SYRIAN REFUGEE ADOLESCENT MENTAL HEALTH

UNDERSTANDING SYRIAN REFUGEE ADOLESCENTS'

CONCEPTUALIZATIONS OF MENTAL HEALTH

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TITLE: Understanding Syrian Refugee Adolescents' Conceptualizations of Mental Health

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ABSTRACT

Background: Since 2011, there has been ongoing conflict in Syria, resulting in the displacement of over 11 million people. Over 40,000 Syrian refugees resettled to Canada and of that, 52% were under the age of 19, falling into the adolescent age group. Adolescence (ages 10-19) is a critical stage for physical, psychosocial and cognitive development. As a result, mental health challenges often first emerge during adolescence. Refugee adolescents are a particularly vulnerable group, as normal adolescent stress is compounded with resettlement stress. Further research is needed to understand how Syrian refugee adolescents conceptualize mental health so that their needs can be better addressed.

Methods: Data was collected using semi-structured interviews with older Syrian refugee adolescents (n=7) and service providers (n=8) in the Greater Toronto Area. Interviews were recorded and transcribed verbatim. Data analysis was guided by grounded theory.

Results: The findings indicate that conceptualizations of mental health are highly dependent on how the concept is framed. The term mental health was poorly understood amongst Syrian adolescents. However, when different terms were used to describe mental health, including stress, pressure and comfort, it was clear that adolescents had a much deeper understanding of the concept. Once appropriate mental health framing was employed, adolescents were able to identify factors that they believed influence mental health status. Factors identified by adolescents and service providers included individual, social and system-level factors.

Conclusions: Syrian adolescent perspectives are crucial in fully understanding their conceptualizations of mental health. The comparison of adolescent and service provider perspectives allowed for a comprehensive understanding of adolescent mental health, while identifying differences in perspectives between the two groups. This study recommends future strategies for policy makers, service providers and researchers to effectively address Syrian adolescents' mental health.

ACKNOWLEDGEMENTS

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LIST OF ABBREVIATIONS

Blended Visa Office-Referred Refugees – BVORs
Canadian Coalition for Global Health Research – CCGHR
Community Sponsors – CSs
Community Youth Development – CYD
Constituent Groups – CGs
English Second Language – ESL
Global Accelerated Action for the Health of Adolescents – AA-HA!
Government-Assisted Refugees – GARs
Greater Toronto Area – GTA
Groups of Five – G5
Hamilton Integrated Research Ethics Board – HIREB
Immigration, Refugees and Citizenship Canada – IRCC
Interim Federal Health Program – IFHP
Literacy Enrichment Academic Program – LEAP
North York Community House – NYCH
Post-Traumatic Stress Disorder – PTSD
Privately Sponsored Refugees – PSRs
Resettlement Assistance Program – RAP
Service provider organizations – SPOs
Social Insurance Number – SIN
Sponsorship Agreement Holders – SAHs
United Nations High Commissioner for Refugees – UNHCR
United Nations – UN
World Health Organization – WHO

DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration that the content of the research in this document has been completed by Talia E. Filler and recognizes the contributions of Dr. Olive Wahoush, Dr. Kathy Georgiades and Dr. Nazilla Khanlou in both the research process and the completion of this thesis.

CHAPTER 1: INTRODUCTION

The conflict in Syria is regarded by many as the largest humanitarian emergency of our time, resulting in the displacement of over 11 million people. Over 40,000 Syrian refugees resettled to Canada since 2015 and approximately 52% were under the age of 19 (CIC, 2017e, 2017b; Lifeline Syria, 2015). Adolescence is a critical phase of development for individuals between the ages of 10 and 19. As adolescents transition from childhood to adulthood, they experience a number of physical, psychosocial and cognitive changes, increasing their risk for mental health challenges (Alderman, Freeman, & Lobach, 2017). Mental health is defined by the World Health Organization (WHO) as "a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community" (WHO, 2004). Refugee adolescents are at an even greater risk for mental health challenges, as normal adolescent stress is compounded with preflight, flight and resettlement stress (Mina Fazel, Reed, Panter-Brick, & Stein, 2012). Mental health challenges during the adolescent years have lasting impacts on mental health status, physical health, educational attainment, workforce participation and satisfaction into adulthood (Fink et al., 2015). In fact, researchers have found that 70% of adults experiencing mental health challenges started experiencing mental health problems during adolescence (Das et al., 2016). Thus, it is important to address the mental health and wellbeing of adolescents in a timely manner, as mental health and wellbeing in adolescence greatly contributes to health in adulthood.

When addressing refugee adolescent mental health, it is important to recognize pre-migration contexts, as this highly influences mental health status. In the literature, it is often assumed that mental health conceptualizations are similar amongst different refugee groups (Kirmayer et al., 2011). However, mental health and wellbeing conceptualizations are dependent on a number of factors, including type and severity of conflict experienced before resettlement, societal and political views in the country of resettlement and individual identity (Gifford, Bakopanos, Kaplan, & Correa-Velez, 2007; Khanlou, 2008). These factors are heavily dependent on personal contexts at specific points in time. Due to the distinct pre-migration experiences of Syrian refugees, the mental health and wellbeing of this group may differ from other refugee groups, and this needs to be further explored.

Given their recent resettlement to Canada in large numbers and their vulnerability, it is important that the mental health of Syrian refugee adolescents is better understood. Conceptualizations of mental health, factors that promote good mental health and factors that contribute to poor mental health need to be identified so that service providers and policy makers can better address the needs of Syrian adolescents. The insights of both Syrian refugee adolescents themselves, as well as service providers, are essential in gaining a comprehensive understanding of their mental health.

1.1 Thesis Goals and Structure

The purpose of this study was to explore how Syrian refugee adolescents conceptualize mental health through the perspectives of older adolescents and service providers.

The study objectives were to:

I. Gain an in-depth understanding of how Syrian Refugee adolescents conceptualize mental health through adolescent and service provider perspectives.

II. Identify factors that promote good mental health.

III. Identify factors that contribute to poor mental health.

IV. Disseminate findings.

The first chapter of this thesis begins with a brief description of the research topic and study objectives. The second chapter presents background information on Syrian refugee adolescents, including their resettlement process and mental health. The third chapter provides an overview of the methodology used in this study, including details on the theoretical framework that informed this study, information on data collection and details pertaining to the data analysis. Next, results and main themes that emerged from the data are presented in the fourth chapter. Chapter five provides a discussion of the study results, concluding with recommendations and future directions for research, policy and practice. It is important to note that from this point throughout this thesis, the term youth refers to adolescents and youth unless specifically indicated.

CHAPTER 2: BACKGROUND

This section will begin with a brief description of the conflict in Syria and the process of resettling to Canada. Next, refugee adolescent mental health will be explored. Finally, contextual factors that influence mental health conceptualizations will be presented.

2.1 Conflict in Syria and Resettling to Canada

Since 2011, there has been ongoing conflict in Syria, resulting in the displacement of more than 11 million people. Over 5.5 million people have sought asylum outside of Syria and over 6.3 million people have been internally displaced within Syria (United Nations High Commissioner for Refugees [UNHCR], 2017b). The majority of Syrian refugees have fled to Syria's neighbouring countries, including Turkey, Lebanon and Jordan. To date, there are approximately three million Syrian refugees in Turkey, one million in Lebanon and 650,000 in Jordan. Iraq and Egypt have also seen an increasing number of Syrian refugees, hosting more than 241,000 and 122,000, respectively (United Nations [UN], 2017). This displacement can be attributed to the conflict, which has resulted in poor living conditions that continue to impact the region. School attendance has dropped over 50 percent and around one quarter of schools have either been damaged or are used as shelters (UN, 2017). Over half of Syria's hospitals have been badly damaged or completely destroyed. Water supply has decreased to less than 50 percent of its pre-conflict levels and round 9.8 million people are food insecure, with many more living in poverty (UN, 2017).

The severity of this conflict resulted in the need for the international community and the Canadian government to take action. Since the 1951 United Nations Convention Relating to the Status of Refugees and the signing of the 1967 Protocol by Canada on June 4th, 1969, Canada has been recognized as one of the world leaders in protecting and advocating for the rights of refugees (Canadian Civil Liberties Association, 2016). The 1951 Convention is a legal document that defines the term "refugee", recognizes the rights of individuals who are granted asylum and states the responsibilities of nations that grant asylum (Office of the United Nations High Commissioner for Refugees, 1967). Within this document, a convention refugee is defined as

> "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (Office of the UNHCR, 1967, p. 3).

The 1951 Convention was limited to protecting European refugees post-Second World War. The 1967 Protocol was introduced to address these time and geographical limitations, giving the Convention universal coverage for all refugees (UNHCR, 2011). Over the past 40 years, more than half a million refugees have resettled to Canada (Citizenship and Immigration Canada [CIC], 2018a). In 2015, the government committed to welcoming 25,000 Syrian refugees by the end of February 2016. By January 2017, this number almost doubled, as 40,000 Syrian refugees had resettled to Canada (CIC, 2017a).

It has been suggested that this is Canada's largest response to a refugee crisis since 1980. Syrian refugees resettled as either Government-Assisted Refugees, Privately Sponsored Refugees or Blended Visa Office-Referred Refugees (CIC, 2017). Government-Assisted Refugees (GARs) are refugees that are referred by UNHCR to the Government of Canada for settlement. They are then screened by representatives from Canada and are usually among the most vulnerable refugees. The Government of Canada supports GARs during the first year of their arrival through the Resettlement Assistance Program, which is funded by Immigration, Refugees and Citizenship Canada (IRCC). The Resettlement Assistance Program (RAP) provides support to refugees for a number of resettlement-related factors, including meeting them at the airport upon entry into Canada, providing temporary housing, help to find a permanent place to live, obtaining basic household items, documentation for health insurance, school access for children, general assistance with life in Canada and a limited monthly income (CIC, 2017c). GARs are resettled in communities that have well-established refugee support programs. Currently, there are 23 communities with IRCC-funded service provider organizations (SPOs) that provide necessary support for refugees. At present, there are over 21,000 refugees supported as GARs in Canada (CIC, 2017a).

Privately Sponsored Refugees (PSRs) are refugees sponsored by private groups. Private sponsorship groups take responsibility for providing financial, social and emotional support for the refugees that they sponsor. There are a number of different private sponsor groups that are eligible to sponsor refugees, including Sponsorship Agreement Holders, Constituent Groups, Groups of Five and Community Sponsors.

Sponsorship Agreement Holders (SAHs) are incorporated organizations that have a formal agreement with the IRCC and sponsor several refugees each year. Constituent Groups (CGs) are a group of individuals authorized by SAHs. Groups of Five (G5s) consist of five or more Canadian citizens who have collectively arranged to sponsor a refugee and bear the responsibility of providing both financial and non-financial support. Lastly, Community Sponsors (CSs) are organizations located in the community where the refugee will resettle (CIC, 2018b). Private sponsors provide financial and other resettlement support for up to one year following the refugee's arrival. Sponsors are responsible for providing clothing and household items, locating interpreters, selecting health care practitioners, enrolling the family in school and language training, providing orientation to life in Canada and helping search for employment. Currently, there are around 14,000 PSRs in Canada (CIC, 2017a).

Lastly, Blended Visa Office-Referred Refugees (BVORs) are refugees identified by UNHCR and are matched with private sponsors in Canada by Canadian Visa Officers (CIC, 2017f). This is a blended program where refugees receive six months of support from their private sponsor and the next six months of support from IRCC through the RAP program. There are around 4,000 Syrian refugees that entered Canada under the BVOR program (CIC, 2017b).

As soon as Syrian refugees arrive in Canada, they receive an Interim Federal Health Program (IFHP) certificate, permanent residence card and Social Insurance Number (Canadian Council for Refugees, 2017; Government of Canada, 2017). The IFHP provides refugees with both basic and supplemental health coverage. In Ontario,

applications for OHIP are completed in the first few days as refugees are eligible for provincial insurance without delay. IFHP-funded services are similar to those covered through provincial and territorial health insurance plans, including clinical or hospital services from medical doctors, registered nurses and other licensed health professions, laboratory, diagnostic and ambulance services and prenatal and postnatal care. In addition, the IFHP covers supplemental services similar to those covered under provincial and territorial social assistance plans. This includes limited visual and urgent dental care, home and long-term care, services from allied health care practitioners and assistive devices (Government of Canada, 2017). Additionally, a permanent residence card confirms a person's status within Canada. A permanent resident is defined as a person who can remain in Canada permanently but is not a citizen (CIC, 2017g). Lastly, a Social Insurance Number (SIN) is obtained by refugees, which gives them eligibility to work in Canada and access to government programs and benefits (Employment and Social Development Canada, 2016). A list of key background definitions is provided in Appendix A.

As of January 2017, over 7000 Syrian refugees resettled to the Greater Toronto Area (GTA), which is about 18% of the total Syrian refugee population admitted to Canada. The GTA is comprised of the City of Toronto and the surrounding areas of Durham, York, Peel and Halton (Ontario Ministry of Finance, 2001). Of the Syrian refugees in the GTA, approximately 55% are PSRs, 36% are GARs and 9% are BVORs (CIC, 2017f). The GTA is home to many settlement agencies with specific programs for the Syrian community (Lifeline Syria, 2015). Although immigration policy is governed

under federal and provincial jurisdiction, municipalities play a vital role in the resettlement and integration of refugees (City of Toronto, 2017). In 2015, the City of Toronto Refugee Resettlement Program was initiated. The program aims to foster coordination between municipal services, community-based settlement services and other government sectors. It also aims to improve community-based services to ensure all new Torontonians receive necessary support (City of Toronto, 2016).

2.2 Resettlement Process

When faced with conflict, people take many different paths to flee and seek asylum. In general, if an individual is fleeing from persecution in their country of origin, they may either be displaced internally within that country or they may seek asylum in another country. For those seeking asylum in Canada, the UNHCR first identifies refugees for resettlement. Those requesting to go to Canada or those who fit the criteria for resettlement in Canada are referred by the UNHCR to the local IRCC team. The IRCC team then screens for fit and determines whether they will enter Canada as a GAR, PSR or BVOR. Refugees that enter as GARs are identified by IRCC as being the most vulnerable. Refugees that are screened for entry as a PSR or BVOR often have relatives or friends in Canada (Parliament of Canada, 2007). For more information regarding Canada's resettlement process, please visit the Government of Canada's Immigration and Citizenship website (CIC, 2017d).

Syrian refugee adolescents enter Canada with their family members or are unaccompanied. According to IRCC, an unaccompanied minor is an individual under the

age of 18 "who is not accompanied by a parent or adult who is legally responsible for them" (Immigration, Refugees and Citizenship Canada, 2013). Of the Syrian refugees that resettled to Canada, approximately 52% were under the age of 19, and therefore many fall into the adolescent age group (CIC, 2017e, 2017b; Lifeline Syria, 2015).

2.3 Adolescent Mental Health

Adolescence is a critical phase for biological, cognitive, psychological and social development (Women Deliver, 2017). Biological development at this stage refers to puberty and is marked by hormonal changes (Rogol, Roemmich, & Clark, 2002). Physical changes also take place, including increased height, increased muscle mass, changes to body fat distribution and development of secondary sexual characteristics, which are influenced by both individual (i.e. sex) and external factors (i.e. stress and environment) (Sawyer et al., 2012). Cognitive development is another key marker of adolescence, including changes to behavioural and emotional responses, perceptions of risk and reward, decision-making and impulse control. Hormonal changes during puberty also influence cognitive development related to arousal, motivation, perceptions and social attachment. Cognitive development is also regulated by social and environmental factors (Blakemore & Robbins, 2012).

Biological and cognitive changes are accompanied by psychological and social adaptations during the adolescent years (American Psychological Association, 2002). Adolescents are in a transition stage from childhood to adulthood, during which sense of identity often changes. Sense of identity includes the beliefs one has about their values,

goals and interest. It also includes self-esteem, which relates to how one feels about their identity, and this can be either positive or negative. In addition, adolescents seek greater independence and autonomy. In doing so, they orient their attention towards their peers and away from their parents, which can influence parent-adolescent relationships (American Psychological Association, 2002).

