The majority of the participants reported that they would cope with depression and PTSD through active, social, avoidant and cognitive coping mechanisms (see Table 30).

Table 30 Results Pertaining to Coping Mechanisms

Results Pertaining to Coping Mechanisms

Coping Categories	Category Total Score	Examples
Active Coping	30	"I kept myself busy in a lot of stuff... for example... plant some vegetables, have fun so I forget a little bit the situation I am in." (ID019)
Social Coping	29	"I would motivate myself by socializing, I forgot what happened to me, and was back to my old life." (ID033)
Avoidant Coping	21	"I would stay in bed and I would not wake up. I was avoiding to do anything, my daughter would be helping me serve the children." (ID027)
Cognitive Coping	21	"I mean, just like things are hard on us there are also other people who have it harder. I mean, just like they say - the one who sees the disaster of other people, his problems will get easier"(ID006)
Emotional Coping	13	"honestly, I cried a lot. Whenever my husband came back from work he'd find me in a bad state, I would be overwhelmed and crying." (ID020)
Religious Coping	6	"I'd be patient and pray." (ID035)
Not Coping	4	"I don't know how to describe it. I would feel like I'm suffocating, and sometimes I would cut my hands. When I see blood I would feel better. Sometimes I would hate myself, as if I want to get rid of my life." (ID033)

Note: Multiple answers possible under category total scores

The distribution of answers pertaining to coping mechanisms did not vary much based on the type of vignette presented to the participants (i.e. depression or PTSD) (see Table 31).

Table 31 Disorder Comparison - Coping Mechanisms

Disorder Comparison - Coping Mechanisms

Coping Categories	Depression	PTSD
Active Coping	15	15
Social Coping	14	15
Avoidant Coping	7	10
Cognitive Coping	6	11
Emotional Coping	7	6
Religious Coping	3	3
Not Coping	3	1

Participants residing in sub-standard living conditions reported engaging in more coping mechanisms overall than participants living in standard conditions, scoring higher across all coping mechanism categories (see Table 32).

Table 32 Living Conditions Comparison - Coping Mechanisms

Living Conditions Comparison - Coping Mechanisms

Coping Categories	Standard	Sub-standard
Active Coping	12	18
Social Coping	10	19
Avoidant Coping	7	10
Cognitive Coping	3	14
Emotional Coping	4	9
Religious Coping	1	5
Not Coping	1	3

Majority of the participants from South and Beirut Mount Lebanon areas reported engaging in active and social coping mechanisms. Whereas participants from North Lebanon primarily relied on cognitive coping. Participants from Bekaa reported engaging equally in social and avoidant coping mechanisms (see Table 33).

Table 33 Area Comparison - Coping Mechanisms

Coping Categories	North	Beirut Mt Lebanon	Bekaa	South
Active Coping	5	7	2	16
Social Coping	5	8	3	13
Avoidant Coping	5	4	3	9
Cognitive Coping	8	4	1	8
Emotional Coping	3	2	1	7
Religious Coping	0	0	1	5
Not Coping	1	0	0	3

The distribution of answers pertaining to coping mechanisms did not vary much based on the gender of participants, although females were more likely than males to report engaging in avoidant, cognitive and emotional coping mechanisms. Males were more likely than females to engage in religious coping practices (see Table 34).

Table 34 Gender Comparison - Coping Mechanisms

Coping Categories	Females	Males
Active Coping	15	15
Social Coping	15	14
Avoidant Coping	13	8
Cognitive Coping	13	8
Emotional Coping	9	4
Religious Coping	1	5
Not Coping	2	2

Experience and Knowledge

When asked whether or not the participants had experienced something similar to the depression or PTSD vignette presented to them, 73% ($n = 29$) said that they had and

28% ($n = 11$) said they had not. The vast majority of the participants, irrespective of the vignette story presented to them, did not know what the terms depression and PTSD meant, and could not define them. However, when talking about their own life experience, it became evident that many individuals have experienced symptoms and aspects of depression and PTSD, yet they were not aware that this cluster of symptoms has a technical name. For example, a female participant (ID036) who did not know what PTSD was, described her experience as follows: “We fled, with the military flights over us and the shots [fired], we fled and came here to Lebanon. We got scared a lot. For about two years we stayed like this: if I see a [gun] shot fired or [see] police on the road I get scared. Of course the food and drinks and sleep [were affected] of course, I stayed here a year not able to sleep. Every time we hear something we get scared. Yes of course, I stayed a year like this in Lebanon even more than a year until we got used to it.”

When asked whether anything could be done to prevent depression or PTSD, the majority of participants stated that nothing can be done. The majority of those who felt that there was a way to prevent mental disorders stated that it can be achieved through increased awareness and practice of self-care (see Table 35).

Table 35 Results Pertaining to Prevention

Results Pertaining to Prevention

Prevention Categories	Category Total Score	Examples
Can't prevent	25	"Nothing can be done to prevent PTSD" (ID001)
Awareness	7	Includes the following: "education on mental health", "knowing early signs and symptoms", "practicing mindfulness and acceptance".
Self-care	6	Includes the following: "going on a trip", "regularly attending therapy", "surround yourself with good relationships".
Avoidance	2	Includes the following: "avoidance of triggers" and "avoidance of negative people".
Prayer	2	"Pray and read the Quran because it is the only solution for everything"(ID029)
Resolve past issues	1	"To prevent... I would ask a friend to take me on a ride, and I'd repeat the action until I get rid of my fear even if it takes a long time." (ID014)

Note: Multiple answers possible under category total scores

CHAPTER V DISCUSSION

The aim of the present study was to explore the underlying beliefs on causes of depression and PTSD, as well as the subsequent help-seeking behaviours and coping mechanisms that Syrian refugees in Lebanon resort to. As far as it can be deduced, this is one of the first few studies of this nature conducted in Lebanon, which highlights the Syrian refugee' perspectives on mental illness, and the subsequent steps that they take to treat or cope with depression and PTSD. However, The results of this study are of particular significance to the Lebanese Government, the Ministry of Health and all aid and civil society organisation which aim to improve the mental health policy and practices across the country in response to the huge mental health needs among the Syrian refugee population. As such, the study also aimed to suggest culturally appropriate, and feasible mental health support programs, derived from knowledge of depression and PTSD through the Syrian refugee cultural lens.

The uniqueness of this study is that it largely corroborates the key findings in terms of previously reported causal beliefs, help seeking behaviours and coping mechanisms used by the Syrian refugee population, except for the religious aspect. Whereas multiple previous studies (Al Laham et al., 2020; Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020) have shown the causes of mental disorders and subsequent help-seeking behaviours to be strongly rooted in religious beliefs, this study found only a minimal association of this kind. This outcome was unexpected, but it could be explained by the rapidly shifting life conditions and priorities of the refugee population in the face of multiple crises that are currently taking place in Lebanon.

Causal Beliefs

Participants of this study provided multiple causal explanations for the mental disorders they were presented with, which supports the fact that people in general consider multiple problem sources in order to fully understand the predicament that they find themselves in (Hassan et.al, 2015). Past research of Syrian nationals displaced inside Syria (Hassan et al., 2015), and Syrian refugees residing in Greece (Ben Farhat et al., 2018), Germany (Zbidat et al., 2020), and Lebanon (Al Laham et al., 2020), have shown that causes of mental disorders are believed to emanate from losses, violence and socio-economic pressures, as well as religious beliefs, particularly the influence of the Jinn. Whilst this study found support for previously established causal beliefs related to difficult socio-economic life circumstance, past traumatic experiential events, loss and separation, almost no association was found for religious beliefs or spiritual entities such as the Jinn. This outcome was unexpected, but it could be explained by the rapidly shifting life conditions and priorities of the refugee population in the face of multiple crises that are currently taking place in Lebanon. The 2020 Vulnerability Assessment of Syrian Refugees in Lebanon (UNHCR et al., 2020) reports that 89%³ of all Syrian refugee households live in extreme poverty, struggling to survive on less than USD 3.84/capita/day. More than 58% of all Syrian refugee families reside in conditions deemed to be below humanitarian standards⁴, and the percentage of households with poor food consumption⁵ has quadrupled between 2019 and 2020 (UNHCR et al., 2020). The Syrian refugee population rely on

³ A 34% increase compared to 2019 (UNHCR et al., 2020).

⁴ Defined as shelters in danger of collapse, or in overcrowded conditions of less than 4.5m²/person (UNHCR et al. 2020).

⁵ Defined as decrease in the number of meals consumed per adult per day (from 2.2. in 2019 to 1.9 in 2020), and a 30% decline in dietary diversity per household (UNHCR et al. 2020).

pharmacies for primary health care needs, citing cost of transportation, medication and doctor's fees as the primary barrier to health care access (UNHCR et al., 2020). Whilst the overall life circumstances for Syrian refugees in Lebanon have always been difficult, the recent economic and socio-political challenges, along with the COVID-19 pandemic have significantly worsened these conditions (World Food Programme, 2020). In light of such growing difficulties, it can be assumed that the people affected by them have a tangible and external factor to focus on as the predominant cause of their predicament. It is therefore not entirely surprising that the majority of Syrian refugee participants of this study believed depression and PTSD to be caused by current life conditions, including financial difficulties, poor living circumstances, lack of access to food, essential health services and medication. Studies that look at changes in migrant values and beliefs, such as the study by Williams et al., (2014), show that migrant values can change as a result of different kinds of experiences. As revealed in the study by Lamensdorf Ofori-Atta and Linden (1995), a persons' causal beliefs and treatment preferences in terms of mental health, can be affected by changes in income, acculturation and education factors. The multiple crises in Lebanon, as demonstrated by the VASyR study findings (UNHCR et al., 2020), have negatively affected the socio-economic status of the Syrian refugees in a relatively short time period of only a year. This could be a factor that accounts for the observed lack of religious causal explanations, with a shift towards a focus on life circumstances, although further research is needed in order to understand better the relationship between changes in socio-economic status and causal beliefs related to mental health.