Collectively, these factors contribute to the vulnerability of the adolescent population, specifically with regards to mental health. Researchers have suggested that mental health challenges often first emerge during adolescence (Kieling et al., 2011; Thomas, 2014). In general, mental health difficulties affect 10-20% of the adolescent population, with depression being the leading cause of disability, neuropsychiatric disorders being leading cause of years lost due to disability and suicide being the third leading cause of death in this age group (Canadian Mental Health Association, 2016; Das et al., 2016; Women Deliver, 2017). Mental health challenges during adolescence have lasting impacts on mental health status, physical health, educational attainment, workforce participation and satisfaction into adulthood (Fink et al., 2015). Approximately 70% of adults living with mental health challenges or illnesses started experiencing mental health problems during adolescence, speaking to the importance of this critical development period (Das et al., 2016; Mental Health Commission of Canada, 2016). Although adolescence is recognized as a specific stage of development, adolescents are often grouped with children or adults in research, social programs and health services (Kleinert & Horton, 2016). As a result, the mental health needs of adolescents may not be

appropriately addressed (Kieling et al., 2011). For the definition of mental health used in this study, please see Appendix A.

2.4 Refugee Adolescent Mental Health

Adolescents make up a significant portion of the Syrian refugee population. Of the 5.5 million who have sought asylum outside of Syria, over 2.5 million are under the age of 18 (UNHCR, 2017). Refugee adolescents are a particularly vulnerable group, as normal adolescent stress is compounded with resettlement stress (Mina Fazel et al., 2012). There are three phases of resettlement, namely preflight, flight and resettlement; each phase of refugee resettlement elicits stressors that pose risks to mental health and contribute to mental health status later in life (Hirani, Payne, Mutch, & Cherian, 2016; Lustig et al., 2004).

2.4.1 Preflight

Preflight is defined as the time before one leaves their country of origin (Sullivan & Simonson, 2016). During this time, refugees experience chaos in their communities and disruptions to daily living, such as reduced access to schools, hospitals and workplaces. Due to reduced access to schools, children and youth suffer from limited opportunities for social, academic and cognitive development (Papadopoulos, 2001; UN, 2017). Refugees also face great distress during this phase, as their safety, as well the safety of their family and friends, is threatened (Sullivan & Simonson, 2016). Further, refugees experience a great deal of uncertainty about what the future holds for themselves

and their families. They must make life-changing decisions including whether they should stay or flee from their country of origin, who to bring with them and how to go about doing so (Papadopoulos, 2001). Adolescents who are exposed to war sometimes experience anxiety, depression, paranoia and insomnia (Lustig et al., 2004). These experiences threaten sense of empowerment, identity and meaning of life, which represent critical development domains during adolescence (Schweitzer, Melville, Steel, & Lacherez, 2006).

Studies have found that there is a dose-response relationship between exposure to trauma and psychological distress, where psychological distress increases as exposure to trauma increases (Schweitzer et al., 2006; Steel, Silove, Phan, & Bauman, 2002). Reports suggest a strong correlation between pre-migration experiences and post-traumatic stress disorder (PTSD) (Wilson, Murtaza, & Shakya, 2010). One study in the United States estimated that between 25 and 50% of refugee children and youth experience PTSD (Kinzie, Jaranson, & Kroupin, 2007). Service providers suggest that most preflight mental health problems are undetected and are therefore unaddressed (Wilson et al., 2010).

2.4.2 Flight

Flight is the phase of physical relocation before arriving in the country of resettlement (Lustig et al., 2004). For Syrian refugees coming to Canada, this involves the journey through Syria, transitional placements (i.e. refugee camps or transit country) and entry into Canada. During flight, adolescents are often separated from their family members and caregivers. Research has shown that many adolescents living in refugee

camps experience mental health challenges. They may experience greater emotional instability once separated from their family (Lustig et al., 2004). Feelings of uncertainty regarding their citizenship status while in refugee camps may also contribute to distress amongst adolescents (Kirmayer et al., 2011). In some countries, unaccompanied adolescents are held in detention centres (Lustig et al., 2004). Detention centres are confined areas where some refugees must stay until their application for refugee status is processed or until applicants are removed from the country. Individuals in detention centres often have incomplete or no documentation when they arrive in Canada. The conditions within detentions centres are often very poor (Mares & Jureidini, 2004). According to the UNHCR, the detention of refugees is "inherently undesirable", stating that freedom from detention is a fundamental human right. As a result, illegal entry into a country based on the need to seek asylum is not considered a crime (UNHCR, 2007). Physical safety during this phase is also a concern, as exposure to infectious diseases, malnutrition, food insecurity, domestic abuse and sexual violence is common (Measham et al., 2014). Outbreaks of measles, hepatitis A, leishmaniasis, poliomyelitis, meningitis and scabies have been reported throughout Syria and refugee camps in neighbouring countries (Sharara & Kanj, 2014).

Research has shown that refugee adolescents rely on coping mechanisms that distract them from the hardships they face while in refugee camps. These include suppressing emotions (i.e. keeping quiet), wishful thinking and prayer, which are said to distract them from directly dealing with the challenges they faced. As a result, these coping mechanisms may hinder psychological development. The psychological wellbeing

of parents was also shown to directly impact the wellbeing of adolescents themselves (Lustig et al., 2004). Studies found that youth living in refugee camps reported higher rates of depression when their parents experienced psychological distress (Miller, 1996).

2.4.3 Resettlement

Once in Canada, adolescent refugees face further challenges that may contribute to poor mental health, as they are dealing with the realities of being separated from their home country, family and friends. In addition, they are dealing with a number of other stressors including language barriers, discrimination, educational difficulties and lack of resources (Hadfield, Ungar, & Ostrowski, 2017). Of particular importance is one's sense of identity and how this plays a role in resettlement stress. Sense of identity is largely related to acculturation, which is the process by which people adapt to other cultures that they are exposed to (Bartlett, Mendenhall, & Ghaffar-Kucher, 2017). Refugee adolescents acculturate differently than their parents as they try to adapt to Canadian culture more quickly, which can cause familial distress (Lustig et al., 2004). Refugees also experience cultural bereavement, which is the feeling of grief that occurs when one loses their connection with their homeland, and this may also lead to mental health challenges (Eisenbruch, 1990). Cultural bereavement is associated with guilt, anger and ambivalence (Lustig et al., 2004).

Different styles of parenting can also cause challenges for refugee adolescents. For example, Syrian families often rely heavily on the eldest children to supervise and discipline younger family members. These traditional Syrian ways of parenting are often not accepted in Canada, which may cause child protective services to intervene. Societal

barriers also impact the relationship between Syrian refugee parents and children. Refugee parents often have difficulty learning English and finding employment, which puts pressure on their children to take on greater responsibilities. This is particularly the case for adolescents who are old enough to work, as they have to balance the financial needs of their family with their schooling. This has been deemed challenging for refugee children, resulting in negative mental health outcomes (Hadfield et al., 2017).

School environments may also be stressful for refugee adolescents, as many have gaps in their education due to the war and during their time in refugee camps. Gaps in education create challenges for refugee adolescents as they try to integrate into the Canadian school system (Hadfield et al., 2017). Depending on their age of arrival to Canada, learning English and successfully navigating secondary school and post-secondary school options can be difficult. The pressure may be compounded given their strong desire and value for education. At school, refugees may also experience bullying from their peers, often related to one or more factors such as lack of fluency in English, accent, religion and ethnicity (Khanlou, Shakya, & Muntaner, 2009).

Research reports indicate that the most vulnerable time for refugees is between eight to 24 months after resettlement due to reduced government support, health coverage and vocational training (Desai & Romano, 2017). This time delay may also be due to the initial hope refugees have when they finally resettle in a safe country, distracting them from the reality of their situation for some time (Lustig et al., 2004). Understanding the experiences refugee adolescents face at each stage of migration is essential for planning

and implementing effective mental health services in the country of resettlement (Murray, Davidson, & Schweitzer, 2010).

2.4.4 Resilience

Despite being at an increased risk for mental health challenges, adolescent refugees also show great strength and resilience (Schweitzer et al., 2006). Resilience is defined as the ability to "withstand adversity through individual and collective strengths, resources and capabilities" (Panter-brick et al., 2017, p.1). Many refugee youth display resilience through their dedication to achieving their dreams and goals in their country of resettlement. Resilience is highly influenced by familial support. For example, refugee adolescents who felt more supported by their parents, siblings and friends were found to be less depressed than those who did not feel the same type of support (Hassan et al., 2015). When the appropriate supports are in place, positive schooling experience can serve as a protective factor for refugee adolescents, contributing to resilience. It is important that schools make an effort to integrate refugees into mainstream schooling, while still supporting their unique needs (Taylor & Sidhu, 2012). Positive integration will allow for a more inclusive environment and foster a stronger school community. The presence of a like-ethnic community can also foster resilience once in the country of resettlement (Wood & Newbold, 2012).

2.4.5 Programs and Services

Programs and services that effectively target adolescent needs are essential to ensuring refugee wellbeing. The Ecological Systems Theory has had a positive role in supporting the development of effective refugee mental health interventions (Lustig et al., 2004; Miller & Rasco, 2004). The Ecological Systems Theory states that development occurs between an individual and their environment, which is multi-leveled and includes the individual, their family, the community and society as a whole. According to Miller (2004), individuals creating programs should consider how they can target refugees on all ecological levels. Miller also expresses the importance of creating programs that target stressors that refugees themselves identify as having the most significant impact on wellbeing. In many cases, exposure to trauma does not influence adolescent mental health as largely as other stressors. Stressors that influence refugee adolescent wellbeing to a larger degree may include unemployment, physical health problems, family discord, violence and poverty-related issues (Miller & Rasco, 2004). Therefore, documenting stressors arising from multiple ecological levels and their influence on wellbeing is essential to creating effective programs and services that positively impact mental health.

2.5 Conceptualization of Mental Health Across Cultures

Cultural influences play a major role in shaping how people define and conceptualize mental health. According to Cauce et al. (2002), conceptualizations of mental health are often unique to individual ethnic groups, thereby warranting services that target individual groups. Due to the distinct pre-migration experiences of different

refugee groups, their health and mental wellbeing may differ from one another and thus, specific attention is needed to examine and understand these differences (Cauce et al., 2002; Khanlou, 2008). In Syria, the term mental health is either not commonly understood or is viewed very negatively (Hassan et al., 2015). Suffering, on the other hand, is viewed as a normal part of life, suggesting that interventions for mental health challenges may be unnecessary. When identifying illness, the soul and body are considered as a whole rather than separate entities. As a result, symptoms associated with mental health challenges are often described as physical complaints. For example, when experiencing mental health challenges, individuals from Syria may describe these feelings as physical symptoms, such as feeling tired, tightness in the chest, pain in the heart and numbness of body parts. Reports in the literature recommend that clinicians should avoid labelling patients with psychiatric terms, as the stigma associated with these conditions is significant and may result in patients being alienated by their community (Hassan et al., 2015).

Although many Syrians are starting to identify mental health challenges as a result of violence and social/economic pressures, there are still context-specific religious and cultural explanations for these challenges. In most instances, there is no distinction made between mental health and mental illness. Many Syrians believe that in order to deal with mental health challenges, you must pray (Hassan et al., 2015). This idea is widely held by both Christian and Muslim Syrians. It is important to identify how mental health is expressed and understood and the types of interventions that are acceptable so that individuals from different cultures can be effectively supported. Canadian ideas of

dealing with mental health challenges may not be appropriate when working with refugee adolescents. A clear understanding of these differences will inform culturally appropriate and evidence-based care, which is crucial when working with refugee adolescents**.**

2.6 Adolescent Perspectives

The inclusion of the target population's perspectives and voices is essential to fully understanding the mental health of adolescents (WHO, 2014). The Community Youth Development (CYD) approach "views young people's involvement as vital to their own development and that of their communities" (Makhoul, Alameddine, & Afifi, 2012, p. 914). Previous studies have shown that engaging adolescents in their own health care increases the effectiveness of services (WHO, 2015). When adolescents design services for themselves, they are more likely to create a program that will be accepted by their peers, as they are familiar with the likes and dislikes of people their age. Engaging with refugee adolescents enables them to describe their experiences from their own cultural perspective (Donnelly et al., 2011). This engagement allows researchers and service providers to fully capture the complexity and diversity of mental health conceptualizations among this population. As a result, programs such as those targeting mental health have a greater impact on the target population (International Planned Parenthood Federation, 2008).

A Canadian study by Edge, Newbold and McKeary (2014) provides key insights from refugee youth of different ethno-cultural backgrounds. When asked to describe what health meant to them, mental wellbeing was a recurrent theme, which included sense of

belonging, positive identity and self-confidence. However, when asked specifically about mental health, it was clear that youth felt uncomfortable discussing the topic. Participant youth stated that mental illness was not acknowledged in their culture or was greatly stigmatized. As a result, mental illness was not often discussed. One participant suggested that programs aiming to improve mental health should not be labeled as mental health programs. The insights from this study would not be possible without the voices of the refugee youth themselves. Thus, engaging with the Syrian adolescent refugee population was an important approach that may provide key insights to inform existing and future services.

2.7 Service Provider Perspectives

Information from service providers who work directly with adolescent refugees provided key insights into refugee youth mental health. A study of recently arrived refugees in Canada found that they have high mental health needs, which can be quite complex due to the combination of pre-migration trauma and social factors within Canada (Vasilevska, Madan, & Simich, 2010). The study reported that addressing the needs of adolescent refugees can be quite challenging due to language barriers and lack of services that target their specific age and ethno-cultural groups. These factors led service providers to express the need for adolescent friendly services, which should include immediate mental health care for those experiencing severe challenges once in their country of resettlement, as well as preventative initiatives that support the mental health and wellbeing of adolescents before challenges arise. In creating such services and supports, it

is essential that there be collaboration between settlement workers, mental health service providers and counselors (Vasilevska et al., 2010).

Service providers also emphasized the importance of creating culturally appropriate services. They recommended that services should not only focus on treating immediate trauma but also on building resiliency. Service providers can better facilitate programs when they take the time to build trust, increase active listening and learn about the Syrian culture. It is also important for service providers to recognize their own biases and views of mental health and acknowledge how their views are likely different from the population they are working with (Vasilevska et al., 2010).

Service providers have suggested ways to effectively implement and facilitate programs that foster good mental health. One suggestion was to serve clients where they settle. Public transit can be complicated, costly and time consuming, thereby making it difficult for people to access programs. Service providers also suggested that programs should be consistent and predictable. Refugees experience constant change, so it is important that they have reliable programs to attend (Vasilevska et al., 2010).

2.8 Summary and Rationale

Syrian refugee adolescents are a vulnerable group. Not only do they deal with the normal stresses that accompany adolescent development, but they also experience pre-migration, migration and resettlement stress. Therefore, Syrian refugee adolescents are at an increased risk for mental health challenges. Given their context and vulnerability, there is a need to understand how Syrian adolescents conceptualize mental health. To fully

understand their conceptualizations, it is important that insights are solicited from both adolescents and service providers who work with Syrian refugees directly. Ultimately, understanding their conceptualizations and identifying factors that influence mental health will improve service provision and inform efforts that target Syrian adolescent mental health.

CHAPTER 3: METHODOLOGY

This chapter will begin by defining the study design and theoretical approach. This will be followed by a description of the study procedures, including ethics and recruitment. Lastly, the data analysis approach will be defined.

3.1 Study Design

This study used a qualitative exploratory approach and analysis was informed by grounded theory. Qualitative research aims at "describing, interpreting, and generating theories about social interactions and individual experiences as they occur in natural, rather than experimental, situations" (O'Brien, Harris, Beckman, Reed, & Cook, 2014). Exploratory research aims at addressing topics that are not well understood and are not extensively studied (Given, 2008). Given the recent arrival of Syrian adolescents to the GTA, their conceptualizations of mental health have not been extensively studied. Therefore, exploring these concepts warranted a study design that allowed for the generation of themes and codes inductively. A qualitative exploratory design allowed for a more nuanced understanding of the cultural influences that play a role in shaping how adolescents conceptualize mental health.

An essential component of global health research is inclusion, meaning that diverse groups of people are equitably represented in research (Canadian Coalition for Global Health Research, 2015). To best achieve this, and equitably represent Syrian refugee adolescent voices, participants need an opportunity to share their perspectives in their own words (Peters, 2010). This is especially valuable for participants who have

limited literacy skills and can best express themselves verbally through interviews, which may be the case for recently arrive refugee adolescents who are learning English (Peters, 2010).

Input from community partners is an integral part of shaping qualitative research when working with diverse and vulnerable communities (Israel, Schulz, Parker, & Becker, 1998). In the current study, community partners reviewed study documents and interview guides to promote cultural appropriateness, noted biases and helped strengthen interview guides to ensure they were understood cross-culturally (Lu & Gatua, 2014).