The previous research study attributed the economic challenges and unemployment faced by the study participants to the geographic isolation of the Wadi Khaled area (Al

Laham et al., 2020). The results of the current study demonstrate that the socio-economic challenges as perceived cause of mental illness are not limited to a specific geographic area, but instead have become a geographically wider-spread issue. The majority of the participants from South and Beirut Mount Lebanon areas attributed the causes of depression and PTSD to current life conditions, and the majority of these participants also resided in sub-standard living conditions. Such living circumstances are indicative of a lower socio-economic status (UNHCR et al., 2020), and higher exposure to post-migration stressors related to meeting basic survival needs. The critical importance of post migration stressors as they relate to mental health outcomes for refugees have been noted by Zbidat et al., (2020), demonstrating that they have a greater impact on manifestation and progression of mental illness compared to pre-migration factors.

The subsequent most frequently reported causes of depression and PTSD were the past incidents, traumatic events, as well as the loss of and separation from family, friends and country of origin, captured under the “experiential” and “social” categories respectively. Furthermore, discrimination, stigma and social isolation were also reported to cause mental distress. These finding supports the results of the previous studies conducted in Lebanon, Greece and Germany showing that war experiences (e.g. torture, violence etc.), separation, loss, death, discrimination and social isolation were deemed traumatic, and considered as major causes of mental distress by Syrian refugees (Al Laham et al., 2020; Ben Farhat et al., 2018; Zbidat et al., 2020). Everyday problems, recent traumatic events, a broken home or death of a loved one, effectively the top three most reported causal categories of this study, were grouped under “psychosocial” factors in a study by Pang et al., (2018). Interestingly, when using the Pang et al., (2018) adaptation of the causal beliefs scale, Tan et al., (2020) found that those individuals who attributed their

mental illness to be caused by psychosocial factors, were more willing to seek help and perceive less stigma associated with the illness. Studies have shown that attributing mental illness to factors external to oneself is positively associated with help-seeking (Kleinberg et al., 2013), and reduces stigma as well as desire for social isolation (Jorm & Griffiths, 2008). As such, although Tan et al., (2020) studied a cultural group quite different from Syrian refugees, their findings could explain why so many Syrian refugees attributed mental illness to psychosocial factors. It can further help explain the observed differences in causal attributions between individuals presented with the depression and PTSD vignettes. Participants who were given the PTSD vignette linked the cause of the disorder to an experiential event, which is not surprising since the PTSD described in the vignette follows a very clear and tangible event – a car accident. Whereas in the depression vignette, the cause is not so clear, which perhaps explains why the majority of the respondents who were presented with this vignette linked it to a current life condition - a prominent and pressing life stressor from their own experiences. In all cases, both causal categories fit perfectly under Pang et al., (2018) “psychosocial” factors umbrella classification - mental illness factors external to oneself.

In terms of gender differences, the majority of the female participants attributed depression and PTSD to current life condition causes, whereas the majority of males believed the disorders to be caused by experiential circumstances. This could be explained by the fact that Syrian women traditionally are in charge of the day-to-day household duties (e.g. cooking, raising children), and therefore they are the first ones to directly experience the consequences of poor living conditions, lack of access to food, medication and education for their children (Care Middle East and North Africa, 2021). Furthermore, women are also the first ones to suffer as a result of the household having to adapt

stringent food related coping strategies⁶, by giving priority to their children and the husband first (Care Middle East and North Africa, 2021; UNHCR et al., 2020). When it comes to Syrian men, traditionally they have been the ones to be in charge of making life-changing decisions that impact the whole family, such as leaving Syria (Oxfam, 2021). Having taken these decisions, the majority find themselves living in dire socio-economic conditions, unable to provide for their families or find a way out of these difficult circumstances. As such, they could be attributing mental illnesses to the experiential circumstances of the past – namely back to the moments when these decisions to flee were taken, amidst a war and the associated atrocities that they witnessed. There is no evidence to support this assumption however, and further research is needed to test this theory.

Help-seeking Behaviours

Overwhelming majority of the participants reported that they would turn to their family members, friends and acquaintances in order to seek help and treat mental health disorders (e.g. in the form of talking, advice seeking and doing activities together) irrespective of whether they were presented with the depression or the PTSD vignette. This is consistent with the findings of multiple studies done with refugee populations in general, with Syrian refugees across multiple settings, and in Lebanon specifically (Al Laham et al., 2020; Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020).

The second most popular choice in terms of help-seeking avenues was the category of mental health professionals (i.e. psychologists, psychiatrists etc.), which could be explained by the fact that attitudes towards MHPSS have been observed to be rapidly changing among Syrian refugee and internally displaced population groups (Hassan et al.,

⁶ Reducing the portion sizes or number of meals per person per day (UNHCR et al., 2020).

2015). Mental health practitioners working with these population groups have recently noted this change in attitudes, and attribute it to the shared war experiences, which also tend to lessen the stigma surrounding mental illness (Hassan et al., 2015). This change in attitudes could also help explain why seeking psychological/psychiatric treatment was the third most frequently chosen option in this study.

The third most popular help-seeking avenue was turning to God. Whilst numerous studies have found that refugees from Arab origins, and Syrian refugees specifically often turn to religious and traditional healers as a more culturally acceptable, and less stigmatising healing avenue (Al Laham et al., 2020; Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020), the findings of this study show a slightly different trend. When study participant spoke about turning to God, they referred to doing so in complete privacy with a direct line to their creator, without the need to go through third parties (e.g. religious or traditional healers). When God was chosen as a source of help, it was done so with an absolute conviction that only this source can resolve all the problems, and not because it is the most culturally acceptable or less stigmatising.

The participants who reside in sub-standard living environments (i.e. South and Beirut Mount Lebanon areas) overwhelmingly chose to turn to their family members, friends and acquaintances (i.e. social support) for help. Whereas those living in standard living conditions, such as the majority of the participants from the North Lebanon area, would almost equally turn to social support or seek help from mental health professionals. Participants residing in sub-standard living environments overwhelmingly chose not to treat depression or PTSD, or turn to the social support networks for treatment. In comparison, the individuals living in standard living conditions would seek treatment from mental health professionals as their first choice. This difference in help-seeking behaviours

based on the living environment could be attributed to socio-economic status and subsequently affordability of services, as demonstrated in studies such as Packness et al., (2019). As noted earlier, the Syrian refugee population in Lebanon has been found to increasingly rely on pharmacies for primary health care needs, citing cost of transportation, medication and doctor's fees as the primary barrier to health care access (UNHCR et al., 2020). Individuals residing in sub-standard living conditions are therefore less likely to afford paying for visits to a mental health professional and resort to seeking help from avenues immediately available to them, such as their family, friends and acquaintances. Whereas Syrian refugees residing in standard living conditions may be better off financially, and in a position to seek professional mental health services. Inability to afford services could also partly explain why a large number of participants stated that they would not attempt any treatment at all, instead choosing to "get used to it and just let it pass" (ID013) or "accept the idea of it all" (ID008). Further research studies into the relationship between socio-economic status, living conditions and accessibility of mental health services are needed, as causality between the observed factors cannot be inferred due to the qualitative nature of this study,

There are almost no gender differences in terms of turning to the social support networks in pursuit of help, however more women than men would choose to see a mental health professional. A similar trend can be observed in the reported treatment mechanisms for depression and PTSD, namely women's preferred choice of treatment are the mental health services, followed closely by social support networks and no treatment. Whereas men primarily choose to treat mental disorders with the help of their social network, or do not have any treatment all together. This could be explained by the fact that women in general score higher than men on "Psychological Openness" (Tan et al., 2020), and thus

are more up for seeking help from a mental health specialist. Whereas being seen as seeking help from a psychologist would imply weakness on the part of men (Addis & Mahalik, 2003), and in Arab cultures men must be perceived to remain strong for their families (Zbidat et al., 2020).

Stigma and Help-seeking Behaviours

When asked what would people say about Layla/Louai if they knew that she/he has depression/PTSD, the majority of the respondents who happened to also be residing in sub-standard living conditions felt that there would be no stigmatisation at all. This could be explained by the fact that the main causal beliefs were psychosocial in nature, and thus associated with reduces stigma (Jorm & Griffiths, 2008; Tan et al., 2020). In terms of gender differences, there were more female participants who reported that Layla/Louai would not be stigmatised for experiencing depression/PTSD, which could be explained by the fact that women in general score higher than men on “Indifference to Stigma” (Tan et al., 2020), and thus are less influenced by it.

For those who stated that Layla/Louai will be stigmatised, the majority felt that the labels used would be the shaming or insulting type (e.g. “crazy” or “animal”), followed by stigmatisation in relation to mental instability (e.g. “mentally ill” or “retarded”). Female participants said that it would be the shaming or insulting type, faking or pretending type, and weakness related. Male participants indicated that the most common type of stigmatizing would be shaming and insulting, as well mental instability related. Furthermore, those residing in sub-standard living conditions (i.e. South Lebanon and Beirut and Mount Lebanon participants) reported more instances of using shaming or insulting type of stigmatisation, and mental instability related stigma than participants from standard living environments. While there is little research with regards to the exact

labelling used by Syrian refugees to imply stigma, it is overwhelmingly evident that presence of any stigma, including self-stigmatisation, is negatively correlated with help seeking and treatment outcomes (Al Laham et al., 2020; Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Merhej, 2019, Zbidat et al., 2020). The results of this study also support these findings, as the majority of participants stated that experiencing stigma would lead to worse or more severe forms of depression and PTSD, refusal to seek help and social isolation, as well as negative impact or complete cessation of the treatment.

Coping

The majority of the participants reported that they cope with depression and PTSD through active, social, avoidant and cognitive coping mechanisms. This is consistent with the findings of Hassan et al., (2015) stating that common ways of minimising or overcoming distress include working, seeking companionship, as well as withdrawal and doing nothing. Participants residing in sub-standard living conditions, mostly participants from South and Beirut Mount Lebanon, reported engaging in more coping mechanisms overall than participants living in standard conditions, and female participants were more likely than males to report engaging in avoidant, cognitive and emotional coping mechanisms. Males were more likely than females to engage in religious coping practices. Both of these gender specific findings are overall very much in line with the work of Hassan et al., (2015). Whilst many refugee men and women engage in numerous positive coping mechanisms, there are also many that resort to passive ones such as crying, isolation and denial of the emotional difficulties, because they feel that there are limited opportunities for them to do anything else (Hassan et al., 2015). Avoidance behaviour was found to be a coping strategy among Syrian refugees in Germany, as it allowed them to avoid being in contact with people who brought back traumatic memories (Zbidat et al.,

2020). This does not appear to be the case for Syrian refugees in Lebanon, as none of the participants reported using self-isolation as a means of avoiding painful past memories brought to light by other people.