3.2 Theoretical Approach

The development of this study was informed by the Ecological Systems Theory. Pioneered by Brofenbrenner in 1979, the Ecological Systems Theory states that development occurs through the interaction between an individual and their environment (Bronfenbrenner, 1986). The environment is comprised of four different ecological levels, namely the ontogenic level (individual factors), the microsystem (familial factors), the exosytem (one's community and neighbourhood) and the macrosystem (societal and cultural beliefs). The Ecological Systems Theory has been applied to research that looks at mental health risk and protective factors in children and youth who have experienced trauma (Lustig et al., 2004). Syrian refugee youth mental health can be viewed through this theoretical lens, where conceptualizations are understood as being developed through one's interactions with their environment. Essential to understanding refugee mental health is analyzing how their interactions with the various ecological levels may change

throughout the migration and resettlement process. Ecological Systems Theory is a good fit and relevant for this study because of the importance it places on context and time, which are essential factors in understanding refugee youth development (Yohani, 2008). In this study, the Ecological Systems Theory informed the study design and materials, providing participants with the opportunity to express their conceptualizations of mental health as they may relate to each ecological level.

3.3 Community Partner

Staff at North York Community House (NYCH) supported the development of this research. NYCH is a settlement organization located in Toronto that assists newcomers with settlement and integration. They also provide a wide variety of supports for families, including educational programs, employment services and summer camps. NYCH also provides a variety of Syrian youth programs, making them a key recruitment source. In order to develop a background understanding of the study population, I volunteered at NYCH starting in July 2017. I first volunteered at a summer camp in the GTA for Syrian refugee youth and later attended programs at a high school for newcomer youth. In the high school, programs were held at lunch time and in English Second Language (ESL) classes. The lunch program included providing lunch and snacks for students and allowed time for informal conversation and activities. The activities in ESL classes were more structured and covered a range of topics, including wellness, geography and government systems. This volunteer experience provided me with an opportunity to establish relationships with Syrian students and the Syrian support team.

The Syrian support team included the manager, one social worker, three settlement workers and two child and youth workers. All individuals on the team worked closely with Syrian refugee adolescents in a number of different settings, including schools, community centres and their homes. The team members also spoke Arabic, and many were of Syrian descent. Discussions between myself and the team helped determine how to appropriately discuss mental health with Syrian adolescents, as it is a concept that is either seldom spoken about or is highly stigmatized in this community (Hassan et al., 2015). There is no direct translation of mental health (how it is defined in Canada) from English to Arabic, so it was important to determine multiple ways of explaining the concept along with culturally appropriate probes that would facilitate participant thinking. The team provided feedback on the recruitment materials, including the study poster and recruitment email, to ensure clarity. The entire Syrian team met once in November 2017 and smaller informal meetings with individuals from the Syrian team took place bi-weekly from September 2017 to January 2017. This approach helped me to better understand the study population, anticipate issues and prepare appropriately. It was also important for me to be transparent in my study objectives when collaborating with NYCH staff, which allowed stronger relationships to be formed (Maiter, Simich, Jacobson, & Wise, 2008). Transparency was important as it allowed NYCH staff to better understand the research objectives while maintaining appropriate expectations. Transparency allowed staff to understand the potential impact of this research. The relationship with the NYCH team also informed knowledge translation efforts of the study findings for service providers, schools and community organizations.

3.4 Study Procedures

3.4.1 Inclusion and Exclusion Criteria

Adolescent participants were convention refugees and all self-identified as Syrian – either being born in Syria or having lived there for the majority of their life. Participants had to have refugee status and be either a GAR, PSR or BVOR. Adolescent participants had to be between the ages of 16 to 19 in 2018, had to have moved to Canada less than 5 years ago and had to speak English.

Adolescent exclusion criteria included those not in the appropriate age group, lived in Canada for more than 5 years, unable to communicate in English, refused consent or declined to participate.

Eligible service providers were required to have experience working directly with Syrian refugee adolescents, either through direct mental health work or support work. Service providers had to have an understanding of Syrian refugee youth and their conceptualizations of mental health.

3.4.2 Ethics Approval, Consent and Confidentiality

This research study was approved by the Hamilton Integrated Research Ethics Board (HIREB) on December 20, 2017 (Appendix B). Participant Information Sheets and Consent Forms were provided for all participants prior to the interview (Appendix C: adolescents, Appendix D: service providers). Directly before the interview, study procedures were restated and informed written consent was obtained from each

participant. Parental consent was not required, as the age of independent informed consent in Canada is 16 years (Government of Canada, 2018). Participants were reminded that they could have as much time and information as needed to provide consent for the study and were asked for consent to audio record the interview. Participants were also informed of risks associated with the study. For adolescent participants, these risks included feeling uncomfortable when reflecting on their own feelings and experiences related to mental health and concerns with confidentiality. For service provider participants, these risks included concerns with time commitment and confidentiality. Participants were reminded that they could skip any question or withdraw from the study at any point and that their confidentiality would be maintained at all times. A list of nearby mental health services was kept on-hand during interviews in case adolescents revealed mental health challenges and needed further support. A social worker at NYCH was also notified about the study and was available to accept referrals if needed.

To maintain participant confidentiality, all interview scripts, including hand-written notes, electronic scripts and audio files were coded with a personal identification number (PIN). The PIN replaced participant identification information so that the study materials were not linked to their identity. All interviews were recorded using a Sony digital recorder. Recorded interviews were uploaded to a secure and password-protected laptop using the USB attached to the recorder. All recorded interviews were transcribed verbatim and all identifying information was removed, including names, locations and any other information that would make the participant identifiable. All anonymized transcripts were stored on a password-protected laptop. Consent forms and paper copies

of transcripts were also stored at McMaster University in separate filing cabinets in a locked office. Paper copies of the data will be destroyed upon completion of the study. An electronic archive of the anonymized data will be destroyed after 7 years.

3.4.3 Setting and Recruitment

Syrian refugee adolescents were recruited from the GTA. The GTA includes the city of Toronto and the surrounding areas of Durham, York, Peel and Halton (Ontario Ministry of Finance, 2001). The GTA has a large Syrian refugee population and is home to many refugee agencies and support services. Recent efforts in the GTA have aimed at creating adolescent-friendly mental health services (Lifeline Syria, 2015; Ontario Ministry of Children and Youth Services, 2016). Therefore, the GTA was the study location of choice due to the large percentage of Syrian refugees represented there.

A multistage recruitment approach was employed. First, participants were recruited from NYCH via purposive sampling. Purposive sampling is "the deliberate choice of an informant due to the qualities the informant possesses" (Tongco, 2007, p. 147). Purposive sampling allows for an "in-depth understanding rather than empirical generalizations" (Patton, 2002, p. 230). Participants were recruited through word of mouth and study posters (Appendix E). I explained the study purpose and procedures to all staff at a meeting prior to the initiation of the study. NYCH staff were responsible for initial information sharing with potential participants. If potential participants showed interest, staff either gave them my contact information so that they could contact me directly or with their permission, shared their contact information so that I could contact

them. The method of contact was based on participant preference. Next, participants were recruited via snowball sampling, where current participants were asked to recommend other participants (Petersen & Valdez, 2005).

Service provider participants, who work directly with Syrian refugee adolescents, were recruited via purposive sampling supplemented by snowball sampling. Recruitment aimed to include at least one participant from the following professions: settlement workers, social workers, Syrian youth mentors and psychiatrists. Service providers were contacted through email or phone using contact information found on professional websites (Appendix F).

3.4.4 Limitations

Semi-structured interviews are often subject to social desirability bias, and even more so when the participants and interviewers are of a different ethnicity and socioeconomic status (Louise Barriball & While, 1994). Social desirability bias occurs when participants give responses they believe are socially acceptable rather than providing accurate answers. In this study, social desirability bias was mitigated by creating an open and accepting environment, where participants felt comfortable to express their true thoughts. Probing throughout the interview was also used, which allowed for opportunities to build rapport and fostered a more interactive discussion between the interviewer and participant. Participants were also reminded that there were no wrong answers and that the interviews were confidential.

Language barriers are also a limitation to conducting qualitative interviews with newcomers (Louise Barriball & While, 1994). In this study, all participants were required to speak English as translation supports were not feasible. Strategies to address challenges associated with English language included playing close attention to word choices, using plain English, avoiding jargon and rephrasing as needed during interviews to ensure participants understood questions and explanations. In addition, staff working with newcomer youth reviewed interview guides to ensure wording was appropriate. I developed an in-depth understanding of culture and context factors (through volunteering and literature review) to help understand participant responses, including nonverbal cues and body language.

3.5 Data Collection

3.5.1 Data Collection Tools

Two interview guides were used – one for adolescents (Appendix G) and one for service providers (Appendix H). Both interview guides were developed through the use of previous literature and through input from the thesis committee. The service provider interview guide was also adapted from a guide created by Khanlou and colleagues (Khanlou, Haque, Sheehan, & Jones, 2015). The adolescent and service provider interview guides were pilot tested with three individuals prior to the initiation of data collection. The adolescent interview guide was administered to two of my colleagues and the service provider interview guide was administered to a service provider who works

directly with adolescents. Following pilot testing, appropriate edits were made to the interview guides to ensure clarity.

3.5.2 Semi-Structured Interviews

Data collection occurred between January and March 2018 through semi-structured interviews and were conducted in English. Interviews were conducted in-person at a location the participant felt most comfortable in. For adolescent participants (n=7), this included meeting at their homes or libraries. For service providers (n=8), this included meeting at their offices or libraries. At each location, interviews were held in a space where only the interviewee and myself could hear each other. Almost all (n=14/15) participants consented to being audio recorded and all participants consented that I could take hand-written notes. Interviews lasted between 30 to 70 minutes. After each interview, the audio recordings were compared to the hand-written notes to ensure the notes were comprehensive and of sufficient quality. For the one participant who did not consent to being audio-recorded, the notes were of sufficient quality to be included in the analysis. This occurred late in the study, once the majority of the data had already been collected.

Before each interview started and to ensure participants felt comfortable, the interviewer spent a few minutes building rapport with participants, getting to know them before the interview commenced. Building rapport was especially important for adolescent participants. Each interview began with a review of the information sheet and consent form. This was followed by a definition of mental health and mental illness.

Since interviews were focused on adolescents general understanding of the term mental health and not mental illness, a distinction between these two terms was made to all participants before the interviews commenced. It was clearly stated that interviews were not focused on mental illnesses, which are severe mental health problems that are diagnosed by a mental health professional (Government of Canada, 2015). Once informed consent was obtained, the Participant Information Sheet was reviewed in detail and any questions were answered. Participants were reminded that they only had to answer questions they felt comfortable with, could skip any question at any point and could end the interview at any time.

The interview for adolescent participants started with collecting demographic information including their age, languages spoken, family in Canada and refugee status (GAR, PSR, BVOR). The next set of questions asked about their general understanding of mental health and ended with questions specifically about risk and resilience factors. At the conclusion of the interview, participants were asked if they knew anyone else who might be interested in participating in the study. If they did, participants were asked to reach out to that individual first and if they expressed interest, the participant asked permission to share contact information with me. The adolescent interview guide was longer than the service provider guide, as more probes were needed to ensure participants clearly understood what each question was asking. It is important to note that participants were not asked directly about their own experiences with mental health, but about their knowledge of mental health in general to minimize discomfort and promote discussion.

However, if participants wanted to speak about their own personal experiences, they were able to do so.

Interviews for service providers started with a few demographic questions, including their occupation and type of organization. This was followed by general questions about their experience working with Syrian refugee adolescents and the knowledge and perceptions they believe this group has regarding mental health.

The first adolescent and service provider interviews were reviewed with my supervisor to discuss how the process went to determine if any changes needed to be made to the interview guides and discuss any issues that emerged. No changes were needed to the guides or processes. After each subsequent interview, minor changes were made to the interview guides based on important themes and concepts that emerged in previous interviews. This enabled further exploration of emerging categories and themes. Throughout the data collection period, a journal including notes about interview experiences, possible biases and thoughts was kept and filled out directly following interviews. These records were key to ensuring rigor in the analysis and that data remained true to the voices of participants.

Participants were recruited until data saturation was reached; the point where no new concepts or themes emerged from the data and when the participant group adequately represented Syrian refugee adolescents and service providers (Guest, Bunce, & Johnson, 2006). Additionally, I approached all potential candidates for my interview, evident by the fact that no new names were shared with me and the same adolescents and

service providers were recommended to participate in the study. This suggested that most key informants were included in the study.

3.6 Data Analysis

The data analysis was informed by Corbin and Strauss' grounded theory (2015). Originally developed by Glaser and Strauss (1967), grounded theory is a form of qualitative research that constructs theory grounded in the data. According to Corbin and Strauss, grounded theory "enables researchers to examine topics and related behaviors from many different angles – thus developing comprehensive explanations" (p. 11). Grounded theory allows for the generation of concepts and ideas that are derived directly from data collected during the research and are not predetermined before the start of the research (Corbin & Strauss, 2015). Findings are data-driven, and an inductive approach is taken. In grounded theory, data collection and analysis are an iterative process, whereby the initial data is first analyzed by the researcher, which helps inform subsequent data collection. Although the research question and interview guides were informed by the Ecological Systems Theory, the analytic process required that I code the data without trying to fit it into a pre-existing coding frame and therefore this analysis was data-driven (Braun & Clarke, 2006).

Some grounded theorists suggest that a review of the literature should not be conducted prior to data collection. However, Corbin and Strauss acknowledge the importance of gaining insights into the data through literature review (Streubert & Carpenter, 2011). They also acknowledge that theories can be developed from the data,

but that it is not a necessary outcome (Corbin & Strauss, 2015). While this study did not develop a formal theory, grounded theory analysis procedures were followed, and the coding of interview transcripts was deeply grounded in the participants' narratives.

Grounded theory methodology employs constant comparison, which is "the act of taking one piece of datum and examining it against another piece of datum both within and between documents in order to determine if the two data are conceptually the same or different" (Corbin & Strauss, 2015, p. 93). Constant comparison in this study was applied in three ways, within each individual adolescent and service provider interview, within each participant group and between participant groups.

Three main coding steps were taken, namely open coding, axial coding and selective coding. Open coding is the interpretive process by which data are broken down into more manageable parts. During this step, parts of the data are compared against one another for similarities and differences. Conceptually similar events, actions and interactions are grouped together to form categories and subcategories. Constant comparison methods and questioning during open coding allows for the most appropriate categorization and grouping of data, while minimizing bias. Axial coding followed, which is the step where categories are related to their subcategories, and these relationships are tested against the data. Essentially, the fractured data is put back together. This is done using the paradigm, which is an analytic tool that helps to carry out coding around a category. The paradigm tool allowed me to sort out and arrange concepts appropriately by asking questions and thinking about potential linkages. The paradigm focuses on three aspects of the phenomenon: the conditions in which the phenomenon occur, the

actions/interactions in response to what is happening, and the consequences/outcomes of the actions taken. The last analytic step is selective coding, which involves the integration of categories, reducing the data from many categories into larger concepts. In some grounded theory studies, these larger categories are unified around a central core category to develop a theory (Lawrence & Tar, 2013). Since a formal theory was not the intention of this study, the analysis concluded with the data reduced into broader concepts.

3.7 Reflexivity

Reflexivity is a central element of qualitative research and is a key component of "humility", one of the main principles in Global Health Research (Canadian Coalition for Global Health Research, 2015). Reflexivity refers to "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). To fully engage in reflexivity, researchers must consider a number of factors, including personal characteristics such as gender, race, age, sexual orientation, immigration status, personal experiences, linguistic tradition, beliefs, biases, preferences, theoretical and political/ideological stances (Berger, 2015). Being aware of one's own biases is essential in fully understanding the participants, the research questions, data and analysis. Research is deemed more credible and accurate when researchers are able to be transparent in identifying their own biases, knowledge-base and beliefs (Cutcliffe, 2003).

Throughout the entire study process, both during the development, data collection and analysis, I was aware of my own biases. I acknowledged my own conceptualizations of mental health, as they may have influenced the way I carried out this research. I grew up with the belief that good mental health is critical in maintaining overall health. I recognized that this may not be the case for participants and that personal conceptualizations of mental health are heavily influenced by context. For example, conceptualizations of those born and raised in Canada are often influenced by western culture, which may be different from participant experiences. Many participants in this study were likely exposed very different influences. Biases from these sources were mitigated by maintaining and referring to the journal/field notes throughout the duration of the study.