Bracketing Comparison

Before initiating data collection, the researcher used bracketing in order to write down their own opinions and expectations from this study (see Appendix E), thus setting these aside temporarily in order to minimise their impact on the data collection and analysis. The first assumption made during the bracketing exercise was that in line with multiple research findings (El Chammay et al., 2013; El Chammay et al., 2016; Kerbage et al., 2016), the majority of Syrian refugees in Lebanon will have first-hand, recent experience of depression and/or trauma but only a very small proportion will know of and/or access MHPSS services. This assumption was upheld to some extent, since 73% ($n = 29$) of the participants said that they had experienced something similar to the stories of Layla/Louai. The vast majority of the participants, irrespective of the vignette story presented to them, did not know what the terms depression and PTSD meant, which could be indicative of never having been exposed to MHPSS services or mental health terminology. Furthermore, only a limited proportion of the participants indicated that they would seek help from mental health professionals, which does not mean that they actually did so in the past.

The second assumption made was that majority of the participants would attribute depression and PTSD to religious or supernatural causes, as well as war experiences. And in line with these causal beliefs, it was expected that the majority of Syrian refugees would turn to religious healers or medical doctors as the first line of help and healing. Whilst war experiences were among the top three causal beliefs mentioned, religious and supernatural

ones were almost entirely absent. Furthermore, whilst medical doctors did get mentioned as a possible avenue of help, religious leaders were not considered at all. This was quite an unexpected outcome, but it could be explained by the fact that previous studies conducted with this population group took place before October 2019⁷ and thus before the multiple crises that have erupted in Lebanon since. As discussed in the previous sections, and evidenced by studies such as the 2020 Vulnerability Assessment of Syrian Refugees (UNHCR et al., 2020), the socio-economic situation of the Syrian refugees has deteriorated drastically in a matter of months, leaving 89%⁸ of all Syrian refugee households in extreme poverty. In these circumstances, struggle for survival takes precedent, and it is quite possible that the previously reported causal beliefs and subsequent coping mechanisms have shifted to reflect the more pressing needs among this population group.

Recommendations

Several recommendations for culturally appropriate, and feasible mental health support programs can be drawn from this study. Firstly, at the grassroots level, there is a fundamental need for awareness campaigns that tackle general knowledge on mental health symptoms, whilst also working towards de-stigmatising mental health in general. However, in order to make these initiatives effective, it is of vital importance to engage the many qualified Syrian refugees who have knowledge, experience and practice in improving community mental health and psychosocial wellbeing, in the design and implementation of such campaigns. Involvement of these individuals from early on, will ensure a more culturally appropriate design and implementation, and will lead to a better community buy-in towards the messages being delivered (Hassan et al., 2016).

⁷ At least in terms of data collection.

⁸ A 34% increase compared to 2019 (UNHCR et al., 2020).

Furthermore, experienced Syrian refugees could also be involved in creating opportunities to raise awareness about mental health at the community leader levels.

Secondly, there is great need for more community level MHPSS that are delivered through psychosocial programmes as opposed to psychiatric and clinical settings. This will increase the acceptability of such services and decrease the stigma associated with being seen to take part in them (Hassan et al., 2016). Since the findings of this study point to the fact that the majority of the participants will look to engage in some sort of activity as a means of coping with their mental distress, MHPSS can be made available through community centres, child friendly spaces, schools, women's groups, worship centres and sports activities. In order to make the MHPSS accessible to both men and women, care should be taken in order to tailor these programmes in culturally and gender appropriate ways. For example, it is essential to make safe spaces available for women and girls only, where they have the opportunity to discuss and seek support with more sensitive concerns such as domestic abuse and life changes (Hassan et al., 2016). Men would be more likely to engage in MHPSS if they were made available in the evenings and through meaningful activities or sports practices (Hassan et al., 2016).

As a component of the MHPSS, there should be a focus on decreasing stigma related to mental health overall. This study clearly showed that although majority of the participants had experienced symptoms and aspects of depression and PTSD, they were not aware that this cluster of symptoms has a technical name. Overt expression of strong emotions are considered acceptable in Syria, however the explicit labelling of the emotions and distress as a mental health issue constitutes a source of shame and poses a risk of being stigmatized (Hassan et al., 2016). As such, practitioners are encouraged to avoid using psychological jargon and psychiatric labelling in order to create a better therapeutic

alliance and generate less stigma (Hassan et al., 2016). As such, the psychosocial activities could be focus, for example, on providing practical means for managing strong emotions as opposed to explicitly labelling them as cognitive-behavioural techniques to deal with “emotional dysregulation” .

On a final note, it is important to recognise that all the MHPSS need to be provided along-side initiatives that aim at mitigating the difficult living conditions and the extremely challenging socio-economic situation. As highlighted by Hassan et al., (2016), improving livelihood opportunities and living conditions may contribute to improving the overall mental health of Syrian refugees potentially more than interventions geared only towards psychological support.

Strength and Limitations

The strengths of this study are, firstly, that this is one of two qualitative studies conducted with Syrian refugees in Lebanon, focused on their causal beliefs, helps-seeking behaviour and coping mechanisms. While the previous study of such nature focused exclusively on Wadi Khaled area (Al Laham et al., 2020), this study sampled participants from all areas of Lebanon (North, South, Beirut and Moutn Lebanon and the Bekaa). All interviews were conducted in Arabic, by a person (the research assistant) who speaks the Syrian Arabic dialect, and has multiple years of experience of working with several refugee populations. This, to some degree, counteracted a possible linguistic and cultural bias, thus the findings should not be distorted by linguistic and cultural misunderstandings. At the same time, since the researcher was also present during the interviews, and visibly a foreigner, this could have introduced some social desirability bias from the side of the participants. To avoid possible condemnation or judgement, the participants may

deliberately have failed to mention, for example, how they would stigmatise other individuals known to have mental health issues.

The uniqueness of this study is that it largely corroborates the key findings in terms of previously reported causal beliefs, help seeking behaviours and coping mechanisms used by the Syrian refugee population, except for the religious aspect. Whereas multiple previous studies (Al Laham et al., 2020; Ben Farhat et al., 2018; Hassan et al., 2015; Markova & Sandal, 2016; Zbidat et al., 2020) have shown the causes of mental disorders and subsequent help-seeking behaviours to be strongly rooted in religious beliefs, this study found only a minimal association of this kind. This outcome was unexpected, but it could be explained by the rapidly shifting life conditions and priorities of the refugee population in the face of multiple crises that are currently taking place in Lebanon.

Due to the limitations in terms of the scope of this research study, the time and resource availability, it was not possible to use additional research methods (e.g. participant feedback gathering, quantitative data gathering), which would allow for further data triangulation and validation of the results. Furthermore, due to the time limitations, coding of the gathered information was done only by the author alone. Having multiple coders would contribute better towards achieving coding consistency, intercoder reliability and potentially generate further interpretations of the gathered data (Church et al., 2019).

In the current context of Lebanon, amidst a national pandemic with numerous total lockdowns initiated by the Government of Lebanon, it was very difficult to sample equally from all areas of the country. Initially the research team was reliant upon an international NGO in order to receive potential participant referrals. However, once the Government imposed a one month long total lockdown, the NGO operating hours were severely reduced, slowing down the data collection process, and also the ability to sample from

different areas. For this reason, the researcher applied to the ethics committee and got the approval to introduce snowball sampling as part of the data collection process, in order to try to reach participants from all areas of the country. Nevertheless, despite best efforts, only three participants could be identified from the Bekaa area, which remains largely under-represented in the current study.

It is also important to recognise that the answers collected in this study represent the beliefs of individuals held at a specific moment in time, in a set context, and are susceptible to change under a different set of circumstances, as pointed out by (Hassan et al., 2015). As such, and also due to the qualitative nature of this study, the results cannot be generalized to the entire Syrian refugee population in Lebanon, nor to the highly heterogeneous population of all refugees as a whole. Future studies should try to replicate the results of the current study in larger and more representative samples.

References

- Abu-Rayya, H. M. (2007). Acculturation, Christian religiosity, and psychological and marital well-being among the European wives of Arabs in Israel. *Mental Health, Religion & Culture, 10*, 171–190.
- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *The American psychologist, 58*, 5–14. doi:10.1037/0003-066x.58.1.5
- Ahn, W. K., Proctor, C. C., & Flanagan, E. H. (2009). Mental health clinicians' beliefs about the biological, psychological, and environmental bases of mental disorders. *Cognitive Science, 33*, 147–182. doi:10.1111/j.1551-6709.2009.01008.x
- Al Ibraheem, B., Kira, I. A., Aljakoub, J., & Al Ibraheem, A. (2017). The health effect of the Syrian conflict on IDPs and refugees. *Peace and Conflict: Journal of Peace Psychology, 23*, 140-152. doi:10.1037/pac0000247
- Al Laham, D., Ali, E., Venables, E., Mousally, K., Nahas, N., & Alameddine, A. (2020). Perceptions and Health-Seeking Behaviour for Mental Illness Among Syrian Refugees and Lebanese Community Members in Wadi Khaled, North Lebanon: A Qualitative Study. *Community Mental Health Journal, 56*, 875–884. doi:10.1007/s10597-020-00551-5
- Atwoli, L., Stein, D. J., Koenen, K. C., & McLaughlin, K. A. (2015). Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences. *Current opinion in psychiatry, 28*, 307–311. doi:10.1097/YCO.0000000000000167
- Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2000). Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures. *Spine-affiliated Society Meeting Abstracts, 25*, 3186-3191.
- Ben Farhat, J., Blanchet, K., Juul Bjertrup, P., Veizis, A., Perrin, C., Coulborn, R. M.,