3.8 Rigour

Rigour refers to the trustworthiness of a study, both in how it is conducted and how the results are determined. Key components of establishing trustworthiness include the study's credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). These can be attained through a number of strategies including triangulation, thick description and audit trail. Triangulation involves the use of multiple data sources to enhance the credibility of the study. The current study used two different data sources, namely Syrian refugee adolescents and service providers. Investigator triangulation also took place, as three researchers were involved in data analysis (Farmer, Robinson, Elliott, & Eyles, 2006). While all transcripts were analyzed by the primary researcher, two

service provider transcripts and two adolescent transcripts were chosen for independent

analysis by the supervisor and an additional researcher. The supervisor was an expert in

qualitative research with refugee populations and the additional researcher was a novice

researcher. These transcripts were chosen based on the strength of interview,

comparability and dissonance. Next, thick description was developed, as I provided

extensive details about study context and participants (Ballinger, 2006), which included

in-depth interviews, as well providing in-depth background information on Syrian

refugee's context and experiences during their preflight, flight and resettlement process.

Most importantly, in achieving data saturation in the analysis, I ensured that the results

produced were thick and rich, as no new themes were emerging. Lastly, an audit trail was

created, as I demonstrated how my thinking progressed throughout the duration of the

project (Ballinger, 2006). All research decisions and activities are available through

information from interviews (audio recordings and transcripts), journal entries, field

notes, audio recordings, the examination of data multiple times and by the separate

analysis of four selected transcripts by the two additional researchers. There were

minimal differences in the analyses and choices of words. All word choices were agreed

with.

CHAPTER 4: RESULTS

This section will start with a brief description of the population demographic data, followed by the five themes that emerged from the semi-structured interviews with adolescents (A) and service providers (SP). It is important to note that the terms "youth" and "adolescent" are used interchangeably by participants but refer to older adolescents aged 16 to 19.

4.1 Demographic Information

Adolescent participants (n=7) ranged in age from 16 to 19 years and were mostly female (n=6). All spoke Arabic as their first language. The average number of years in Canada was 2.3. There was a significantly higher representation of PSRs (n=6) compared to GARs (n=1). All participants had family members with them in Canada. It is important to note that a number of participants experienced gaps in their education before coming to Canada (n=4).

Table 1

Demographic information for adolescent participants

Average Age (Years)	Gender (M/F)	Language Spoken	Current Level of Education	Years in Canada	Type (PSR/ GAR/ BVOR)	Employment/ Volunteer Experience	Education Gaps (Y/N)	Refugee Camp (Y/N)
18	F: 86% M: 14%	Arabic English	Grade 10: 14% Grade 12: 72% College: 14%	2: 86% 4: 14%	GAR: 14% PSR: 86%	Employment: 29% Volunteer: 57% None: 14%	Y: 57% N: 43%	Y: 43% N: 57%

Service providers (n=8) represented a number of different fields, including social workers, youth advisors, youth mentors, settlement workers and psychiatrists. Service provider experience ranged from one year to 20 years in the field.

Table 2

Demographic information for service provider participants

Occupation	Organization Type	Years of Experience
Social worker: 12.5%	Community Organization: 25%	Between 1 and 20+
Newcomer Youth Advisor: 25%	Non-Profit Organization: 38%	
Syrian Youth Mentor: 12.5%	Mental Health Organization: 12%	
School Settlement Worker: 25%	Hospital/University: 25%	
Psychiatrist: 25%		

4.2 Knowledge of the Term "Mental Health"

In general, Syrian adolescents were not very familiar with the term mental health. Initially, four of the seven adolescent participants stated that they had never heard of mental health. Three participants had heard of it but did not know the meaning or had difficulty explaining what it meant, with one participant stating, "yeah basically it's like I don't know how to explain it like, I'm really bad at it" (A3). This demonstrates the complexity and lack of knowledge associated with this term amongst Syrian refugee adolescents.

Service providers, however, placed more of an emphasis on the differing levels of mental health knowledge that exist amongst adolescents. When asked what Syrian adolescents know about mental health, almost all service providers stated that there are varying levels of knowledge, with some never having heard of the term, a number being

more familiar with the term but not fully understanding its meaning and others being very

in-tune with the concept. SP3 expressed:

> It depends on who you're talking to. There's some people if you say the word
> mental health they would would be like "what, what I don't know what you're
> talking about." There's some people you'd say it to and they would respond by
> like, you know, they don't want to talk about it like "yeah yeah yeah we
> know"…and there's the group that is really engaged you know and, if you dig
> deeper into that and get into the specifics you want to talk about coping strategies
> for example, again the same response is like "what the heck is that" or "I don't
> want to talk about it" or "yeah let's have a, you know, let's talk about it, what
> does that mean" you know…it really depends on who you're talking to and it's
> really fascinating to see that it can be it can be any response. (SP3)

This statement demonstrates that service providers recognize the importance of

individuality in how adolescents conceptualize mental health.

For those adolescents who had heard of the term, it was understood as a

biomedical concept. They believed that mental health was dependent on cognitive

function and the presence or absence of illness. For example, one participant stated that

poor mental health was associated with memory problems and the inability to learn new

things. This participant followed up with me after the interview stating that they were

referring to a mental illness called Alzheimer's disease. Another participant also focused

on cognitive function and the presence of disease, stating:

> For me…it's not like solving problems mental like brain health. Mental health for
> me it's…like having…like clear brain without thinking of anything you know?...
> thinking may cause diseases. (A7)

Service providers also recognized that Syrian adolescents conceptualize mental

health as an illness. When asked about how adolescents conceptualize mental health, a

service provider stated "I think more in line with psychosis like really psychotic

behaviors and a lot of, you know, assumptions that people with mental health are

hospitalized kind of and in psychiatric institutions" (SP1). This provides insight into the fact that many Syrian adolescents in this study did not understand mental health and mental illness as being separate terms. Mental health is not understood on a continuum, but instead is conceptualized as an illness that is present or absent.

In addition, adolescents and service providers discussed the stigmatization of mental health that exists among the Syrian community, as the concept itself is perceived negatively. According to participants, if you experience mental health challenges, you are considered "crazy". There is a great amount of fear and embarrassment associated with the term. An adolescent participant stated: "to be honest it scares me. For example, if I get bullied like "oh I'm going to have mental health" you know? And I don't want that to happen just to me to anyone" (A3).

Service providers recognized that mental health is rarely discussed in the Syrian community as a result of this stigmatization and fear. A service provider stated:

> Hm, it's a very tricky topic to talk about with the Syrian youth, mental health or mental health wellbeing, is not a topic that is commonly talked about in the community or in the culture itself…there is the stigma like when you talk about mental health and no one wants to touch that topic you know because it's usually stigmatized, it means…in the Arabic term that you are "crazy" …they have this fear like if we talk about it there it means there's something wrong with you, you know? So it's very hard to bring that topic without having to kind of make the person feel uncomfortable, you know? But, so for them like mental health equals being crazy basically. (SP4)

This statement explains how stigmatization can hinder discussion about mental health, which can result in or be caused by lack of knowledge and fear.

The translation of the term mental health from English to Arabic was also discussed amongst service providers. Although in Canada there are separate terms for

mental health and mental illness, there is only a single word in Arabic, and it is associated with being crazy. A service provider stated that "when…you try to translate the term mental health into Arabic it doesn't come right it doesn't sound right, so it's very hard" (SP4). This stigmatization highlights the complexity associated with language translation, as there is no direct translation of mental health (in how it is defined in this study) to Arabic.

4.3 Influence of Language in Facilitating Discussion

The terminology used in discussions of mental health is very important. The term "mental health" was not well understood by Syrian adolescents, as described in the section above and thus, discussion was often hindered when this term was used. However, when different terminology was used to describe the concept of mental health, adolescents expressed a much deeper understanding. For example, when the interviewer used words such as stress, pressure, tired and comfort, adolescents could discuss their mental health in-depth and could identify influencing and related factors. When asked about stress, all adolescents had heard of the term, could describe it, and could speak to factors that enable and prevent it. An adolescent participant recognized the impact of stress on overall health, stating: "if you always feel stressed and afraid then yeah that [has a] big big effect on your health" (A6).

Adolescent participants also used the word comfort to describe positive mental health experiences. When discussing individuals that help facilitate good mental health, one participant referred to her supervisors, as they make her feel comfortable:

[My supervisors] really help me…when [I] go and talk to them they're really good, they really make you feel happy… when I have a problem I go and talk to them… they like made me feel so **comfortable** with them from the first week. (A1)

Service providers discussed using words such as stress, pressure and comfort when talking to Syrian adolescents about their mental health, which is congruent with those used directly by adolescents. One provider described using the word stress to discuss mental health:

...well I use the language of stress…I think that's it's a very universally understood word and I truly believe that most of the problems of refugee youth are related to environmental and social stressors and we could get into a discussion about PTSD and depression and sort of a more bonafide DSM type psychiatric illness but I think that the highest yield is to begin discussion around stress or stressors. (SP8)

When asked what other words they would use to discuss mental health with Syrian adolescents, another stated:

…stress and comfort…I just use this language you know when you're going through something, where there's certain things that really affect your stress levels or your comfort levels, or happiness or things like that…[I ask adolescents] "are you comfortable" you know, or are you stressed yeah, pressure, that's like the words I use, pressure and stress. (SP3)

This statement indicates how the use of terminology can facilitate or hinder discussion. The use of appropriate terminology is essential in effectively understanding adolescents' conceptualizations of mental health.

Despite the importance of using alternative terminology, service providers also noted the importance of exposing Syrian adolescents to the term mental health. When asked if she uses the word "mental health" with Syrian adolescents, a service provider (SP8) responded with "absolutely absolutely I use that word". They explained that there

needs to be a balance between using alternative terminology to facilitate discussion and using the actual term mental health, so that adolescents understand the term when they encounter it in the future.

4.4 Individual Factors

A number of individual factors were identified as having an influence on conceptualizations of mental health, as well as mental health status, by Syrian refugee adolescents and service providers. These personal factors include optimism and thinking about the future, achieving one's full potential and assuming an adult role.

4.4.1 Optimism and Thinking About the Future

Many Syrian adolescents expressed a sense of hope, optimism and excitement for their new life in Canada. They believed that they would have a better quality of life and more freedom, which would ultimately lead to positive mental health outcomes. For female participants, this freedom was attributed to gender equality, as being female no longer placed restrictions on their daily living activities:

> I feel like so happy cause I'm here like I can do whatever I want cause…the girls and boys equal. Like why you going to be like "oh girls are different than the boys, girls have to do this and boys have – boys can do this" you know what I mean? We all equal, like I can work if boy can work, I can work too. If boy can ride a bike, I can ride a bike too. If I can cook, the boy can cook too (A1)

In contrast, few service providers recognized the outward optimism that Syrian adolescents had in Canada. While they recognized their resilience and strength, they did

not discuss the excitement and appreciation adolescents had for being in Canada. This illustrates an adolescent perspective that service providers may need to be cognizant of.

Adolescents also expressed their ability to think about the future once in Canada, meaning they recognized that dwelling on the past would contribute to poor mental health outcomes:

> live your life…you have to be happy and not think about bad thing life if you have any problems in the past like just forget about it and continue your life, cause if you think about your past…you're not going to be happy…for me like, I can forget about the problem like what happened with me. I like to forget like about problem cause its nothing it's like in the past, why am I going to think about it again? (A1)

Adolescents noted that their parents sometimes discussed wanting to move back to Syria and often thought of the past, which made the adolescents sad and stressed: "I see people dying in Syria and I feel so sad, and in Lebanon I'm happy now. In Canada like I'm so happy I'm not going back in Syria, my dad sometimes says let's go in Syria" (A4).

This misalignment between adolescents and their parents in thinking about the future and moving forward is important to highlight, as it speaks to differences in thinking that may lead to conflict and challenges.

Service providers recognized the importance that adolescents placed on thinking about the future in contributing to good mental health. However, they also identified stressors related to thinking about the future. According to service providers, adolescents place more emphasis on stressors related to resettlement and the future than stressors related to the past. For example, one service provider stated that Syrian adolescents were less concerned about their past trauma and history and more concerned with current/future familial relationships and school success:

they prioritize other things than their migration history and what has happened in the past…I think that that's a function of both having the status here and having one's stability and safety assured which reduces post traumatic symptoms hugely, but I think it's also a function of the time like there there's been usually a period for the Syrians where they've been in refugee camps in Jordan or in Lebanon or in other places or in Turkey for a year, two years, three years and then they come to Canada…they don't prioritize trauma as much as they do family conflict, school conflicts, things like that, that's my experience. (SP8)

The optimistic and forward-thinking mentality that Syrian adolescents have contributes to positive mental health outcomes in Canada. However, stressors related to the future are important to recognize, as it is these stressors that often impact mental health.

4.4.2 Achieving Full Potential

Adolescents highlighted the importance of achieving their full potential through a number of different means, including setting goals, taking on greater responsibilities and developing skills. They discussed how these actions contributed to increasing self-efficacy, as they believed they were more skilled and capable of achieving their goals.

During their first two to three years in Canada, adolescents were focused on becoming acquainted with their new life. However, having now been in Canada for two to four years, adolescents were finally able to start setting their own goals and putting them into action:

I started thinking of like to stop worrying about what others says and to start [thinking] about… what I want to do, you know, so I started like learning English like every night I used to come home even if I didn't have homework, I used to go over all my work you know and then I used to study every day (A3)

Service providers echoed this sentiment, highlighting the fact that when the bulk

of Syrian refugees first resettled to Canada, there was a lot of confusion. However, after

being in Canada for a few years, adolescents were starting to take control of their own

goals and ambitions:

> Like there's just – I've known some youth who when I first started working at the schools and now it's a year later, and it's just, they're just doing so much, and you know, they're doing so well in their classes and they're starting to think about their goals (SP3)

These statements highlight how length of time being resettled in Canada can

influence wellbeing for refugee adolescents. It may take two to three years before

adolescents feel they can focus on their own goals and ambitions and once they do,

increased self-efficacy and positive mental health outcomes may ensue.

Adolescent participants also discussed the importance of being given more

responsibilities, specifically in terms of employment and volunteering. When asked how

to deal with stress in Canada, adolescents answered with the ability to take on

responsibility, stating that they deal with stress "when they start to take job and take

responsibility" (A7). The impact of responsibility is two-fold; it provides adolescents with

a sense of personal accomplishment, thereby improving their self-esteem, and also

provides them with the opportunity to give back to their community, which they find

rewarding. Another adolescent participant discussed the importance of volunteering, as it

gave her the opportunity to give back to her community:

> it's actually really hard if you don't speak English especially for newcomers, that's why they need like all the help they can get like translating, and they always help with translating in school yeah that's why I went…to help the ESL teacher because… I know what they go through cause like I've been through it… it makes me feel like really good cause like helping others is the best thing, especially by

language…I love anything that comes to like newcomers I would definitely do it like I would go translate…just do anything they need…anything they want cause like it's really important (A3)

Adolescent participants also stated that employment and volunteering provided them with opportunities to develop relationships with others and improve their English, which fostered a sense of self-fulfillment.

Yeah so from 4 o clock to 6 o clock I work with the kids like from age 5 to age 13 years old, and like we play games, we help them reading and when I work there like it's good for me and it's good for them [the kids]. Like I learn more how to read and how to write English…I learn how to talk to people and this and that's good for me…I really love this job, like when I was younger like my dream was…to go and work program after school with the kids…cause I really love kids… we learn from them…it's not like just the language and they learn from us like things you know what I mean? (A1)

Service providers also discussed the importance of delegating tasks to adolescents, allowing them to take on greater responsibility and develop leadership skills. An example from one service provider about a community event that was put on by Syrian adolescents highlighted the impact on their wellbeing. The adolescents were responsible for organizing and planning a "Syrian cultural night", giving them the opportunity to express themselves and their lives back home. The event included food, art and a number of performances:

I feel like when you give them a project and you know you tell them that "hey you know this is what you guys are in charge of let's see how we can get this done" they really take to it and they really take the initiative because it was something that that they really connected to you know they wanted to showcase their culture… we gave them all these tasks… once everyone had their own parts, they really took to it as it was theirs… that's something that that really helped them out like it kept them focused… they would come every single week cause they were dedicated (SP6)

Service providers linked sense of responsibility to mastery or having fully

acquired skills, which is an essential contributor to positive mental health outcomes.

When refugees come to Canada, they often experience being "de-skilled", as they are

unfamiliar with life in Canada, which can cause mental health challenges. Thus, skill

development was linked to improving self-esteem and confidence. Another service

provider described the impact that developing art skills had on young Syrian refugees:

> It really is more about getting children and youth to explore the expressive arts because we know it can be a huge source of mastery, self-esteem, creativity, self-expression…it's really interesting I mean when you think about the experience of a newcomer, it's almost like you're suddenly so deskilled right you've come to this place where you don't speak the language, you don't know how to get a bus, you don't know how to buy food, you're so deskilled, you're almost rendered to the point of being a baby, so you can see how mastery and learning to do stuff and getting skills is so golden and so valuable. (SP8)

This suggests that skill development has a positive impact on mental health. It

also sheds light on the importance of creating opportunities for Syrian adolescents to take

on more responsibilities in their communities.