- Mayaud, P., & 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*, 1-12. doi:10.1186/s12916-018-1028-4
- Beshai, S., Watson, L. M., Meadows, T. J. S., & Soucy, J. N. (2019). Perceptions of cognitive behavioural therapy and antidepressant medication for depression after brief psychoeducation: Examining shifts in attitudes. *Behavior Therapy*, *50*, 851–863. doi:/10.1016/j.beth.2019.01.001
- Care International in Lebanon. (2018). Syrian refugees in Lebanon eight years on: what works and why that matters for the future. Retrieved from <https://reliefweb.int/report/lebanon/syrian-refugees-lebanon-eight-years-what-works-and-why-matters-future>
- Care Middle East and North Africa (2021). If we don't work we don't eat. Syrian women face mounting food insecurity a decade into the conflict. Retrieved from <https://reliefweb.int/sites/reliefweb.int/files/resources/CARE%20Syrian%20Women%20Face%20Mounting%20Food%20Insecurity%20-%20FINAL%20-%20Web.pdf>
- Chen, S., Wu, Q., Qi, C., Deng, H., Wang, H., Wang, X., He, H., ... Liu, T. (2017). Mental health literacy about schizophrenia and depression: a survey among Chinese caregivers of patients with mental disorder. *BioMed Central Psychiatry*, *17*, 1-8. doi: 10.1186/s12888-017-1245-y
- Chu, T., Keller, A. S., & Rasmussen, A. (2013). Effects of post-migration factors on PTSD outcomes among immigrant survivors of political violence. *Journal of Immigrant and Minority Health*, *15*, 890–897. doi:10.1007/s10903-012-9696-1
- Church, S. P., Dunn, M., & Prokopy, L. S. (2019). Benefits to Qualitative Data Quality

- with Multiple Coders: Two Case Studies in Multi-coder Data Analysis. *Journal of Rural Social Sciences*, 34, 1-14.
- Close, C., Kouvonen, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews. *Globalization and Health*, 12, 47. doi:10.1186/s12992-016-0187-3
- Christensen, L. B., Johnson, R. B., & Turner, L. A. (2014). *Research Methods, Design, and Analysis, 12th edition*. Pearson
- El Chammay, R. E., Karam, E., & Ammar, W. (2016). Mental health reform in Lebanon and the Syrian crisis. *The Lancet Psychiatry*, 3, 202-203. doi:10.1016/S2215-0366(16)00055-9
- El Chammay, R., Kheir, W., & Alaouie, H. (2013). Assessment of mental health and psychosocial support services for Syrian refugees in Lebanon. Lebanon: UNHCR.
- El Khoury, S. J. (2019). Factors that impact the sociocultural adjustment and well-being of Syrian refugees in Stuttgart – Germany. *British Journal of Guidance and Counselling*, 47, 65-80. doi:10.1080/03069885.2018.1520196
- Erdal, K., Singh, N., & Tardif, A. (2011). Attitudes about depression and its treatment among mental health professionals, lay persons and immigrants and refugees in Norway. *Journal of Affective Disorders*, 133, 481-488. doi:10.1016/j.jad.2011.04.038
- Erfanian, F., Heydari, A., Roudsari, R. L., & Bahmani, M. N. D. (2000). A Narrative on Using Vignettes: Its Advantages and Drawbacks. *Journal of Midwifery & Reproductive Health*, 8, 2134-2145.
- Farhood, L. F., & Dimassi, H. (2012). Prevalence and predictors for post-traumatic stress

- disorder, depression and general health in a population from six villages in South Lebanon. *Social Psychiatry and Psychiatric Epidemiology*, 47, 639–649.
doi:10.1007/s00127-011-0368-6
- Fernando, S. (2014) Globalization of psychiatry – A barrier to mental health development. *International Review of Psychiatry*, 26, 551-557.
doi: [10.3109/09540261.2014.920305](https://doi.org/10.3109/09540261.2014.920305)
- Fischer, C. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19, 583–590.
- Gammouh, O. S., Al-Smadi, A. M., Tawalbeh, L. I., & Khoury, L. S. (2015). Chronic diseases, lack of medications, and depression among Syrian refugees in Jordan, 2013-2014. *Preventing Chronic Disease: Public Health Research, Practice, And Policy*, 12, 1-9. doi:10.5888/pcd12.140424.
- Georgiadou, E., Zbidat, A., Schmitt, G. M., & Erim, Y. (2018). Prevalence of Mental Distress Among Syrian Refugees with Residence Permission in Germany: A Registry-Based Study. *Frontiers in psychiatry*, 9, 393.
doi:10.3389/fpsyt.2018.00393
- Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in Public Health*, 6, 1-7. doi:10.3389/fpubh.2018.00179
- Government of Lebanon, & United Nations. (2020). Lebanon Crisis Response Plan 2017-2020 (2020 update). Retrieved from <https://reliefweb.int/report/lebanon/lebanon-crisis-response-plan-2017-2020-2020-update>
- Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS ONE*, 15, 1-17.
- Hader, M. (2017). Mental health during the Syrian crisis: How Syrians are dealing with the

psychological effects. *International Review of the Red Cross*, 99, 927-935.

doi:10.1017/S1816383119000080

Hagmayer, Y., & Engelmann, N. (2014). Causal beliefs about depression in different cultural groups-what do cognitive psychological theories of causal learning and reasoning predict? *Frontiers in Psychology*, 5, 1-18. doi: 10.3389/fpsyg.2014.01303

Hassan, G., Ventevogel, P., Jefee-Bahloul, H., Barkil-Oteo, A., & Kirmayer, L. J. (2016). Mental health and psychosocial wellbeing of Syrians affected by armed conflict. *Epidemiology and Psychiatric Sciences*, 25, 129–141. doi:10.1017/S2045796016000044

Hassan, G., Kirmayer, L.J., Mekki-Berrada, A., Quosh, C., el Chammay, R., Deville-Stoetzel, J.B... 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. Retrieved from: <https://www.unhcr.org/55f6b90f9.pdf>

Hechanova, R. & Waelde, L. (2017). The influence of culture on disaster mental health and psychosocial support interventions in Southeast Asia. *Mental Health, Religion & Culture*, 20, 31-44. doi: 10.1080/13674676.2017.1322048

Hofmann, S. G., & Hinton, D. E. (2014). Cross-cultural aspects of anxiety disorders. *Current psychiatry reports*, 16, 450. doi:10.1007/s11920-014-0450-3

IOM. (2018). Global Migration Indicators 2018. Retrieved from https://publications.iom.int/system/files/pdf/global_migration_indicators_2018.pdf

Janmyr, M. (2016). Precarity in Exile: The Legal Status of Syrian Refugees in Lebanon. *Refugee Survey Quarterly*, 35, 58. doi:10.1093/rsq/hdw016.

- Javanbakht, A., Amirsadri, A., Abu Suhaiban, H., Alsaud, M. I., Alobaidi, Z., Rawi, Z., & Arfken, C. L. (2019). *Journal of Immigrant Minority Health*, 21, 664: 685. doi: 10.1007/s10903-018-0797-3
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Mental health literacy: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166, 182–6.
- Jorm, A. F., & Griffiths, K. M. (2008). The public's stigmatizing attitudes towards people with mental disorders: how important are biomedical conceptualizations?. *Acta Psychiatrica Scandinavica*, 118(4), 315–321. doi:10.1111/j.1600-0447.2008.01251.x
- Karam, E. G., Howard, D. B., Karam, A. N., Ashkar, A., Shaaya, M., Melhem, N., & El-Khoury, N. (1998). Major depression and external stressors: The Lebanon Wars. *European Archives of Psychiatry and Clinical Neuroscience*, 248, 225–230.
- Karam, E. G., Mneimneh, Z. N., Dimassi, H., Fayyad, J. A., Karam, A. N., Nasser, S. C., Chatterji, S., and Kessler, R. C. (2008). Lifetime Prevalence of Mental Disorders in Lebanon: First Onset, Treatment, and Exposure to War. *Public Library of Science Medicine*, 5, 579-586.
- Karam, E. G., Karam, G. E., Farhat, C., Itani, L., Fayyad, J., Karam, A. N., Mneimneh, Z., Kessler, R., & Thornicroft, G. (2019). Determinants of treatment of mental disorders in Lebanon: barriers to treatment and changing patterns of service use. *Epidemiology and Psychiatric Sciences*, 28, 655–661. doi:10.1017/S2045796018000422
- Kazour, F., Zahreddine, N. R., Maragel, M. G., Almustafa, A. M., Haddad, R., Soufia, M.

- & Richa, S. (2016). Post-traumatic Stress Disorder in a Sample of Syrian Refugees in Lebanon. *Comprehensive Psychiatry*, *72*, 41-47.
doi:10.1016/j.comppsy.2016.09.007.
- Kerbage, H., El Chammay, R., & Richa, S. (2016). Mental health legislation in Lebanon: Nonconformity to international standards and clinical dilemmas in psychiatric practice. *International Journal of Law & Psychiatry*, *44*, 48-53.
doi:10.1016/j.ijlp.2015.08.031
- Kessler, R. C., & Bromet, E. J. (2013). The epidemiology of depression across cultures. *Annual Review of Public Health*, *34*, 119–138. doi:10.1146/annurev-publhealth-031912-114409
- Kleinberg, A., Aluoja, A., & Vasar, V. (2013). Social support in depression: structural and functional factors, perceived control and help-seeking. *Epidemiology and psychiatric sciences*, *22*, 345–353. doi:10.1017/S2045796013000504
- Kuittinen, S., Punamäki, R. L., Mölsä, M., Tiilikainen, M., & Honkasalo, M.-L. (2017). Causal attributions of mental health problems and depressive symptoms among older Somali refugees in Finland. *Transcultural Psychiatry*, *54*, 211–238.
doi:/10.1177/1363461516689003
- Lamensdorf Ofori – Atta, A. M., & Linden, W. (1995). The effect of social change on causal beliefs of mental disorders and treatment preferences in Ghana. *Social Science & Medicine*, *40*, 1231-1242. doi:10.1016/0277-9536(94)00248-R
- Lee, C. Y., Furnham, A., & Merritt, C. (2017). Effect of directness of exposure and trauma type on Mental Health Literacy of PTSD. *Journal of Mental Health*, *26*, 257–263.
doi:10.1080/09638237.2016.1276531
- Lindert, J., vonEhrenstein, O.S., Priebe, S., Mielck, A., & Brähler, E. (2009). Depression