4.4.3 Assuming Adult Role

The desire that adolescents have for responsibility does have limitations – when

the responsibility is too advanced for their stage in life, they feel an immense amount of

pressure, which has been attributed to poor mental health outcomes. One adolescent

discussed the pressure she puts on herself to take care of her siblings and succeed in

school, all while maintaining a positive demeanor. She stated that her parents constantly

worry about her and her siblings' wellbeing, academic success and subsequent

employment opportunities in Canada, which puts pressure on her, stating "this give me

big responsibility so yeah make me worry…make me work more hard so they can feel

better like they are good" (A7).

Service providers discussed this same concept, referring to Syrian adolescents in

Canada as being "adultified", meaning they adopt the role of an adult and must assume

responsibility that is beyond what is appropriate for their age. They stated that

adultification starts during the migration phase while in refugee camps. In these camps,

many adolescents did not attend school and had to work. A service provider discussed the

impact this may have on adolescent wellbeing:

> There are some youth who told me like "I literally went from being 10 years old to
> a grown man"…they're like "we skipped school", they're like "we didn't have
> school for 6 for 5 or 6 years, we were working random shops" so he said, so
> they're telling me like "we didn't have a childhood" basically like they literally
> skipped the ages from 10 to 16 where you're supposed to grow and develop as a
> child you know go outside learn how to do all these different sports and what not,
> they skipped all that stuff instead of working right away trying to find ways to
> survive right, so I can only imagine what kind of impact that would have on
> someone's mental health like developmental as well right like you skip a whole
> period that's supposed to help you down the road. (SP6)

Adolescents and service providers discussed the adultification that also takes place

once in Canada due to a number of factors, one most prominently being language

acquisition. Typically, adolescents are able to learn English much faster than their

parents. Therefore, they often need to assist their parents with tasks not considered

suitable for their age, including banking, rental agreements and doctor's appointments.

An adolescent participant discussed going to the doctor with her mother so she could

translate and how it was difficult for her to understand:

> when I came to Canada and I went to the doctor…so I went with my mom right
> and she had a problem in her back and he [the doctor] was telling me like she has
> this problem I wasn't really understand so it's important to go to the doctor like

same language so we can understand what happened to us and like what's wrong with us you know what I mean (A1)

Service providers also discussed the increase in responsibility for adolescents in Canada:

you know you are crippled without the language...the adolescents they're very quick, or the ones I've met, their parents are very slow by comparison and usually the father in my experience doesn't learn and the mother does and so then you've got the split between the parents...one of the challenges around language is the child then has to go to the bank with the parents, cause the parents can't , so you know you've got this adultified parentified child (SP5)

The concept of being adultified or taking on responsibility that exceeds what is appropriate for the adolescent development stage highlights a key factor that may contribute to mental health challenges. Adultification speaks to the complexity of Syrian adolescents' roles and responsibilities within their families and communities in Canada.

4.5 Social Factors

Findings from this study suggest that social factors also have a large influence on how mental health is conceptualized. This includes cultural background of social supports, family, friends and peers and community members.

4.5.1 Cultural Background of Social Supports

In general, adolescents and service providers spoke about the cultural background of those who provide social support, whether it be teachers, service providers or other community members. Adolescents discussed the importance of having Arabic-speaking supports during the first couple of years in Canada solely for language purposes.

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However, they stated that the cultural background of the social supports did not matter, and even less so when English was no longer an issue. Service providers also recognized the importance of language for social supports:

> I think getting to know someone's goals and kind of needs and desires...is an intimate process, so there has to be a relatability, you know, and I have to be able to...build trust and build a safe kind of environment with the person and without language, that's really difficult. (SP3)

In contrast to the adolescents, service providers placed an emphasis on the importance of having people provide support who are of the same background as the Syrian adolescents, beyond just having the language. When asked if those providing social support should be of Syrian background, one service provider responded:

> I would say yes. I think automatically there's just a connection. Just naturally imagery I think, knowing that someone understands. I think especially someone who has that same similar ethnic cultural background who has been here a little longer – who kind of understands how to balance living biculturally (SP1)

There is a clear contrast between the importance that Syrian adolescents and service providers place on the background of social supports. While adolescents recognize the importance of language, once language is no longer an issue, the background of the person providing support does not matter. This is an important contrast to highlight, as it may shape who is able to facilitate effective supports and programs.

4.5.2 Family

Family was referred to as important in shaping one's mental health, including parents, siblings and extended family members. In particular, parents were described as having a very positive role in supporting the mental health of their adolescent children in

Canada. One adolescent explained that she goes to her mother when she is feeling down: "I talk with it with my mom and she really helped me… she give me like more energy like I feel like okay there is people around me that help me so I don't have to be sad and mad" (A1).

Adolescents emphasized the importance of trust, which they felt comfortable placing in their family. They stated that this trust is what allows them to open up to their family when they are struggling. Openly discussing their challenges with others was a common coping mechanism identified by adolescent participants. An adolescent discussed the importance of speaking to others when she feels down, especially her parents:

> I feel more comfortable to talk with my dad and my parents in general yeah and my siblings, like they understand me more…I'll be better with them…since I was child until now I used to talk to my mom and dad and they… taught me to always talk to them…not to others yeah because your parents always won't say what you tell them they will be secret. (A7)

Adolescents discussed the influence that parents had on their participation in activities that supported their mental health. When asked how they had heard about and became involved in programs that positively impacted their wellbeing, all participants said that their parents told them about the programs and encouraged them to attend. One participant discussed how to get adolescents engaged in programs and suggested getting parents more involved, stating:

> Call their parents and let them know about the program like let their parents send them to the program cause for example me I heard of all a lot of programs but I didn't go until a settlement worker called like my mom and my mom said "go that's going to help you" so I just went you know? Cause I listen to my mom. (A3)

This was in contrast to service providers, who mostly discussed the difficulties that exist between the parent-adolescent relationships and their influence on mental health challenges. They spoke about the pressure and stress that parents cause their children and attributed this stress to them being over-controlling of their children's cross-cultural biases. Service providers also discussed how parents often want to maintain their Syrian cultural identity and ways of living, and resist their children's desire to adapt to Canadian culture, which can provoke conflict and challenges:

> In Syria, the culture is different and they come here and I see lots of parents are having problems with their youths. Here, they could come late home and I mean it's unlike back home, back home was not safe for them girls specifically to stay late. Here, the bussing, but the parents are not used to it, it would take them some time okay and that's why the conflict starts between parents and their youth and we see that a lot (SP7).

The differences in how adolescents and service providers perceive the influence of parents on mental health status is important to highlight. At this stage of their resettlement, adolescents regarded their parents in a very positive manner and viewed them as an important factor in maintaining good mental health, which is a perspective that service providers may need to adopt.

4.5.3 Friends and Peers

Adolescents spoke about the influence that friends and peers have on mental health. In terms of stress and mental health challenges, adolescents referred to the difficulty in leaving their friends back home. This hardship was exacerbated by the difficulty in making friends once in Canada, which was often due to language barriers. An

adolescent mentioned the sadness she felt during the first few months in Canada due to

her lack of friends:

> I was like really sad cause like I left all my friends back at home in Syria and I came to Canada and they had problems like I used to cry every single day cause when I came here I didn't have friends I didn't even speak English I was crying like "mom when am I going to learn English nobody wants to talk to me in school" (A3)

Service providers also discussed the difficulty in making friends but placed more

of an emphasis on the cultural differences between adolescents from Canada and

adolescents from Syria:

> My kids born here right and newcomer…they don't have the same mentality that's why they cannot get along. You see them sitting in the same room, different interests, different way of thinking, culturally they're more open here (SP7)

However, when adolescents finally made friends, they discussed how they were

much happier. It provided them with another source of support, establishing relationships

with people they could trust and confide in. According to adolescents, making friends

gave them strength and confidence:

> Just having friends…nothing's going to affect you, friends are really one of the important part of life cause like, yeah I'll say there's fake friends sometimes but some of them…really can help you, you know? Because you can tell them everything. That's why it's not going bother you you're not going to keep anything inside, yeah. (A3)

While positive social interactions with friends and peers were discussed as factors

influencing good mental health, negative social interactions were said to be quite

detrimental to overall wellbeing. Bullying by peers was highlighted by both adolescent

participants and service providers. Adolescents discussed the hardships around being

bullied in school. All accounts of bullying were linked to language, stating that they were made fun of because of their English language skills and/or accents:

> some people it make you sad if you can't read, like I go in the school I'm angry cause everybody the people laugh at me cause I didn't know speak English. At the gym it happened me and here in Canada I didn't speak English I'm in the gym she talk with me bad word and she told me something bad and I told the teacher I'm crying cause like she told me something bad in English I didn't know what did she mean, she talk with her 2 friend about me and I tell her I didn't know what you talking about me… and I'm angry from her and I'm feel so sad and I cry so much. (A4)

The statement captures the emotional impact that bullying has on wellbeing, highlighting the sadness and anger that resulted from Syrian adolescents being bullied.

4.5.4 Community Members

The communities in which Syrian adolescents reside in are dynamic and multifaceted, and thus play an important role in facilitating good mental health. Community supports discussed by adolescents and service providers included schools and faith-based programs. Adolescents spoke about the impact that teachers have in creating an open and inclusive environment. Many adolescents compared the compassion of their school teachers in Canada to their teachers back home, who were said to have lacked compassion. In describing teachers in Syria, an adolescent participant stated: "the teachers…so mean with you…[they say] "why you don't do that, are you stupid?" something like that, not all of them, but some" (A6).

However, when describing their teachers in Canada, adolescents were very appreciative of their support. Some adolescents even attributed their own success to the support of their teachers:

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> I'm…in the middle of grade 11 and now I'm okay…because of my teacher they always encourage me because they say they see…my ability and they see that I can do something and…they see my marks, my work so they told me…I was the student of the month…because of them they always encourage me and they told me "don't worry you can do it" yeah that's why. (A6)

These statements capture the stark contrast between adolescent's views of teachers in Canada compared to Syria, which speaks to the important role that teachers have when working with Syrian refugees. Being aware of this impact may help garner greater sensitivity and support by teachers.

One Syrian adolescent discussed learning about meditation from her teacher, as she facilitated meditation practices once a week. This greatly helped the adolescent participant manage her stress levels:

> when I stress out when I have tests exams…when I feel I'm tired, I go either to some yoga or drink water lay down…in my school last semester… I had English course yeah our teacher every Friday was giving us exercises about mindfulness and these types of meditation so she's the person who lead me to this way of doing like taking care of my health and set it as the priority of everything. (A7)

This further captures the influence teachers can have on their students' mental health.

Service providers also recognized the influence that teachers can have on wellbeing. One service provider said that "teachers are usually very good at that…being made to feel worthwhile by the way we're treated" (SP5). They also discussed that logistically, teachers are interacting with students every day and often have more contact with them than other community members, and as a result, they have a significant influence on wellbeing.

Faith-based supports were frequently mentioned by adolescents as contributing to good mental health. Church was described as a place where adolescents felt supported. Church was also associated with creating volunteer and employment opportunities for adolescents. Throughout these volunteer and employment opportunities, they were able to engage with others their age who spoke English, which gave them an opportunity to create friendships with people from Canada and also improve their English language skills:

> church yeah…there is children there you just you have to go there and play with them, let them feel happy…I [meet] new people yeah, especially youth people so there is a lot of people…from Arabic countries like Syria or Iraq but they can't speak Arabic so that's good for me to speak with them English to improve my English, yeah that's why yeah I feel better there (A6).

Adolescents also discussed the importance of support from older community members, as they carry lots of wisdom and experience. They valued having advice from those older than them, which was reflected amongst most adolescent participants. When asked about supports in the community, an adolescent participant said: "You should always listen to older people cause like it doesn't matter where they from, how old they are, who they are, as long as like they're telling you to like giving you advice cause they know more than you" (A3).

The importance that adolescent's place on older community members is important to highlight, so that efforts aimed at supporting them are appropriately designed and carried out by those who will have the most influence.

4.6 System-Level Factors

System-level factors also contributed to the mental health of Syrian adolescents. System-level factors include navigation challenges and education system challenges and benefits.

4.6.1 Navigation Challenges

The ability to navigate systems in Canada was deemed very challenging by Syrian adolescents and could elicit stress. System navigation was difficult for a number of reasons, such as lack of support system knowledge and transportation barriers, all which were exacerbated by language barriers. One participant discussed being stressed when she first came to Canada, then explained that when she understood the systems, she felt much better: "when I came to Canada that was my problem…stress…I'm always shy but now I'm okay because I know the system…everything it's going to be better" (A6). Service providers also acknowledged the initial difficulty for Syrian adolescents to navigate the systems in Canada:

> I think the beginning was just a general confusion on everybody's part and they just had no means of kind of becoming less confused because of the language barrier mainly to start with but also the cultural barrier. (SP3)

Transportation barriers were also frequently cited, as many participants claimed they did not have cars and had to take multiple busses to get to one location, which took a very long time. This prevented adolescents from attending programs that they found contributed to positive mental health. When asked what leads people to become stressed

and tired in Canada, one participant discussed having a lack of knowledge on the system,

which was heightened by not being able to get around:

> Not knowing what to do, where to go, for me I didn't feel like that cause I had all
> my family here but like I knew other people who didn't have anyone, they went
> through a lot, they went like a lot of places till they settled, yeah, it's really hard
> especially when you don't have a car, yeah cause like when my friend came, she
> didn't have a car she only had her, her sister and her mom. She didn't have a
> father, we didn't have a car, we didn't know what to do (A3)

The difficulty of bussing was exacerbated by the cold weather during winter in

Canada, which was a new experience for adolescents. Cold weather further limited their

participation in activities, like social programs, jobs or volunteering after school. One

participant discussed wanting to move to a different school, so she could be located closer

to her job:

> It's so far it's 2 buses to get there…it's so hard that's why I want to change the
> school and one day it was so cold outside I was waiting the bus from 3:15 until 4
> o'clock, like I get to my job when it was 5 o'clock…it was so cold I was freezing.
> That's why I want to change the school cause I think it's going to be the same in
> winter. (A1)

It is important to recognize these barriers, as they limit Syrian adolescent

involvement in programs that have been linked to improving their mental health.

4.6.2 Education System Challenges and Benefits

The education system was discussed amongst both adolescents and service

providers as having an influence on mental health status. Given their age when they

arrived in Canada, Syrian adolescents were only able to stay in high school for a few

years until they had to transition out. One adolescent participant discussed the quick

transition as being a barrier to achieving her goals, as she wanted to stay in high school to further develop her academic skills so that she could attend university:

> I'm sad cause I came to Canada grade 10, I didn't finish all of them like my grade, and now I can't speak like good English...I want to be lawyer like I want to finish...[learning] how to write, how to read and how to speak (A2)

Service providers also discussed the difficulty that Syrian refugee adolescents face in having to leave high school so quickly and transition into a job, more schooling or adult school, which may lead to stress and poor mental health outcomes. They also highlighted the importance of the school system in enabling or limiting teachers' ability to properly support adolescents, stating "good teaching is dependent on the system that permits enough children to be able to give them proper teaching" (SP5), by providing teachers with proper training and appropriate class sizes. One service provider talked about the challenges in transitioning out of high school to attend adult school, including age restrictions and required courses:

> We are trying to inform these students like age 19 you can't stay in a regular high school anymore you have to go to an adult school and that is for newcomers it's not easy...the problem with the adult school, which we are encountering now, like they force them to take history geography to be able to graduate...why they have to waste their like 6 months? (SP7)

Service providers also mentioned the lack of supportive learning environments in schools for people experiencing mental health challenges, particularly for ESL students. Many school programs that are offered for students experiencing mental health challenges are not geared towards newcomers with language barriers. One service provider discussed the lack of Section 23 classes for Syrian refugees:

> One thing we really lack is we do not have supportive learning environments that are in ESL...section 23 classroom is a classroom that's delivered in settings that

for students who can't be in a regular classroom, either they're having a lot of mental distress or they're so disruptive that they can't be in a regular classroom but the Section 23 classroom is a really important [part] of how we help youth and children here in in Ontario, there's no ESL curriculum delivered in any Section 23 classroom and right now…I think it's going to become an issue (SP8)

This statement highlights how schools may not be appropriately equipped to work with Syrian refugee adolescents who have mental health challenges, which can disrupt successful resettlement.