- and anxiety in labor migrants and refugees-A systematic review and meta-analysis. *Social Science and Medicine*, 69, 246–257. doi:10.1016/j.socscimed.2009.04.032
- Markova, V., & Sandal, G. M. (2016). Lay explanatory models of depression and preferred coping strategies among Somali refugees in Norway. A mixed-method study. *Frontiers in Psychology*, 7, Article ID 1435.
- Mayrig, P. (2000). Qualitative Content Analysis. *Forum: Qualitative Social Research*, 1, 1-10.
- Merhej, R. (2019). Stigma on mental illness in the Arab world: beyond the socio-cultural barriers. *International Journal of Human Rights in Healthcare*, 12, 285–298. doi:10.1108/IJHRH-03-2019-0025
- Naal, H. (2018). *Predictors of mental health literacy in a sample of university students in Lebanon* (Unpublished masters dissertation). Haigazian University, Beirut, Lebanon.
- Naja, W. J., Aoun, M. P., El Khoury, E. L., Abdallah, F. J., & Haddad, R. S. (2016). Prevalence of depression in Syrian refugees and the influence of religiosity. *Comprehensive Psychiatry*, 68, 78–85. doi:10.1016/j.comppsy.2016.04.002
- Nguyen, D., & Bornheimer, L. A. (2014). Mental health service use types among Asian Americans with a psychiatric disorder: considerations of culture and need. *Journal of Behavior Health Services and Research*, 41, 138-152. doi: 10.1007/s11414-013-9383-6
- O'Connor, M., Casey, L., & Clough, B. (2014). Measuring mental health literacy – review of scale-based measures. *Journal of Mental Health*, 23, 197-204. doi: 10.3109/09638237.2014.910646
- O'Reilly, M. (2012). 'Unsatisfactory Saturation': a critical exploration of the notion of

- saturated sample sizes in qualitative research. *Qualitative Research* 13, 190-197.
doi:10.1177/1468794112445106
- Packness, A., Halling, A., Simonsen, E., Waldorff, F. B., & Hastrup, L. H. (2019). Are perceived barriers to accessing mental healthcare associated with socioeconomic position among individuals with symptoms of depression? Questionnaire-results from the Lolland-Falster Health Study, a rural Danish population study. *British Medical Journal Open*, 9, e023844. doi: 10.1136/bmjopen-2018-023844
- Pang, S., Subramaniam, M., Lee, S. P., Lau, Y. W., Abdin, E., Chua, B. Y., Picco, L., Vaingankar, J. A., & Chong, S. A. (2018). The Singaporean public beliefs about the causes of mental illness: results from a multi-ethnic population-based study. *Epidemiology and psychiatric sciences*, 27, 403–412.
doi:10.1017/S2045796017000105
- Pickren, W. E. (2014). What is resilience and how does it relate to the refugee experience? Historical and theoretical perspectives. Retrieved from
https://www.researchgate.net/publication/300586166_What_Is_Resilience_and_How_Does_It_Relate_to_the_Refugee_Experience_Historical_and_Theoretical_Perspectives
- Reliefweb. (2019). UNHCR Lebanon Factsheet, January 2019. Retrieved from
<https://reliefweb.int/report/lebanon/unhcr-lebanon-factsheet-january-2019>
- Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental healthcare utilization and access among refugees and asylum seekers in Europe: systematic review. *Health Policy*, 123, 851-863.
doi:10.1016/j.healthpol.2019.02.007
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H.,

- & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality and Quantity*, *52*, 1893-1907. doi:10.1007/s11135-017-0574-8
- Slewa-Younan, S., Yaser, A., Guajardo, M., Mannan, H., Smith, C. A., & Mond, J. M. (2017). The mental health and help-seeking behaviour of resettled Afghan refugees in Australia. *International Journal of Mental Health Systems*, *11*, 1-8. doi:10.1186/s13033-017-0157-z
- Tan, G., Shahwan, S., Goh, C., Ong, W. J., Samari, E., Abdin, E., Kwok, K. W., Chong, S. A., & Subramaniam, M. (2020). Causal beliefs of mental illness and its impact on help-seeking attitudes: a cross-sectional study among university students in Singapore. *British Medical Journal open*, *10*, e035818. doi:10.1136/bmjopen-2019-035818
- Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & 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*, 51-64. doi:10.1186/s13033-017-0156-0
- UNHCR. (2019). Global Trends – Forced Displacement in 2018. Retrieved from <https://www.unhcr.org/globaltrends2018/>
- UNHCR., UNICEF., & WFP. (2018). VASyR 2018: Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR). Retrieved from <https://www.unhcr.org/lb/wp-content/uploads/sites/16/2018/12/VASyR-2018.pdf>.
- UNHCR., UNICEF., & WFP. (2020). VASyR 2020: Vulnerability Assessment of Syrian Refugees in Lebanon (VASyR). Retrieved from <http://ialebanon.unhcr.org/vasyr/#/>
- Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and

psychotherapy. *Psychology and Psychotherapy*, 83, 75–89.

doi:10.1348/147608309X467807

Weiner, B. (1985). An attributional theory of achievement motivation and emotion.

Psychological Review, 92, 548 - 567. doi:/10.1037//0033-295X.92.4.548

Williams, N. E., Thornton, A., & Young-DeMarco, L. C. (2014). Migrant Values and

Beliefs: How are they Different and How Do They Change? *Journal of Ethnic*

Migrant Studies, 40, 796-813. doi: 10.1080/1369183X.2013.830501

World Food Programme. (2020). Assessing the Impact of the Economic and COVID-19

Crises in Lebanon. Retrieved from [https://docs.wfp.org/api/documents/WFP-](https://docs.wfp.org/api/documents/WFP-0000116784/download/)

[0000116784/download/](https://docs.wfp.org/api/documents/WFP-0000116784/download/)

World Health Organization. (2010). WHO-AIMS Report of Mental Health System in

Lebanon. Retrieved from

https://www.who.int/mental_health/who_aims_report_lebanon.pdf?ua=1

World Health Organization. (2018a). Mental Health Promotion and Mental Health Care in

Refugees and Migrants – Technical Guidance. Retrieved from

[http://www.euro.who.int/_data/assets/pdf_file/0004/386563/mental-health-](http://www.euro.who.int/_data/assets/pdf_file/0004/386563/mental-health-eng.pdf?ua=14)

[eng.pdf?ua=14](http://www.euro.who.int/_data/assets/pdf_file/0004/386563/mental-health-eng.pdf?ua=14)

Zbidat, A., Georgiadou, E., Borho, A., Erim, Y., & Morawa, E. (2020). The perceptions of

trauma, complaints, somatization, and coping strategies among Syrian refugees in

Germany - a qualitative study of an at-risk population. *International Journal of*

Environment Research and Public Health, 17, 693–708.

doi:10.3390/ijerph17030693

Zimmermann, M., & Papa, A. (2019). Causal explanations of depression and treatment

credibility in adults with untreated depression: Examining attribution theory. *Psychology and Psychotherapy: Theory, Research and Practice*, 93, 537–554. doi:10.1111/papt.12247

Appendix A NGO Support Letter



Dear Sir/Madam,

CISP is an international non-governmental organization, that is operating in Lebanon since 1996, registered officially as of 2009. Since the beginning of the operations in Lebanon, CISP has successfully implemented more than 60 projects funded and/or co-funded by the European Commission (EC Trust Fund, ECHO, EC), UN Agencies (UNRWA, UNICEF, OCHA), the Italian Ministry of Foreign Affairs, and the Italian Cooperation. The completed projects are both of humanitarian and development nature across the following sectors; shelter, water sanitation and hygiene, basic assistance, education, health, livelihoods and sustainable tourism. CISP has a strong reputation among Lebanese Authorities, and is known to be supporting numerous vulnerable population groups (Lebanese, Syrian refugees and Palestinian refugees) across the areas of Beirut Mt Lebanon, North and South Lebanon.

In my capacity as the CISP Lebanon Country Director I would like to extend all the needed support to enable a safe and successful completion of a thesis study conducted by Ms Mirdza Abele. Ms Abele approached me in early September 2020 and provided me with the following details on the study:

Study course title and University: MA in Clinical Psychology, Haigazian University;

Research study title: "Lay causal beliefs, help-seeking behaviours and coping strategies for depression and PTSD among Syrian refugees living in Lebanon".

Purpose of the Study

The primary purpose of this study is to explore, the lay casual theories of depression and PTSD, the subsequent help-seeking behaviours and coping mechanisms used among Syrian refugees residing in Lebanon. Through gaining an understanding of these factors, this study also aims to suggest culturally appropriate, and feasible mental health support programs that could be adopted by the humanitarian aid community supporting this population group.

Research Design

In order to study the lay casual theories of depression and PTSD, the subsequent help-seeking behaviours and coping mechanisms used among Syrian refugees residing in Lebanon, a phenomenological qualitative research design will be employed. Thematic saturation sampling and purposeful maximum variation will be used, in order to gather and analyse data until all concepts, patterns and key themes that have emerged. The aim is to collect samples from a wide range of Syrian refugees in order to obtain maximum variation (e.g. both genders, different age ranges, different duration of refuge in Lebanon etc.), as well as thematic content saturation (e.g. with regards to causal beliefs, help seeking behaviours and coping strategies).

Inclusion Criteria

The participants must be a Syrian refugees who has sought refuge in Lebanon as a result of the 2011 war; and must be 18 years or older.

FINANCIAL NUMBER 2031593

ARIDA BLDG - 2ND FLOOR - MDAWWAR ST. - FURN EL-CHEBBAK - BEIRUT - LEBANON
TEL /FAX: +961 1 611493 - E-MAIL: cispleb@cyberia.net.lb

CISP HEADQUARTERS: VIA GERMANICO, 198 - 00192 ROME - ITALY
TEL: +39063215498 - FAX: +39.63216163 - E-MAIL: cisp@cisp-ngo.org - WEB: WWW.CISP-NGO.ORG

In line with the above defined study details, in my capacity and authority limits as the representative of CISP Lebanon, I am willing to support Miss. Abele in the following way:

1. Support her by identifying Syrian refugees who meet the study inclusion criteria. CISP will pre-screen their beneficiary database in order to identify potential study participants in line with the inclusion criteria.
2. Support her by creating an initial contact between the potential participant and the researcher. CISP will contact potential eligible participants, and determine whether or not they would be interested in participating in the research study. CISP will provide initial overall information about the study as detailed by Ms Abele. In the event that the individual is interested, consent will be sought from them to share their contact details with the researcher who will make a follow up call and arrange data collection details.
3. If necessary, CISP is ready to offer office premises that can be used by Ms Abele to do face-to-face interviews.

I wish Ms Abele all the best of luck with her research and hope that the study findings can bring the needed knowledge on the psychological well-being of Syrian refugees in Lebanon. CISP Lebanon will greatly benefit from such information in order to enhance the psychosocial support service models developed to support the refugee community. Please do not hesitate to contact me for any information or further support needed.