Almost all adolescent participants discussed a lack of education around mental health in schools, both in Syria and in Canada. Service providers agreed, acknowledging the lack of education services that focus on mental health. One service provider discussed starting a mental health workshop this year for high school students, which was the first time anything of this nature had been administered by her organization. However, she was the only one facilitating these workshops and could not reach enough students on her own:

Yeah I'm the first person to just start this program, so I'm kind of developing it from scratch… I'm one person and this program is brand new to this organization and I think there's only one other organization in Toronto that has another person like me in their organization… so, no I'm not covering – I'm not even covering all the schools just within this organization. (SP1)

However, despite these challenges within the school system, there were a number of benefits to programs and services offered in schools. Adolescents discussed the benefits of having social and academic programs after school, which they did not have in Syria. An adolescent participant discussed after school homework help in allowing her to deal with stress:

I'm always feel stressed and afraid and I'm always like "oh is that good for me? I'm going to do it or not?" like here in Canada they just be relax they told you

"just be relax you have time don't worry you still young" but in my country no nothing from that you just have to study you have to study everything without any helps or anything else yeah but here, there is a lot of helps after school so in my country, there is no help after school, in Canada if I want…extra help the teacher can stay with me and help me yeah that's why yeah I prefer everything here it's better than my country (A6)

Collectively, these examples highlight how system-level factors can both promote and hinder positive mental health outcomes for Syrian adolescents.

4.7 Summary

This chapter presented findings on how Syrian adolescents conceptualize mental health from the perspective of both adolescent's themselves and service providers. In general, Syrian adolescents had very little knowledge of the term mental health. However, their understanding of the concept was much more nuanced. When different language was used to describe the concept, they were much more receptive and were able to engage in effective discourse on the subject. Terms such as stress, pressure and comfort elicited discussions on mental health, allowing Syrian adolescents to share their thoughts on factors that influence good and poor mental health. It is clear that adolescents' general understanding of mental health is multifaceted and influenced by a number of different factors including personal, social and system-level factors. At the personal level, adolescents acknowledged the importance of optimism, goal setting and the ability to take on responsibility in facilitating good mental health outcomes. However, when the responsibilities exceeded what was appropriate for their developmental stage, adolescent's felt pressure and stress, leading to poor mental health outcomes. At the social level, mental health was influenced by family, friends/peers and community

members. Lastly, system-level factors included difficulty navigating through systems in Canada as well as influences of the education system structure on mental health.

While there was much information provided by service providers that mirrored the thoughts of adolescent participants, there were some differences between adolescent and service provider views on mental health, which will be further discussed in the next section.

CHAPTER 5: DICSUSSION

This chapter presents a summary of the study findings, including the interpretation of how Syrian refugee adolescents conceptualize mental health through the perspectives of both adolescents and service providers, highlighting where their perspectives overlap and where they diverge. The study findings will also be compared to previous literature, indicating similarities and differences between Syrian refugees and other refugee groups. The same headings used in the results will be maintained in this section of the discussion, as each theme will be further explored in comparison to the broader literature. This will be followed by recommendations for service providers, researchers and policy makers on how to effectively address Syrian adolescent mental health. Next, limitations, strengths and future directions will be addressed. The chapter will end with conclusions drawn from this study.

In this study, Syrian adolescents' conceptualizations of the term mental health were difficult to ascertain as the term was not well understood. When alternative related terms were used, participants were better able to discuss the concept of mental health.

5.1 Factors that Influence Mental Health Conceptualizations

5.1.1 Knowledge of the Term "Mental Health"

When first asked about their understanding of the term mental health, adolescent participants stated that they were either not familiar with the term or had heard of the term, but had difficulty explaining what it meant. A recent study found that terms

including "psychological state", "psychological wellbeing" and "mental health" were not commonly understood by the Syrian population (Hassan et al. 2015). In the current study, some adolescent participants were hesitant to discuss the term and seemed uncomfortable when it was raised. Other adolescents who were familiar with the term understood it as a biomedical concept, as they believed mental health status was dependent on cognitive function. Models of illness commonly adopted by Syrians describe the body and soul as being interlinked, with no separation between concepts relating to psychological wellbeing and biological state (Hassan et al., 2015). In this way, the term mental health was understood as an illness that was either present or absent. Service providers also recognized that Syrian adolescents often conceptualize the term mental health as a biomedical concept. Conceptualizing mental health as illness occurred even though a distinction between mental health and mental illness was clearly stated before the interviews commenced.

Mental health was also discussed as a term that incites fear and is stigmatized within the Syrian community (Ballard-Kang, Lawson, & Evans, 2017; Hassan et al., 2015). Adolescent participants stated that the word mental health is associated with being "crazy" and that those who experience mental health challenges are often embarrassed and ashamed, as it is perceived negatively. This sentiment of fear and embarrassment was echoed by service providers. In western society, there are different terms to describe mental health and mental illness. However, in Arabic, there is only a single term and it has a negative connotation (Hassan et al., 2015). As a result, mental health is often

neglected and seldom discussed, which leads to lack of knowledge and further perpetuates fear.

Although a broader understanding of mental health is adopted in Canada, there is still stigma and fear associated with the term mental health among Canadian youth. Canadian studies have found that often, youth perceive mental health negatively, which is similar to the perspective of Syrian youth. These studies suggest implementing more robust mental health curriculums in school to reduce the stigma associated with the term mental health (Mcluckie, Kutcher, Wei, & Weaver, 2014; Zhao et al., 2015).

5.1.2 Influence of Language in Facilitating Discussion

However, when different terminology was used to describe the concept, it became clear that Syrian adolescents' understanding of mental health was much more nuanced. Service providers were asked about other terms they would use to describe mental health to Syrian adolescents. Some of the most commonly used words included stress, pressure and comfort. When these words were used when speaking with adolescent participants, participants were much more receptive and were able to describe mental health on a deeper level. Stress, pressure and comfort did not carry the same negative perception that the term mental health did, and the use of these words led to fruitful discussions around factors that adolescents believed influence mental health status.

5.1.3 Individual Factors

Once mental health was framed appropriately, adolescents identified individual, social and system-level factors that influence mental health. Previous literature has suggested that the Syrian population used to believe mental health challenges were influenced by supernatural or spiritual forces. However in recent years, this has started to change, as factors such as violence, social and economic pressures are being identified by the Syrian population as having an influence on mental health status (Hassan et al., 2015). Service providers also spoke to these factors but at times had different perspectives than adolescents. The differing perspective between adolescent and service provider will be discussed later.

Individual factors including optimism, thinking about the future, achieving full potential and assuming an adult role were identified as having a positive influence on mental health status. Having a sense of hope and optimism for new opportunities in Canada was a mindset many adolescents adopted themselves and they discussed how this influenced positive mental health outcomes. However, service providers did not recognize the optimism that adolescents expressed in Canada to the same degree. Being cognizant of this optimism and enthusiasm may help service providers better understand adolescent attitudes in Canada and may enable them to better address Syrian adolescent needs.

Consistent with previous literature, stressors related to the future were identified as having a larger impact on Syrian refugee adolescent mental health status compared to stressors related to past trauma. According to Miller and Rasco (2004), exposure to trauma does not influence adolescent mental health as largely as other stressors. Stressors

that influence mental health to a larger degree for the adolescent refugee population include those related to family, school and health (Miller & Rasco, 2004).

In addition, achieving one's full potential, self-efficacy and self-esteem were also identified by adolescents and service providers as factors that influence mental health, which is discussed in previous literature (Khanlou & Crawford, 2006; Lustig et al., 2004). The ability to develop skills and take on responsibility was identified by participants as crucial for creating a sense of purpose and improving self-efficacy. The availability of employment and volunteer opportunities was particularly important. Most adolescent participants had opportunities to work and volunteer, and they all attributed this experience to having a positive influence on mental health. Adolescents reported that these experiences provided them with a sense of purpose, allowed them to develop English skills and provided them with an opportunity make social connections with other young people, thereby improving their self-esteem. The multi-level benefits that employment and volunteer opportunities offer needs to be further explored, as creating appropriate opportunities for Syrian adolescents can significantly benefit mental health for this group and possibly others.

Lastly, assuming an adult role was also identified by both adolescent and service providers. Both participant groups recognized the mental health challenges that arise from taking on responsibilities beyond what is accepted as being appropriate for adolescents. This has been identified in previous literature as a contributing factor to mental health challenges (Fazel & Stein, 2002). Assuming too much responsibility can put a strain on

the success of adolescents once in Canada. Further work is needed to identify ways to support families, so that the burden of responsibility does not fall onto the adolescents.

5.1.4 Social Factors

Social factors were also identified by both adolescents and service providers. A discrepancy was noted between the importance that adolescents and service providers placed on the cultural background of social supports. Adolescents discussed the importance of having social supports who are able to speak Arabic during the few first years of resettlement, as adolescents are often not proficient in English. However, the cultural background of these social supports was not deemed as being important. Cultural background was even less of a concern for adolescents once language was no longer an issue. On the other hand, service providers believed Syrian adolescents would much prefer social supports who were of the same cultural background. This difference in perspective is important to highlight, as service provider's current perspective may be restrictive when creating social supports. More opportunities for social supports from any cultural background may be created when the adolescent perspective is recognized.

Family was another social support discussed by adolescents and service providers. Service providers discussed the complicated relationship that often exists between parents and adolescents, which they believe elicits stress and can lead to mental health challenges. However, Syrian adolescents had a completely different perspective. They discussed their parents in terms of positive mental health outcomes in Canada, as they could trust and rely on them for support (Hassan et al., 2015). Adolescents discussed their

participation in programs that they believed supported mental health and attributed their

participation directly to their parents. When asked how they got involved in these

programs, adolescents said that their parents were called by a settlement worker who

informed them about the program, and their parents then told the adolescents to attend.

Culturally, Syrian adolescents place a great deal of importance in the opinions of older

individuals. Previous studies have found that Syrian adolescents believe their parents

should have more authority than other cultural groups believe (Smetana, Ahmad, &

Wray-Lake, 2015). Participants in the current study discussed how they must always

listen to advice given by older people, as they know best. This finding suggests that

service providers need to shift their view of the parent-adolescent relationship for the

Syrian population so that they can increase parental engagement when working with

adolescents. The support of parents is warranted for this population and needs to be

scaled up.

Parent-adolescent relationships have been previously discussed in refugee mental

health research. A study of Afghan, Colombian, Sudanese and Tamil newcomer youth

found that while youth identified the importance of family as a support system, they

preferred going to their friends, as they felt no obligation to follow the advice their friends

gave (Shakya, Khanlou, & Gonsalves, 2010). Another study reported that southeast Asian

refugee youth perceived the relationship with their parents negatively (Hyman, Vu, &

Beiser, 2000). Two main reasons were identified in creating a difficult parent-adolescent

relationship: communication challenges and unreasonably high expectations (Hyman et

al., 2000). While these challenges were identified by service providers in the current study, Syrian adolescents did not report the same experience as other refugee adolescents.

In this study, peers were also identified by adolescents and service providers as social factors that influence mental health status. Although positive relationships with peers led to good mental health outcomes, many adolescent participants experienced bullying by peers first-hand and associated this bullying with mental health challenges. The bullying mostly took place in the form of making fun of adolescents for their lack of English proficiency and accents. Experiences of bullying have been widely reported amongst other refugee groups and has been linked to poor mental health outcomes (Correa-Velez, Gifford, & Barnett, 2010; Hassan et al., 2015; Kirmayer et al., 2011; Shakya et al., 2010). The presence and rate of bullying needs to be recognized, and effective ways to mitigate bullying must be further explored.

Community members, including teachers and faith-based supports, were also discussed as social supports (Earnest, Mansi, Bayati, Earnest, & Thompson, 2015; Shakya et al., 2010). Teachers were highly regarded by adolescents and were reported as being much more supportive, encouraging and compassionate compared to their teachers in Syria. Some participants attributed much of their own personal success directly as a result of their teacher's support. Service providers also recognized the importance of teachers. Given the length of time teachers spend with students every day, they can make meaningful impacts, and their support is very much appreciated by adolescents. Teachers need to be aware of their impact and influence on refugee wellbeing, as this may help

them be even more sensitive and supportive of the Syrian students they work with to help them achieve better outcomes.

The different support from teachers in Canada compared to those from their country of origin was also experienced by other refugee groups (Earnest et al., 2015; Hyman et al., 2000). The helpful and friendly nature of teachers created a positive experience for refugee youth. However, the supportive nature of teachers at times created challenges for some, namely those in a study on southeast Asian youth, as they had to adjust to different styles of authority and become familiar with new styles of teaching and learning (Hyman et al., 2000).

Consistent with previous literature, adolescents also mentioned that faith-based supports provided helpful social supports that contributed to positive mental health outcomes (Shakya et al., 2010). Syrian participants were often connected to churches through their family members in Canada. This gave them the opportunity to establish a social network consisting of other individuals their age. The church offered programs that were consistent and reliable, as they occurred every Sunday. Previous research reported that programs aimed at supporting refugee groups should be consistent and predictable (Vasilevska et al., 2010). Many refugees have endured stress and uncertainty and so they need programs that are reliable. These findings support the reason behind Syrian adolescents enjoying the consistency of church programs, which take place every week.

5.1.5 System-Level Factors

Lastly, system-level factors were identified by both adolescents and service providers, including navigation challenges and education system challenges and benefits. Navigating systems in Canada was deemed very challenging by adolescents. They included lack of knowledge on support systems and difficulty with the transportation system. Service providers and adolescents discussed the general confusion that persisted when Syrian refugees first arrived in Canada. However, over time, this confusion was slowly addressed. In addition, difficulty navigating the transportation system prohibited adolescents from getting around easily, thereby limiting involvement in programs that positively influenced mental health. Transportation systems have been identified in previous studies as a major challenge experienced by refugees (McKeary & Newbold, 2010). These system-level challenges need to be addressed by policy makers, so that adolescents are better able to become involved in their community.

Consistent with trends in the literature, this study found that the education system was one of the largest contributing factors to poor mental health outcomes identified by adolescents and service providers (Hadfield et al., 2017; Khanlou et al., 2009). Many Syrian adolescent participants had major gaps in their education due to the war. For a number of years, it was too dangerous to attend school. Those that subsequently moved to refugee camps experienced further educational gaps, as they either did not attend school or had minimal schooling. By the time these older adolescents came to Canada, during the middle or end of their high school years, they had already been out of the school system for a number of years. In brief, having to reintegrate into school, learn a new language,

become familiarized with new ways of teaching and learning, while simultaneously planning for what they were going to do after they completed high school was described as very challenging. Adolescents were only able to stay in high school for a few years until the age of 21, then they either had to enroll in adult school, find a job or continue post-secondary education. Thus, adolescents no longer had access to the supports offered in high school (Bajwa et al., 2017). This rapid transition elicited stress for many and prohibited some from achieving their goals, as they had not yet developed the academic requirements needed for post-secondary education. This quick transition needs to be further addressed by policy makers to facilitate a smoother transition out of high school and ensure appropriate supports continue beyond the high school environment.

5.2 Adolescent Mental Health Policies and Strategies

There are a number of adolescent mental health policies and strategies that exist on a global level. A brief overview of those policies is given below, followed by recommendations from the current study findings.

5.2.1 Global Adolescent Mental Health Policies

Investing in adolescent health in general is an investment in communities and societies as a whole. It was only recently that the importance of adolescent health for creating a sustainable future was recognized on a global scale (Kleinert & Horton, 2016; WHO, 2017). In 2004, no country had a clearly defined mental health policy that targeted adolescents. Since then, the WHO created a global mental health policy guide for children and adolescents. Recommendations are mostly targeted at addressing structural issues,

including mental health education, funded services for adolescents (versus adult services), and appropriate provider training/education about mental health (WHO, 2005). However, despite the WHO's efforts, adolescent mental health was still not fully being addressed (Kleinert & Horton, 2016).

In 2016, the Global Strategy for Women's, Children's and Adolescent's Health, put forth by Every Women Every Child, suggested that countries must invest in child and adolescent health and development by funding programs in partnerships that included government, civil society, the private sector and local community organizations (Every Women Every Child, 2015). Such programs would ideally be multifaceted, targeting health, education, sanitation and overall wellbeing. The strategy noted the importance of identifying context-specific needs as being especially important when working with adolescent refugees. The strategy dedicated an entire section to humanitarian and fragile settings, and highlighted the importance of creating comprehensive packages that meet the context-specific needs of adolescents while using a gender perspective (Every Women Every Child, 2015). Adopting a gender perspective enables recognition of the influence that gender has on adolescents social roles, opportunities and interactions (Food and Agriculture Organization of the United Nations, 1999). Gender plays a role in mental health, as female refugee adolescents experience different barriers to mental health services than their male counterparts (Khanlou, 2010). Therefore, adopting a gender perspective when creating policies on adolescent refugees is essential for their success.