Sincerely,



Ms. Simone Abou Jaoudeh
CISP Lebanon Country Representative
Telephone: 03 280 792
Email: CISPLEB@cyberia.net.lb

Appendix B Depression Vignette

The Vignette Instrument for Depression - Layla

Layla is a 21-year-old refugee from Syria currently living in a refugee settlement in the Bekaa valley of Lebanon. Layla has been feeling unusually sad and miserable for the last few weeks. She is tired all the time and has trouble sleeping at night. Layla does not feel like eating and has lost weight. She can't concentrate during her daily activities, puts off making any decisions and taking actions. Her family members and friends are very concerned about her. Layla feels she will never be happy again and believes her family would be better off without her. Layla is feeling so desperate; she is hoping to fall asleep and never wake up again. Layla is exhibiting symptoms of depression.

أداة المقال القصيرة للاكتئاب

ليلى لاجئة سورية تبلغ من العمر 21 عامًا وتعيش حاليًا في مخيم للاجئين في سهل البقاع في لبنان. خلال الأسابيع القليلة الماضية وعلى غير عاداتها كانت ليلى تشعر بالحزن والتعاسة. إنها متعبة طوال الوقت وتعاني من صعوبة في النوم ليلاً. ليلى لا تشعر بالرغبة في الأكل وفقدت وزنها، ولا تستطيع التركيز خلال أنشطتها اليومية، وتؤجل اتخاذ أي قرارات وإجراءات. يشعر أفراد أسرتها وأصدقائها بقلق بالغ تجاهها. تشعر ليلى أنها لن تستطيع أن تكون سعيدة مجدداً وتؤمن بأن عائلتها ستكون أفضل حالاً بدونها. تشعر ليلى باليأس الشديد وتأمل في النوم وعدم الاستيقاظ مرة أخرى. ليلى تظهر عليها أعراض الاكتئاب.

Questions

- 1- Have you ever experienced something similar yourself? If yes, could you tell me about this experience? Note: Prod for similar experience in terms of symptoms not the events described in the story itself.
- 2- If you did not experience anything similar yourself, do you know anybody who did have this kind of experience? If yes, could you tell me more about it?
- 3- If neither yourself, nor anyone you know experienced something of this nature, could you share with me what you know about depression?

أسئلة

- 1- هل سبق لك أن واجهت شيئاً مشابهاً؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني عن هذه التجربة؟ ملاحظة: اسأل عن تجارب مشابهة من حيث العوارض وليس عن الأحداث الموصوفة في القصة.
- 2- إذا لم تختبر شيئاً مشابهاً ، فهل تعرف أي شخص اختبر هذه التجربة؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني المزيد عنها؟
- 3- إذا لم تختبر بنفسك أو أي شخص تعرفه شيئاً من هذا القبيل ، فهل يمكنك أن تشاركني ما تعرفه عن الاكتئاب؟

Prompts

- What do you understand by the term depression?
- What do you think caused/ causes depression?
- Who can you turn to in order to get help with depression?
- How do you go about treating depression?
- What do you think people would think about Layla if they knew she is experiencing depression?

- Stigma is mark of disgrace associated with a particular circumstance, quality, or person. Did you/that someone you know ever experience stigma because of depression?
- Did experiencing stigma affect who you (or that someone you know) turn to for help?
- Did experiencing stigma impact the way you (or that someone you know) treat depression?

Note: If no previous personal experience/does not know anyone who has had depression, prod to get beliefs about stigma and its impact on help seeking behaviours and treatment options.

- Is there anything you did or can do to prevent or be less likely to experience depression?
- How do you cope with the stress/daily challenges of life whilst experiencing depression?

محفزات

- ماذا تفهم من مصطلح الاكتئاب؟
- ماذا برأيك يسبب الاكتئاب؟
- من الذي يمكنك اللجوء إليه للحصول على المساعدة؟
- كيف تتعامل مع الاكتئاب؟
- ماذا برأيك سيظنوا الناس اذا علموا أن ليلي تعاني من الاكتئاب؟
- الوصمة هي علامة على الخزي المرتبط بظروف أو صفة معينة أو بشخص معين.
- هل تعرضت أنت / ذلك الشخص الذي تعرفه لوصمة بسبب الاكتئاب؟ هل يمكن أن تخبرني المزيد عن هذه التجربة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على عملية طلب للمساعدة؟

○ كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على علاج الاكتئاب؟

ملاحظة: إذا لم تكن هناك خبرة شخصية سابقة / لا تعرف أي شخص مصاب بالاكتئاب ، ابحث أكثر للحصول على معتقدات حول الوصمة للعلم وتأثيرها على المساعدة في البحث عن السلوكيات وخيارات العلاج.

○ هل هناك أي شيء فعلته أو يمكنك القيام به للوقاية من الاكتئاب أو لتقليل احتمالية الإصابة بالاكتئاب؟

○ أثناء المعاناة من الاكتئاب , كيف تتعامل مع الضغوط / تحديات الحياة اليومية ؟

Demographic Questions

1. What is your gender

Female

Male

2. What is your age (in years)?

3. For how long have you sought refuge in Lebanon (in years)?

أسئلة ديموغرافية

1. ما هو جنسك؟

أنثى

ذكر

2. ما هو عمرك (بالسنوات)؟

3. منذ متى وأنت تعيش في لبنان (بالسنوات)؟

The Vignette Instrument for Depression - Louai

Louai is a 21-year-old refugee from Syria currently living in a refugee settlement in the Bekaa valley of Lebanon. Louai has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. Louai does not feel like eating and has lost weight. He can't concentrate during his daily activities, puts off making any decisions and taking actions. His family members and friends are very concerned about him. Louai feels he will never be happy again and believes his family would be better off without him. Louai is feeling so desperate; he is hoping to fall asleep and never wake up again. Louai is exhibiting symptoms of depression.

أداة المقال القصيرة للاكتئاب

لؤي لاجئ سوري يبلغ من العمر 21 عامًا ويعيش حاليًا في مخيم للاجئين في سهل البقاع في لبنان. خلال الأسابيع القليلة الماضية وعلى غير عادته كان لؤي يشعر بالحزن والتعاسة. إنه متعب طوال الوقت ويعاني من صعوبة في النوم ليلاً. لؤي لا يشعر بالرغبة في الأكل وفقد وزنه، ولا يستطيع التركيز خلال أنشطته اليومية، ويؤجل اتخاذ أي قرارات وإجراءات. يشعر أفراد أسرته وأصدقائه بقلق بالغ تجاهه. يشعر لؤي أنه لن يستطيع أن يكون سعيدًا مجددًا ويؤمن بأن عائلته ستكون أفضل حالًا بدونه. يشعر لؤي باليأس الشديد و يأمل في النوم وعدم الاستيقاظ مرة أخرى. لؤي تظهر عليه أعراض الاكتئاب.

Questions

- 4- Have you ever experienced something similar yourself? If yes, could you tell me about this experience? Note: Prod for similar experience in terms of symptoms not the events described in the story itself.
- 5- If you did not experience anything similar yourself, do you know anybody who did have this kind of experience? If yes, could you tell me more about it?
- 6- If neither yourself, nor anyone you know experienced something of this nature, could you share with me what you know about depression?

أسئلة

- 1- هل سبق لك أن واجهت شيئاً مشابهاً؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني عن هذه التجربة؟ ملاحظة: اسأل عن تجارب مشابهة من حيث العوارض وليس عن الأحداث الموصوفة في القصة.
- 2- إذا لم تختبر شيئاً مشابهاً ، فهل تعرف أي شخص اختبر هذه التجربة؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني المزيد عنها؟
- 3- إذا لم تختبر بنفسك أو أي شخص تعرفه شيئاً من هذا القبيل ، فهل يمكنك أن تشاركني ما تعرفه عن الاكتئاب؟

Prompts

- What do you understand by the term depression?
- What do you think caused/ causes depression?
- Who can you turn to in order to get help with depression?
- How do you go about treating depression?
- What do you think people would think about Loui if they knew he is experiencing depression?

- Stigma is mark of disgrace associated with a particular circumstance, quality, or person. Did you/that someone you know ever experience stigma because of depression?
- Did experiencing stigma affect who you (or that someone you know) turn to for help?
- Did experiencing stigma impact the way you (or that someone you know) treat depression?

Note: If no previous personal experience/does not know anyone who has had depression, prod to get beliefs about stigma and its impact on help seeking behaviours and treatment options.

- Is there anything you did or can do to prevent or be less likely to experience depression?
- How do you cope with the stress/daily challenges of life whilst experiencing depression?

محفزات

- ماذا تفهم من مصطلح الاكتئاب؟
- ماذا برأيك يسبب الاكتئاب؟
- من الذي يمكنك اللجوء إليه للحصول على المساعدة؟
- كيف تتعامل مع الاكتئاب؟
- ماذا برأيك سيظنوا الناس اذا علموا أن لوي يعاني من الاكتئاب؟
- الوصمة هي علامة على الخزي المرتبط بظروف أو صفة معينة أو بشخص معين.
- هل تعرضت أنت / ذلك الشخص الذي تعرفه لوصمة بسبب الاكتئاب؟ هل يمكن أن تخبرني المزيد عن هذه التجربة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على عملية طلب للمساعدة؟

○ كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على علاج الاكتئاب؟

ملاحظة: إذا لم تكن هناك خبرة شخصية سابقة / لا تعرف أي شخص مصاب بالاكتئاب ، ابحث أكثر للحصول على معتقدات حول الوصمة للعلم وتأثيرها على المساعدة في البحث عن السلوكيات وخيارات العلاج.