In the same year as the strategy put forth by Every Women Every Child, the *Lancet* Commission on adolescent health and wellbeing highlighted a "triple dividend of

benefits: for adolescents now, for them later as adults, and later still for their children" (Gates, 2016, p. 2358). Building on the work of Every Women Every Child, the commission stressed the importance of adolescent engagement, as their voices are often neglected when creating services targeted at them (Gates, 2016, p. 2358). Systems for training and mentoring youth health advocates were recommended, as youth advocates have the potential to transform the health care system to one that targets and effectively engages the adolescent population (Patton et al., 2016).

WHO followed the lead of Every Women Every Child and the *Lancet* in 2017 with the Global Accelerated Action for the Health of Adolescents (AA-HA!) report. This report calls for greater efforts towards improving adolescent health, suggesting that adolescent mental health is often overlooked (WHO, 2017). The report suggests that evidence-based interventions should be implemented, including interventions at the structural, environmental, organizational, community, interpersonal and individual level. The report further expresses the importance of adolescent participation at all levels. The report suggests that involvement will enhance adolescents' leadership skills, competence and self-esteem (WHO, 2017). These collective global efforts in raising awareness for adolescent health by influential institutions is essential in garnering action by local bodies.

5.2.2 Global Refugee Health Policies

Global refugee health policy is scarce, especially targeted at adolescents. In 2016, the Women's Refugee Commission created a document that outlined challenges that male

and female refugee youth face and how to best address their needs (Women's Refugee Commission, 2016). Many of these suggestions reflected what was stated in the general adolescent health policies previously discussed. The document highlights the importance of having opportunities for employment instead of the reliance on humanitarian aid, as unemployment may result in mental health challenges. Social inclusion and participation were also cited as being important for refugee wellbeing. Youth-specific mental health services were also cited as being of significant importance (Every Women Every Child, 2015; Vasilevska et al., 2010; Women's Refugee Commission, 2016).

Another issue discussed was the lack of opportunities youth had to participate in decision-making processes, leading to feelings of disempowerment. Adolescents noted that they are usually not allowed to voice their opinions and if they do, they are disregarded. Adolescents also stated that they do not know how to engage with decision makers as they often feel alienated, which may contribute to mental health challenges (Makhoul et al., 2012; Women's Refugee Commission, 2016; WHO, 2017).

A number of actions were suggested by the Women's Refugee Commission in order to facilitate good health among adolescent refugees. One action relates to empowering refugee youth through meaningful engagement. This can be done by seeking ideas from youth on issues they consider important, helping youth establish their own programs and creating mentorship programs. Another action suggests supporting the physical and emotional wellbeing of refugee youth by having accessible youth-friendly services, including psychosocial support services, youth outreach groups and peer support programs. Mental health education was also highlighted. Educating refugee youth on their

own health, while educating youth from Canada on the experiences refugees face, will allow for more open and understanding relationships, leading to successful integration (Women's Refugee Commission, 2016).

Another important action suggests facilitating refugee youth networking and information sharing. There is a need for more age-appropriate information on asylum procedures, legal issues, refugee rights and protection risks (Women's Refugee Commission, 2016). Such information must be written in a way that is understandable for all individuals, regardless of previous education and proficiency in English. Recently, social media has been a popular source of information dissemination to refugee youth. Current information will enable them to better navigate health care and social service systems and may promote improved access to mental health care.

5.3 Recommendations

Findings from this study support five key recommendations to assist policy makers, service providers and researchers in strengthening their work with Syrian refugee adolescent mental health. These recommendations include appropriately framing mental health programs, increasing parental involvement, improving employment and volunteer opportunities, school support-related considerations and funding-related changes.

1. <u>Appropriately frame mental health when designing programs and services for Syrian adolescents</u>

It is clear that the ways in which mental health is framed dictates how adolescents' respond and understand the concept itself. The negative connotation associated with the

term mental health ultimately limits adolescents from engaging with the term and related systems. However, when appropriately framed, adolescents are much more receptive to the concept itself. Programs and services labelled with appropriate terms might better target Syrian adolescents. Increased engagement in these programs, and openness to discussing mental health, will enable their conceptualizations to be better understood, and may therefore help their mental health needs to be better addressed.

Program and service labelling starts at the policy level. The importance of mental health framing has been acknowledged in policy research. For example, a study examined how mental health policy framing shifted overtime in Scotland (Sturdy, Smith-Merry, & Freeman, 2012). Prior to 1990, mental health was framed around mental illness and was oriented towards providing treatment for those who were ill. However, since 1990, the policy framing has shifted towards promoting good mental health for all individuals. The ways in which problems are framed dictates what the solutions will be. In their study, framing mental health as more than an illness broadened the scope of mental health policy to include measures that support social, emotional and psychological wellbeing (Sturdy et al., 2012). This is one example of the importance of mental health policy framing. Canada frames mental health similarly to Scotland (Canadian Mental Health Association, 2018). Findings from this study suggest that adolescent perspectives need to be considered and included in policy framing. Being cognizant of the specific terms that Syrian adolescents respond to, including stress, pressure and comfort, will allow Canadian policy makers to further develop policy framing that better targets adolescents in general and refugee adolescents in particular.

2. <u>Increased parental engagement in programs and services for adolescents</u>

Findings from this study suggest that the role of parents is crucial in facilitating good mental health amongst Syrian adolescents, as parents are viewed very positively by adolescents. Adolescents discussed the trusting relationship they have with their parents, which allows them to confide in their parents when they experience challenges. Adolescent participants who discussed the importance of being involved in various programs reported that they learnt about these programs directly from their parents. These programs, which included homework help, youth groups and recreational programs, were deemed very effective in alleviating stress and maintaining good mental health by adolescents.

Adolescent participants who were enrolled in these programs were limited to those who were connected to community services and therefore had relationships with settlement workers who were able to contact their parents. In addition, despite the increasing recognition that parents have a significant influence on students' learning and development, service providers tend to be reluctant in soliciting parental involvement; parents and service providers often assume young people in their late teenage years want more independence (Fan & Williams, 2010; Hill & Taylor, 2004). However, this was not the case for Syrian adolescents. Greater efforts are needed to increase parental involvement in academic and non-academic programming for adolescents.

3. <u>Increase employment and volunteer opportunities for Syrian adolescents</u>

All adolescent participants in this study were engaged in either employment or volunteer opportunities during their time in Canada. They discussed how these

opportunities led to increased self-efficacy and self-esteem, increased English proficiency and an opportunity to develop relationships with others. The potential added benefits that volunteer and employment opportunities offer needs to be widely recognized and scaled up. Specifically, opportunities that are not limited by language barriers should be considered for the Syrian refugee group.

The importance of increasing volunteer and employment opportunities is supported by a recent study that found an increase in spending on social services positively influenced population health measures in Canada at the provincial level (Dutton, Forest, Kneebone, & Zwicker, 2018). The positive influence of social spending on health makes a strong case for redistributing funds from health to social programming to better support the health of Syrians and other adolescents. Increased social spending will provide more employment and volunteer opportunities for Syrian adolescents, directly increasing their mental health.

4. <u>Support for students with gaps in their education beyond secondary school</u>

The transition through high school has been deemed very challenging for adolescent participants. Many Syrian adolescents have experienced gaps in their education, yet they have limited time to become acquainted with the high school system in Canada, as older adolescents need to quickly transition to adult school, the workforce or post-secondary education. Although there are supports in secondary schools for those with education gaps and language barriers, namely the Literacy Enrichment Academic Program (LEAP) and ESL classes, there is a need for more support services for adolescents during their transition out of secondary school, especially for those entering adult school.

According to service providers, adult schools present unique challenges, one being a lack of social support (Knighton, Hujaleh, Iacampo, & Werkneh, 2009). Key learnings from LEAP and ESL classes should be examined and considerations should be made as to how these supports can be incorporated into supporting the transition out of school and during adult school. Extending the upper age limit for ESL students in secondary schools may also be a worthwhile consideration. As a result, Syrian adolescent mental health may be better supported.

In Denmark and other Nordic countries, effective supports have been put into place for refugee students that transition out of high school. Schools called Folk High Schools are institutions for non-formal adult education, as they do not grant academic degrees. The aim of these schools is to help young adults learn language and societal norms. Recent studies have shown that folk schools are effective in supporting refugee youth by promoting inclusion and wellbeing (Børsch, Jervelund, & Skovdal, 2018). Folk High Schools should be further studied, and key learnings from the Folk school system may inform or be applied to the Canadian context.

5. <u>Consistent and long-term funding for service providers</u>

One issue highlighted by service providers was the short-term nature of their contracts, which made it difficult to support Syrian adolescents' wellbeing in the long-term. Short-term contracts were predominantly given to settlement workers and child and youth workers who focused on the Syrian refugee population. Short-term contracts severely limit the work done by service providers; the uncertainty as to whether or not these contracts will be extended limits ongoing planning and engagement with students

and schools. The need to shift funding from project-based funds and short-term contracts is also supported by previous research (Access Alliance, 2017). Creating long term contracts will allow Syrian adolescents and possibly other refugee youth to be better supported.

5.4 Limitations

In addition to the methodological limitations noted in chapter three, there are other limitations that must be addressed. First, study recruitment was very challenging given the sensitive nature of mental health. A number of adolescents initially expressed their interest in participating in the study to staff at NYCH, but when I followed up with the potential participants, they tended to change their mind. In addition, different staff at NYCH kept recommending the same few participants, which demonstrated the difficulty in recruiting a large study sample. Further, six of the seven adolescent participants were female. In this study, information provided by the male participant was similar with that provided by female participants. However, in order to understand if there are significant gender differences in mental health conceptualizations, a larger sample of male participants is needed.

Language barriers were also considered a limitation in the current study. As mentioned in chapter three, simple language was used during interviews to ensure adolescents understood the questions. Despite the use of simple language, some participants expressed the difficulty they had in articulating their thoughts and stated that they would be better able to describe these thoughts if they could say them in Arabic. The

use of service provider participants helped mitigate this challenge, as they were often able to expand on the thoughts of Syrian adolescents. However, the use of translators would be valuable in allowing adolescents to express their views on mental health in more depth.

5.5 Study strengths

The current study begins to address a number of major gaps in the literature relating to refugee adolescent mental health. First, refugee adolescent voices are largely underrepresented in the literature. This study addresses this gap by collecting information from Syrian refugee adolescents directly so that their perspectives are understood. Second, given their recent resettlement to Canada, work focusing solely on Syrian adolescents is missing from the literature. This study explores mental health conceptualizations adopted by a homogenous group of Syrian adolescents to understand their views and begin to address this gap in the literature. Including and comparing adolescent views with those of service providers and the literature was another strength, as this process allowed for a more comprehensive understanding of Syrian refugee adolescent mental health. Findings in this study support and extend what is reported in the literature.

5.6 Knowledge Translation and Dissemination

A key component of research is the dissemination of findings so that they are useable and can be built upon by other researchers (Pablos-Mendez, Chunharas, Lansang, Shademani, & Tugwell, 2005). The collaboration with NYCH is a key step to effectively

disseminating findings. As a community partner in the study, NYCH requested information and recommendations from the study that were tangible and could be applied to their practice. A service provider tool consisting of a short summary (Appendix I) with key findings and recommendations from the study will be shared with NYCH. The summary includes information regarding appropriate mental health framing and similarities and differences that exist amongst adolescent and service provider views on mental health. This summary will be easy to use and applicable to the work of community organizations working with Syrian refugee adolescents. NYCH will also be given the option to receive the full thesis. Additionally, participants who requested a summary of the study results will receive a copy by email.

5.7 Future Directions

The current study offers a number of suggestions for future directions. First, all participating adolescents were connected to a variety of personal networks, including community or faith-based organizations. Harder-to-reach adolescents are often left out of the literature and need to be included in future studies. The use of a translator, or Arabic-speaking researchers, may be necessary to achieve this. Next, gender differences in Syrian adolescent mental health conceptualizations should be further examined in future studies, requiring the recruitment of more male participants. Previous research has suggested that there are gender differences in how mental health is conceptualized and in factors that influence mental health status (Guruge & Butt, 2015). Gender should be further explored in the context of Syrian refugee adolescents.

In addition, differences in mental health conceptualizations between various types of refugees should be examined, namely GARs, PSRs and BVORs. In the current study, there was only one GAR participant. However, the differences identified between the single GAR participant and PSR participants suggest that it would be worthwhile to examine the difference in mental health conceptualization between these groups. Further, given the fact that resettlement stressors change with time, a longitudinal study that examines how Syrian adolescents' conceptualizations change over time would be of value.

5.8 Conclusion

This study used a qualitative exploratory approach to investigate mental health conceptualizations among Syrian refugee adolescents living in the GTA. The aim of this study was to understand how Syrian refugee adolescents conceptualize mental health through the perspectives of adolescents and service providers, so that their mental health can be appropriately understood and addressed. The study findings begin to address several gaps in the literature, including adolescent conceptualizations of mental health from their own perspectives, as well as factors that influence the mental health status of the Syrian refugee adolescent population.

Overall, the study findings indicate that conceptualizations of mental health are highly dependent on how the concept is framed. The terms mental health was poorly understood amongst Syrian adolescents. However, when different terms were used to

describe mental health, terms such as stress, pressure and comfort, it was clear that adolescents had a much deeper understanding of the concept.

Framing mental health appropriately allows for discussion with adolescents regarding factors that they believe influence mental health status. Factors identified by adolescents and service providers included individual, social and system-level factors. Key similarities and differences were identified between factors that adolescents deemed as being important and factors that service providers deemed as being important in influencing mental health. While adolescents and service providers adopted the same views for many factors, there were a number of different perspectives adopted by each group.

The findings from this study support specific recommendations for both service providers and policy makers, allowing the mental health needs of Syrian refugee adolescents to be better understood and better addressed. Recommendations include appropriately framing mental health programs and services so that they are effectively reaching their target population, increasing parental involvement, improving employment and volunteer opportunities for adolescents, school support-related considerations and funding-related changes. It is clear that understanding the conceptualization of Syrian adolescent refugees through their own perspective is crucial in addressing their needs, so that they can have positive mental health outcomes now and later in life.

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Appendix A: Key Background Definitions

Term	Definition
Adolescence	A critical stage of development for individuals between the ages of 10 and 19 (WHO, 2018)
Blended Visa Office-Referred (BVOR) Refugee	Refugees whose initial resettlement is supported by both the Government of Canada and private sponsors (CIC, 2017).
Community Sponsors (CSs)	"An organization, association or corporation that can sponsor refugees to come to Canada. Community sponsors can only sponsor an applicant who already has refugee status" (CIC, 2018b).
Constituent Groups	A group of individuals authorized by sponsorship agreement holders (SAHs) to sponsor refugees to come to Canada (CIC, 2018b).
Convention Refugee	"someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (Office of the United Nations High Commissioner for Refugees, 1967, p. 3).
Government Assisted Refugee (GAR)	Refugees whose initial resettlement in Canada is entirely supported by the Government of Canada or Quebec (CIC, 2017).
Groups of Five (G5)	"Five or more Canadian citizens or permanent residents over the age of 18 who can sponsor one or more refugees to come to Canada to settle in their local community" (CIC, 2018b).
Mental Health	A state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community (WHO, 2004)
Mental Illness	Severe mental health problems characterised by alterations in thinking,

	mood and behaviour associated with significant distress and impaired functioning (Government of Canada, 2015).
Permanent Resident	A person who can remain in Canada permanently but is not a citizen (CIC, 2017g).
Privately Sponsored Refugee (PSR)	Refugees who have been supported by private sponsorship, in which the financial costs of sponsorship and settlement support is provided by private groups or organizations (CIC, 2017).
Sponsorship Agreement Holders (SAHs)	Organizations in Canada that have signed agreements with the Government of Canada to help support refugees from abroad when they come to Canada (CIC, 2018b).
Unaccompanied Minor	An individual under the age of 18 "who is not accompanied by a parent or adult who is legally responsible for them" (Immigration, Refugees and Citizenship Canada, 2013).