○ هل هناك أي شيء فعلته أو يمكنك القيام به للوقاية من الاكتئاب أو لتقليل احتمالية الإصابة بالاكتئاب؟

○ أثناء المعاناة من الاكتئاب , كيف تتعامل مع الضغوط / تحديات الحياة اليومية ؟

Demographic Questions

4. What is your gender

Female

Male

5. What is your age (in years)?

6. For how long have you sought refuge in Lebanon (in years)?

أسئلة ديموغرافية

1. ما هو جنسك؟

أنثى

ذكر

2. ما هو عمرك (بالسنوات)؟

3. منذ متى وأنت تعيش في لبنان (بالسنوات)؟

Appendix C PTSD Vignette

The Vignette Instrument for Post-Traumatic Stress Disorder - Layla

Layla is a 35-year-old refugee from Syria currently living in a shared living space in the Bekaa valley of Lebanon. Whilst leaving Syria, Layla was involved in a serious car accident during which her father was killed. Ever since then, Layla has been feeling unusually irritable and quickly losing her temper in an aggressive way. Layla expects the worst to happen in all life situations and feels the need to constantly be “on guard”. Layla has trouble sleeping and is experiencing nightmares almost every night, during which she re-lives the car accident. Furthermore, Layla is very scared of driving or even being inside a car, and will avoid it whenever possible. When she does ride in a car, Layla experiences fast heart beats, sweating and a state of intense fear. Layla blames herself for the accident and also the death of her father. Her friends are very concerned about her and have tried to talk to Layla about the experience, but she avoids the subject and has also been avoiding spending time with them lately. Layla has lost all interest in her work and hobbies and is at risk of losing her job. Layla is exhibiting symptoms of Post-Traumatic Stress Disorder (PTSD).

أداة المقال القصيرة لاضطراب ما بعد الصدمة

ليلى لاجئة سورية تبلغ من العمر 35 عامًا وتعيش حاليًا في مساحة معيشية مشتركة في سهل البقاع في لبنان. أثناء مغادرتها سوريا ، تعرضت ليلي لحادث سير خطير قُتل خلاله والدها. منذ ذلك الحين ، كانت ليلي تشعر بانفعال و العصبية بشكل غير اعتيادي وتفقد أعصابها بسرعة وبطريقة عدوانية. تتوقع ليلي الأسوأ في جميع مواقف الحياة وتشعر بالحاجة إلى توخي الحذر باستمرار. تعاني ليلي من صعوبة في النوم وتعاني من كوابيس كل ليلة تقريبًا ، حيث تسترجع وتعيش خلالها حادث السيارة. فإن ليلي خائفة جدًا من القيادة أو حتى التواجد داخل السيارة ، وتتجنب ذلك كلما أمكن. عندما تركب سيارة ، تعاني ليلي من دقات قلب سريعة وتعرق وحالة من الخوف الشديد. تلوم ليلي نفسها على الحادث ومقتل والدها. يشعر أصدقاؤها بقلق شديد بشأنها وقد حاولوا التحدث مع ليلي حول التجربة ، لكنها تتجنب الموضوع و

مؤخرًا تتجنب قضاء الوقت معهم. فقدت ليلي كل الاهتمام بعملها وهواياتها وهي معرضة لفقدان وظيفتها. تظهر ليلي أعراض اضطراب ما بعد الصدمة (PTSD).

Questions

- 7- Have you been in a similar situation yourself? If yes, could you tell me about this experience? Note: Prod for similar experience in terms of symptoms not the events described in the story itself.
- 8- If you did not experience anything similar yourself, do you know anybody who did have this kind of experience? If yes, could you tell me more about it?
- 9- If neither yourself, nor anyone you know experienced something of this nature, could you share with me what you know about PTSD?

أسئلة

هل سبق لك أن واجهت شيئًا مشابهًا؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني عن هذه التجربة؟ ملاحظة: اسأل عن تجارب مشابهة من حيث العوارض وليس عن الأحداث الموصوفة في القصة.

-1

-2 إذا لم تختبر شيئًا مشابهًا ، فهل تعرف أي شخص اختبر هذه التجربة؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني

المزيد عنها؟

-3 إذا لم تختبر بنفسك أو أي شخص تعرفه شيئًا من هذا القبيل ، فهل يمكنك أن تشاركني ما تعرفه عن اضطراب ما بعد

الصدمة؟

Prompts

- What do you understand by the term PTSD?
- What do you think caused PTSD?
- Who can you turn to in order to get help with PTSD?
- How do you go about treating PTSD?

- What do you think people would think about Layla if they knew she is experiencing PTSD?
- Stigma is mark of disgrace associated with a particular circumstance, quality, or person. Did you/that someone you know ever experience stigma because of PTSD?
Could you tell me more about this experience?
 - Did experiencing stigma affect who you (or that someone you know) turn to for help?
 - Did experiencing stigma impact the way you (or that someone you know) treat PTSD?

Note: If no previous personal experience/does not know anyone who has had PTSD, prod to get beliefs about stigma and its impact on help seeking behaviours and treatment options.
- Nothing can be done about the accident happening. However, is there anything you did or can do to prevent or be less likely to experience PTSD symptoms?
- How do you cope with the stress/daily challenges of life whilst experiencing PTSD?

محفزات

- ماذا تفهم من مصطلح اضطراب ما بعد الصدمة؟
- ماذا برأيك يسبب اضطراب ما بعد الصدمة؟
- من الذي يمكنك اللجوء إليه للحصول على المساعدة؟
- كيف تتعامل مع اضطراب ما بعد الصدمة؟
- ماذا برأيك سيظنوا الناس اذا علموا أن ليلي تعاني من اضطراب ما بعد الصدمة؟
- الوصمة هي علامة على الخزي المرتبط بظروف أو صفة معينة أو بشخص معين.
-

- هل تعرضت أنت / ذلك الشخص الذي تعرفه لوصمة بسبب اضطراب ما بعد الصدمة؟ هل يمكن أن تخبرني المزيد عن هذه التجربة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على عملية طلب للمساعدة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على علاج اضطراب ما بعد الصدمة ؟
- ملاحظة: إذا لم تكن هناك خبرة شخصية سابقة / لا تعرف أي شخص مصاب باضطراب ما بعد الصدمة ، ابحث أكثر للحصول على معتقدات حول الوصمة وتأثيرها على المساعدة في البحث عن السلوكيات وخيارات العلاج.
- إذا افترضنا أنه لا يمكن فعل أي شيء حيال وقوع الحادث , هل هناك أي شيء فعلته أو يمكنك القيام به للوقاية أو أقل عرضة للإصابة باضطراب ما بعد الصدمة؟
- أثناء المعاناة من الاضطراب ما بعد الصدمة, كيف تتعامل مع الضغوط / تحديات الحياة اليومية ؟

Demographic Questions

7. What is your gender
 - Female
 - Male
8. What is your age (in years)?
9. For how long have you sought refuge in Lebanon (in years)?

أسئلة ديموغرافية

- 1- ما هو جنسك؟
 - أنثى
 - ذكر
- 2- ما هو عمرك (بالسنوات)؟
- 3- منذ متى وأنت تعيش في لبنان (بالسنوات)؟

The Vignette Instrument for Post-Traumatic Stress Disorder - Louai

Louai is a 35-year-old refugee from Syria currently living in a shared living space in the Bekaa valley of Lebanon. Whilst leaving Syria, Louai was involved in a serious car accident during which his father was killed. Ever since then, Louai has been feeling unusually irritable and quickly losing his temper in an aggressive way. Louai expects the worst to happen in all life situations and feels the need to constantly be "on guard". Louai has trouble sleeping and is experiencing nightmares almost every night, during which he re-lives the car accident. Furthermore, Louai is very scared of driving or even being inside a car, and will avoid it whenever possible. When he does ride in a car, Louai experiences fast heart beats, sweating and a state of intense fear. Louai blames himself for the accident and also the death of his father. His friends are very concerned about him and have tried to talk to Louai about the experience, but he avoids the subject and has also been avoiding spending time with them lately. Louai has lost all interest in his work and hobbies and is at risk of losing his job. Louai is exhibiting symptoms of Post-Traumatic Stress Disorder (PTSD).

أداة المقال القصيرة لاضطراب ما بعد الصدمة

لؤي لاجئ سوري يبلغ من العمر 35 عامًا ويعيش حاليًا في مساحة معيشية مشتركة في سهل البقاع في لبنان. أثناء مغادرته سوريا ، تعرض لؤي لحادث سير خطير قُتل خلاله والده. منذ ذلك الحين ، كان لؤي يشعر بانفعال و العصبية بشكل غير اعتيادي ويفقد أعصابه بسرعة وبطريقة عدوانية. يتوقع لؤي الأسوأ في جميع مواقف الحياة ويشعر بالحاجة إلى توخي الحذر باستمرار. يعاني لؤي من صعوبة في النوم ويعاني من كوابيس كل ليلة تقريبًا ، حيث يسترجع ويعيش خلالها حادث السيارة. فإن لؤي خائف جدًا من القيادة أو حتى التواجد داخل السيارة ، ويتجنب ذلك كلما أمكن. عندما يركب سيارة ، يعاني لؤي من دقات قلب سريعة وتعرق وحالة من الخوف الشديد. يلوم لؤي نفسه على الحادث ومقتل والده. يشعر أصدقاؤه بقلق شديد بشأنه وقد حاولوا التحدث مع لؤي حول التجربة ، لكنه يتجنب الموضوع و مؤخرًا يتجنب

قضاء الوقت معهم. فقد لوي كل الاهتمام بعمله وهواياته وهو معرض لفقدان وظيفته. يُظهر لوي أعراض اضطراب ما بعد الصدمة (PTSD).

Questions

- 10- Have you been in a similar situation yourself? If yes, could you tell me about this experience? Note: Prod for similar experience in terms of symptoms not the events described in the story itself.
- 11- If you did not experience anything similar yourself, do you know anybody who did have this kind of experience? If yes, could you tell me more about it?
- 12- If neither yourself, nor anyone you know experienced something of this nature, could you share with me what you know about PTSD?

أسئلة

هل سبق لك أن واجهت شيئاً مشابهاً؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني عن هذه التجربة؟ ملاحظة: اسأل عن تجارب مشابهة من حيث العوارض وليس عن الأحداث الموصوفة في القصة.

-4

5- إذا لم تختبر شيئاً مشابهاً ، فهل تعرف أي شخص اختبر هذه التجربة؟ إذا كانت الإجابة نعم ، هل يمكن أن تخبرني المزيد عنها؟

6- إذا لم تختبر بنفسك أو أي شخص تعرفه شيئاً من هذا القبيل ، فهل يمكنك أن تشاركني ما تعرفه عن اضطراب ما بعد الصدمة؟

Prompts

- What do you understand by the term PTSD?
- What do you think caused PTSD?
- Who can you turn to in order to get help with PTSD?

- How do you go about treating PTSD?
- What do you think people would think about Loui if they knew he is experiencing PTSD?
- Stigma is mark of disgrace associated with a particular circumstance, quality, or person. Did you/that someone you know ever experience stigma because of PTSD?
Could you tell me more about this experience?
 - Did experiencing stigma affect who you (or that someone you know) turn to for help?
 - Did experiencing stigma impact the way you (or that someone you know) treat PTSD?

Note: If no previous personal experience/does not know anyone who has had PTSD, prod to get beliefs about stigma and its impact on help seeking behaviours and treatment options.

- Nothing can be done about the accident happening. However, is there anything you did or can do to prevent or be less likely to experience PTSD symptoms?
- How do you cope with the stress/daily challenges of life whilst experiencing PTSD?

محفزات

- ماذا تفهم من مصطلح اضطراب ما بعد الصدمة؟
- ماذا برأيك يسبب اضطراب ما بعد الصدمة؟
- من الذي يمكنك اللجوء إليه للحصول على المساعدة؟
- كيف تتعامل مع اضطراب ما بعد الصدمة؟
- ماذا برأيك سيظنوا الناس اذا علموا أن لوي يعاني من اضطراب ما بعد الصدمة؟
- الوصمة هي علامة على الخزي المرتبط بظروف أو صفة معينة أو بشخص معين.
-

- هل تعرضت أنت / ذلك الشخص الذي تعرفه لوصمة بسبب اضطراب ما بعد الصدمة؟ هل يمكن أن تخبرني المزيد عن هذه التجربة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على عملية طلب للمساعدة؟
- كيف أثر تعرضك للوصمة (أو هذا الشخص الذي تعرفه) على علاج اضطراب ما بعد الصدمة ؟
- ملاحظة: إذا لم تكن هناك خبرة شخصية سابقة / لا تعرف أي شخص مصاب باضطراب ما بعد الصدمة ، ابحث أكثر للحصول على معتقدات حول الوصمة وتأثيرها على المساعدة في البحث عن السلوكيات وخيارات العلاج.
- إذا افترضنا أنه لا يمكن فعل أي شيء حيال وقوع الحادث , هل هناك أي شيء فعلته أو يمكنك القيام به للوقاية أو أقل عرضة للإصابة باضطراب ما بعد الصدمة؟
- أثناء المعاناة من الاضطراب ما بعد الصدمة, كيف تتعامل مع الضغوط / تحديات الحياة اليومية ؟

Demographic Questions

10. What is your gender

Female

Male

11. What is your age (in years)?

12. For how long have you sought refuge in Lebanon (in years)?

أسئلة ديموغرافية

4- ما هو جنسك؟

أنثى

ذكر

5- ما هو عمرك (بالسنوات)؟

6- منذ متى وأنت تعيش في لبنان (بالسنوات)؟

Appendix D Permission to Modify Tool



Mirdza Abele <abelemirdza@gmail.com>

Fwd: RE: Request for Permission to Modify MHL Interview Schedule

1 message

MIRDZA LEONS ABELE <MABELE@students.halgazian.edu.lb>
To: "abelemirdza@gmail.com" <abelemirdza@gmail.com>

Sat, Apr 17, 2021 at 12:24 PM

----- Forwarded message -----

From: MIRDZA LEONS ABELE <MABELE@students.halgazian.edu.lb>
Date: 17 Feb 2021 11:34
Subject: RE: Request for Permission to Modify MHL Interview Schedule
To: Anthony Jorm <ajorm@unimelb.edu.au>
Cc: Lucy Tavittian <Lucy.Tavittian@halgazian.edu.lb>

Dear Professor Jorm,

Your permission and attachment are well received. Thank you very much for your support and wishes.

Kind regards,
Mirdza

On 17 Feb 2021 00:38, Anthony Jorm <ajorm@unimelb.edu.au> wrote:

Hello Mirdza

You have permission. I have attached the CATI survey questionnaire used for the 2011 National Survey of Mental Health Literacy and Stigma in Australia.

Best wishes for your project.

Anthony Jorm

Anthony Jorm PhD, DSc, FASSA
Professor Emeritus and NHMRC Leadership Fellow
Centre for Mental Health
Melbourne School of Population and Global Health
University of Melbourne
207 Bouverie Street
Carlton
Victoria 3010
Australia
Ph 0413027099

From: MIRDZA LEONS ABELE [mailto:MABELE@students.haigazian.edu.lb]
Sent: Wednesday, 17 February 2021 6:37 AM
To: Anthony Jorm <ajorm@unimelb.edu.au>
Cc: Lucy Tavitian <Lucy.Tavitian@haigazian.edu.lb>
Subject: [EXT] Request for Permission to Modify MHL Interview Schedule

UoM notice: External email. Be cautious of links, attachments, or impersonation attempts

Dear Professor Jorm,

I hope my email finds you well.

My name is Mirdza Abele, and I am an MA Clinical Psychology student at Haigazian University in Lebanon, Department of Social and Behavioural Sciences. I am currently preparing to carry out a research study titled "*Lay causal beliefs, help-seeking behaviours and coping strategies for depression and PTSD among Syrian refugees living in Lebanon*" advised by Dr. Lucy Tavitian (in Cc). This research study has been reviewed and has received clearance from the Haigazian University ethics committee.

The primary purpose of this study is to explore the lay causal theories of depression and PTSD, the subsequent help-seeking behaviours and coping mechanisms used among Syrian refugees residing in Lebanon. Through gaining an understanding of these factors, this study also aims to suggest culturally appropriate, and feasible mental health support programs that could be adopted by the humanitarian aid community supporting this population group. Finally, this study will contribute towards the partial fulfillment of my academic study requirements at Haigazian University.

I will be employing phenomenological qualitative research design, using two vignettes (one for depression and another for PTSD) for the purpose of data collection. I am therefore writing to seek your permission to modify and translate the original Mental Health Literacy Interview schedule that you and your colleagues developed and used in the 1997 study titled "*Mental health literacy: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment.*"

I hope you will look upon my request favourably, and I thank you in advance for your time and consideration. I am available to provide any additional information as necessary.

Sincerely,

Mirdza

Appendix E Bracketing

The purpose of this document is to detail personal beliefs, knowledge and expectations with regards to the potential outcomes of the study of causal beliefs, help seeking behaviour and coping strategies among Syrian refugees residing in Lebanon. In doing so, the aim is to set these personal beliefs and expectations aside temporarily in order to minimise their impact and researcher bias on the data collection and analysis processes (Fischer, 2009).

Refugee Background

In my personal and professional experience majority of the Syrian refugee community live in sub-standard living conditions, with no access to livelihoods, limited freedom of movement, and surviving on USD 3.84/capita/day (UNHCR et al., 2018). I have witnessed and have heard of the discrimination they face as undesirable foreigners who are blamed for draining local resources, taking all the jobs and destabilize the security of the country (Janmyr, 2016). Having worked for an international NGO that supports Syrian refugee families, I have witnessed and heard first-hand accounts of their exposure to traumatic and stressful events (e.g. death, torture, exploitation) before departure, during the travel and whilst in Lebanon (World Health Organization, 2018a). As such, and in line with multiple research findings, my first assumption is that the majority of Syrian refugees in Lebanon have first-hand, recent experience of depression and/or trauma but only a very small proportion will know of and/or access MHPSS services (El Chammay, Kheir, & Alaouie, 2013; El Chammay, Karam & Ammar, 2016; Kerbage, El Chammay, & Richa, 2016).

Causal Beliefs, Coping and Help Seeking

With regards to mental health and illness, and how these two aspects are understood, my assumptions are largely based on the work of Hassan et al., (2015) and Al Laham, Ali, Venables, Mousally, Nahas and Alameddine (2020), because both of these studies provide the most recent findings in respect to causal beliefs, helps seeking behaviours and coping mechanisms among Syrian nationals in general and Syrian refugees residing in Lebanon. I anticipate to discover that the majority of my participants will attribute depression and PTSD to religious or supernatural causes, as well as war experiences. And in line with these causal beliefs, I expect the majority of Syrian refugees to turn to religious healers or medical doctors as the first line of help and healing. I believe that I will encounter a few participants who will have turned to psychopharmacology or psychotherapy for help, but most will have done so in secret due to the existence of stigma, fear and shame associated with mental illness.

Appendix F Ethics Clearance

**HAIGAZIAN UNIVERSITY****Faculty of Social and Behavioral Sciences****Ethics Committee**

Study Title	Lay causal beliefs, help-seeking behaviors and coping strategies for depression and PTSD among Syrian refugees living in Lebanon
Study ID	TA.11.20
Principal investigator(s): <i>Name, title, institution, contact information (email and phone number)</i>	Ms. Mirdza Abele, MA student in Clinical Psychology Haigazian University mabele@student.haigazian.edu.lb
Advisor	Ms. Lucy Tavitian, Instructor in Psychology Haigazian University lucy.tavitian@haigazian.edu.lb
Committee Members	Dr. Hanine Hout Assistant Professor, Department of Education, Haigazian University Hanine.hout@haigazian.edu.lb Dr. Nizar Mehtar Assistant Professor Department of Education Haigazian University

Dear Ms. Abele,

Your submitted reviews have been evaluated and deemed sufficient. You are given the clearance to commence with your research activities for the period spanning February 8, 2021 to February 8, 2022. By the end of the 1-year period, you are expected to submit a progress report detailing the completed research activities. In case your study is complete prior to the designated timeline, please send a closure report specifying so.

Please note that any change to the submitted protocol should be cleared by the committee prior to execution.

HU SBS Ethics committee

2/17/2021

Appendix G Ethics Clearance - Amendment



Mirdza Abele <abelemirdza@gmail.com>

Fwd: Amendment request clearance

1 message

MIRDZA LEONS ABELE <MABELE@students.haigazian.edu.lb>
To: "abelemirdza@gmail.com" <abelemirdza@gmail.com>

Sat, Apr 17, 2021 at 12:24 PM

----- Forwarded message -----

From: SBS Ethics <SBS.Ethics@haigazian.edu.lb>
Date: 11 Apr 2021 09:07
Subject: Amendment request clearance
To: MIRDZA LEONS ABELE <MABELE@students.haigazian.edu.lb>
Cc:

Dear Mirdza,

This is to note that your amendment request sent on Friday the 9th of April 2021, has been reviewed and accepted. As such you may continue your research activities.

You will receive an official clearance letter shortly.

Regards
SBS Ethics Committee