Appendix B: Letter of Research Ethics Approval

December 20 2017

Project Number: 3576

Project Title: Understanding Syrian Refugee Adolescents' Conceptualization of Mental Health and Wellbeing: An Exploratory Analysis

Student Principal Investigator: Ms. Talia Filler

Local Principal Investigator: Dr. Olive Wahoush

We have completed our review of your study and are please to issue our final approval. You may now begin your study.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Filler_Consent_Service Providers	Nov-22-2017	1
Filler_Consent_Youth	Nov-15-2017	2
Filler_Interview Guide_Service Providers	Nov-15-2017	1
Filler_Interview Guide_Youth	Nov-15-2017	2
Filler_Oath of Confidentiality	Sep-26-2017	1
Filler_Poster	Nov-15-2017	2
Filler_Protocol	Nov-21-2017	2
Filler_Sample Recruitment Email_Service Providers	Nov-22-2017	1
Filler_Sample Telephone Correspondence_Service Providers	Nov-22-2017	1

Any changes to this study must be submitted with an Amendment Request Form before they can be implemented.

This approval is effective for 12 months from the date of this letter. Upon completion of your study please submit a **Study Completion Form**.
If you require more time to complete your study, you must request an extension in writing before this approval expires. Please submit an **Annual Review Form** with your request.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Good luck with your research,

Kristina Trim, PhD, RSW
Chair, HiREB Student Research Committee
McMaster University

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; for studies conducted at St. Joseph's Healthcare Hamilton, HIREB complies with the health ethics guide of the Catholic Alliance of Canada

Appendix C: Letter of Information/Consent Form for Adolescents

Letter of Information / Consent Form for Participants
Project Title: "Understanding Syrian Refugee Adolescent's Conceptualization of Mental Health: An Exploratory Analysis"

Local Principal Investigator:	**Student Investigator:**
Dr. Olive Wahoush	Talia Filler
School of Nursing	Department of Global Health
McMaster University	McMaster University
Hamilton, Ontario, Canada	Hamilton, Ontario, Canada
(905) 525-9140 ext. 22802	**(647) 225-9044**
wahousho@mcmaster.ca	fillerte@mcmaster.ca

You are invited to participate in a research study. The following information will describe the purpose of our study and the care we have taken to protect your privacy and confidentiality. This study is being conducted by Talia Filler for her Master's thesis and is being supervised by Dr. Olive Wahoush.

What are we trying to discover?

The purpose of this study is to gain an understanding of how Syrian refugee youth understand mental health and wellbeing and what factors they believe contribute to good and poor mental health. This study is focused on Syrian refugee youth between the ages of 16-19 who live in the Greater Toronto Area (GTA). I hope to learn about mental health and wellbeing from a youth's point of view. This research is being completed for my Master's thesis.

What will happen during the study?

If you choose to participate, you will be interviewed face-to-face for 45 minutes to 1 hour in any location and time convenient for you. This may include the library, community centre or North York Community House. I will conduct the interview and only you and I will be present. With your permission, the interview will be tape-recorded and I will take some handwritten notes. Your identity will not be linked to the recordings or notes. Your participation in this interview is entirely voluntary and confidential. You are able to refuse to answer any question and/or withdraw from the interview at any time.

First, I will ask you some questions about yourself, including your age, when you moved to Canada and school. I will also ask you some questions about your understanding of mental health and wellbeing. Finally, I will ask you some questions

about factors you believe promote good mental health and factors you believe contribute to poor mental health.

During this study, I will focus on mental health and wellbeing. Mental health is the ability to function and cope in everyday life. Mental health problems refer to changes that occur over time and significantly affect the way a person copes or functions. When these changes in mood, thinking and behaviour are associated with stress and impaired functioning, it may be that the person is experiencing mental health challenges. However, we will not be focusing on mental illnesses, which are severe mental health problems that are diagnosed by a mental health professional, including schizophrenia, bipolar disorder, etc.

Are there any risks to doing this study?
It is not likely that there will be any risks associated with this study. However, you may reflect on your own feelings and experiences, which may make you feel uncomfortable. Remember that you can skip any question or stop the interview at any time. You may also be worried about people finding out that you participated in this study, but everything is completely confidential. Only I will know that you participated in the study.

Are there any benefits to doing this study?
It is not likely that the study will directly benefit you, but the information you provide may help researchers and service providers create better programs for Syrian adolescent refugees. In this way, participating in the study may help your community.

Payment
As a token of appreciation for your participation, you will receive a $10.00 gift certificate to Tim Hortons and volunteer hours. You will receive this at the end of the study or when you decide to end the study.

Confidentiality
Your participation in the study is completely confidential. This means that I will be the only one who can access the interview scripts and transcripts. Any information that would allow you to be identified, like your name and age, will be removed from the study results. If you tell me the names of others, I will also remove their names for their privacy. Your interview script and transcript will be coded with a personal identification number and kept in a locked filing cabinet separate from your consent form. The data collected from this study will be stored on a secure and password protected computer file. Only the research team will have access to the information and all of the team members are committed to protecting your privacy and confidentiality. If you decide to end the interview, there will be no penalty to yourself and withdrawal will not affect your compensation. Once the study is complete, an archive of the data, without any identifying information, will be kept for 10 years.

What if I change my mind about being in the study?

Your participation in this interview and study is completely voluntary and confidential. You can withdraw from the study at any time before, during or after the interview. You will have until February 1st, 2018 to withdraw from the study. Any data that you have provided will be destroyed unless indicated otherwise. There will be no consequences if you choose to withdraw. If you want to participate in the study but do not want to answer some of the questions, they can be skipped.

If you choose to withdraw from the study, please contact Talia Filler at the number or email address provided above.

How do I find out what was learned from in this study?

We expect to have this study completed by June 2018. If you would like a summary of the findings, we would be happy to mail or email them to you upon completion of the study. The interviewer will ask for your contact information so we can follow up with your request.

Questions about the study

If you have any questions about this study, please call Talia Filler at (647) 225-9044 or Dr. Olive Wahoush at McMaster University at (905) 525-9140 ext. 22802.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the REB Chair, HIREB at 905.521.2100 x 42013.

CONSENT

- I have read the information presented in the information letter about a study being conducted by Talia Filler and her supervisor Dr. Olive Wahoush of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time.
- I have been given a signed copy of this form. I agree to participate in the study.

I would like to receive a summary of the study's results.   *Yes   No*

If yes, where would you like the results sent:

Email: _____

Mailing address: _____

_____

_____

I agree that the interview can be audio recorded.   *Yes   No*

_____

_____ _____ _____
Name of Participant (Printed)   Signature   Date

Consent form explained in person by:

_____ _____
Name and Role (Printed)   Signature   Date

Appendix D: Letter of Information/Consent Form for Service Providers

Letter of Information / Consent Form for Participants
Project Title: "Understanding Syrian Refugee Adolescent's Conceptualization of Mental
Health: An Exploratory Analysis"

Local Principal Investigator:
Dr. Olive Wahoush
School of Nursing
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 ext. 22802
wahousho@mcmaster.ca

Student Investigator:
Talia Filler
Department of Global Health
McMaster University
Hamilton, Ontario, Canada
(647) 225-9044
fillerte@mcmaster.ca

You are invited to participate in a research study. The following information will describe the purpose of our study and the care we have taken to protect your privacy and confidentiality. This study is being conducted by Talia Filler for her Master's thesis and is being supervised by Dr. Olive Wahoush.

Purpose of the Study:
The purpose of this study is to gain an in-depth understanding of Syrian refugee adolescent's conceptualization of mental health and wellbeing and to identify risk and resilience factors that contribute to their mental health.

Procedures:
If you choose to participate, you will be interviewed face-to-face for 30 to 45 minutes in any location and time convenient for you. I will conduct the interview and only you and I will be present. Participating in this study entails you to share your perspectives on Syrian refugee youth mental health and wellbeing. With your permission, the interview will be tape-recorded and I will take some hand-written notes. Your identity will not be linked to the recordings or notes. Your participation in this interview is entirely voluntary and confidential. You are able to refuse to answer any question and/or withdraw from the interview at any time.

Potential Harms, Risks or Discomforts:
It is not likely that there will be any risks associated with this study. You can skip any question or stop the interview at any time. Discomforts may include the time commitment associated with taking part in this interview and privacy concerns. Every effort will be made to protect your privacy when participating in the interview. To protect

your identity, a personal identification number will be used on all transcripts. Project materials and published study results will not reveal your identity or that of your organization.

Potential Benefits:

It is not likely that the study will directly benefit you. However, your experiences will contribute to advancing knowledge in the refugee mental health area regarding Syrian youth. The information you provide may also inform researchers and service providers to create more effective programs for Syrian refugee adolescents. In this way, participating in the study may help your community.

Confidentiality:

Your participation in the study is completely confidential. This means that I will be the only one who can access the interview scripts and transcripts. Any information that would allow you to be identified, like your name and age, will be removed from the study results. Your interview script and transcript will be coded with a personal identification number and kept in a locked filing cabinet separate from your consent form. The data collected from this study will be stored on a secure and password protected computer file. Only the research team will have access to the information and all of the team members are committed to protecting your privacy and confidentiality. Once the study is complete, an archive of the data, without any identifying information, will be kept for 10 years.

Participation and Withdrawal:

Your participation in this interview and study is completely voluntary and confidential. You can withdraw from the study at any time before, during or after the interview. You will have until February 1st, 2018 to withdraw from the study. Any data you have provided will be destroyed unless indicated otherwise. There will be no consequences if you choose to withdraw. If you want to participate in the study but do not want to answer some of the questions, they can be skipped.

If you choose to withdraw from the study, please contact Talia Filler at the number or email address provided above.

Study Debriefing:

We expect to have this study completed by June 2018. If you would like a summary of the findings, we would be happy to mail or email them to you upon completion of the study. The interviewer will ask for your contact information so we can follow up with your request.

Questions:

If you have any questions about this study, please call Talia Filler at (647) 225-9044 or Dr. Olive Wahoush at McMaster University at (905) 525-9140 ext. 22802.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the REB Chair, HIREB at 905.521.2100 x 42013.

CONSENT

- I have read the information presented in the information letter about a study being conducted by Talia Filler and her supervisor Dr. Olive Wahoush of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time.
- I have been given a signed copy of this form. I agree to participate in the study.

I would like to receive a summary of the study's results.   *Yes   No*

If yes, where would you like the results sent:

Email: _____

Mailing address: _____

_____

_____

I agree that the interview can be audio recorded.   *Yes   No*

_____

_____ _____ _____
Name of Participant (Printed)   Signature   Date

Consent form explained in person by:

_____ _____
Name and Role (Printed)   Signature   Date

Appendix E: Study Poster

Are you a Syrian refugee youth who:

√ Lives in the Greater Toronto Area?
√ Is between the ages of 16-19?
√ Moved to Canada less than 5 years ago?
√ Feels comfortable participating in a one-on-one interview on wellbeing?
* NOTE: interviews will be conducted in English

> If the answer is YES to the above questions, you are **invited to participate in our study** on your understanding of wellbeing.

> You will be asked to participate in a 45 minute to one hour one-on-one confidential interview to share your thoughts on wellbeing.

As a token of appreciation for your participation, you will be offered a $10.00 gift card and volunteer hours.

For more information, please contact Tali Filler at
fillerte@mcmaster.ca

This study has been reviewed by Hamilton Integrated Research Ethics Board.

Email Tali Filler at: fillerte@mcmaster.ca — Email Tali Filler at: fillerte@mcmaster.ca — Email Tali Filler at: fillerte@mcmaster.ca — Email Tali Filler at: fillerte@mcmaster.ca — Email Tali Filler at: fillerte@mcmaster.ca — Email Tali Filler at: fillerte@mcmaster.ca

Appendix F: Recruitment Email for Service Providers

To:
Subject: Request to Participate in an Interview for Master's Thesis

Dear [insert name],

My name is Tali Filler and I am a Master's student studying Global Health at McMaster University. I would like to invite you to participate in a 30 to 45 minute interview for a Master's thesis project, which is being supervised by Dr. Olive Wahoush.

The purpose of the interview is to gather your insights on how Syrian refugee youth conceptualize mental health and wellbeing and to identify risk and resilience factors that contribute to their mental health. I understand that your experience as a [role] would allow you to provide a valuable perspective on Syrian refugee youth mental health and wellbeing.

Participation in this project is completely voluntary and confidential. With your permission, the interview will be audio-recorded and I will take handwritten notes. I will keep all information from the interview secure and confidential. Your name and/or organization will not be linked with the information you provide and you will not be identifiable in the final report. This study has received approval from the Hamilton Integrated Research Ethics Board.

If you are willing to participate, please suggest some possible dates and times for the interview, which can be conducted in any location most convenient for you. I have attached a letter of information and consent form for the project. Please review these and feel free to contact me if you have any further questions via email at fillerte@mcmaster.ca or by phone at 647-225-9044.

Your contribution to this research is very valuable and deeply appreciated. Many thanks in advance for your consideration.

Best,

Tali Filler

Appendix G: Adolescent Interview Guide

Understanding Syrian Refugee Adolescent's Conceptualization of Mental Health:
An Exploratory Analysis
Semi-Structured Interview Guide (Syrian Adolescents)

First, thank you again for your willingness to participate in my study. I would also like to remind you to let me know if there are any questions you would prefer not to answer or any answers you would like to have removed from the record.

The intent of this interview is to learn about your understanding of mental health and wellbeing and to identify factors that promote good mental health and factors that contribute to poor mental health.

Mental health is important for all individuals, which is why I want to talk about it. Mental health is the ability to function and cope in everyday life. It is the ability to enjoy life and deal with challenges that you face every day. Mental health problems refer to changes that occur over time and significantly affect the way a person copes or functions. When these changes in mood, thinking and behaviour are associated with stress and impaired functioning, it may be that the person is experiencing mental health challenges. However, we will not be focusing on mental illness, which are severe mental health problems that are diagnosed by a mental health professional, including schizophrenia, bipolar disorder, etc.

Everything disclosed here is private and confidential. If you say someone's name or location, those will also be kept confidential. Before we begin, do you have any questions?

First a few questions about you (demographic):
1. How old are you?
2. How do you identify yourself (gender)? (Prompt: male, female, unidentified)
3. What languages do you speak?
4. How long have you been in Canada? (Prompt: less than 1 year, 1 year, over 1 year)
5. What is your immigration status? (Prompt: government assisted, privately sponsored, blended)
6. Where have you lived in Canada and where do you live now?
7. Do you have any family members with you in Canada? (Prompt: who are you here with? Who is at home?)
8. What are you doing right now in terms of education, school, employment, etc.? (Prompt: are you in school?)
   - Did you go to school back in Syria? (Prompt: are there any times that you weren't able to go to school? I.e. in refugee camps [Lebanon, Jordan])

Now let's talk about your understanding of mental health and wellbeing (mental health conceptualization):

1. Tell me about your thoughts and ideas about mental health and wellbeing (Prompt: What comes to mind when you hear the word mental health/wellbeing, what does it look like? What does it look like to have good/ poor mental health? What does it look like to be happy, cope with stress, navigate life successfully? What does it look like to be down, tired, sad, etc.?)
2. Is mental health very different to physical health, like when you get sick? (Prompt: how? Is having a healthy mind as important as a health body? Is one more important than the other?)
3. Do people around you talk about mental health? (Prompt: In your family? With your friends? In your community? Have you learnt about this in school? Who do you talk about mental health and wellbeing with?)
4. Do you think it is or isn't important for someone to get help when their mental health and wellbeing is not good? (Prompt: when they're sad, tired, how?)

Now let's will talk about factors that promote good mental health and factors that influence poor mental health:
5. What do you think helps people have good mental health and wellbeing here in Canada?
   - Explain cope: ability to deal with situations, which can be done in different ways: talking to someone, exercising, art, etc.
   - Prompt: what allows people to cope? What personal factors might help? What family and community factors might help?
6. What makes it difficult for people to have good mental health once they are in Canada?
7. How may someone's family and friends influence their mental health and wellbeing? (Prompt: how may someone's family help with their mental health wellbeing? How may they contribute to mental health challenges?)
8. How may school influence one's mental health and wellbeing? (Prompts: Who in schools? How do they help? Certain places in the school?)
   - Can school help with mental health and wellbeing?
   - Can school promote mental health challenges? Why?
9. How do you think community programs, like those put on my NYCH, impact mental health and wellbeing? (Prompt: do programs run by NYCH help people feel good and have improved mental health? Do they produce mental health challenges and stresses? How did you hear about them/ where?)
10. At these programs, do you think it is important to have service providers who are from your community?
    - That speak your language?
    - Are the same gender? (Prompts: why? Do you feel more comfortable with the same gender/opposite gender?)

11. You said you were attending/working in [insert level of education or job]. Do you think being involved in _____ can contribute to mental health and wellbeing? (Prompt: How?)

Opinion Questions

12. What would you like to see implemented or changed in current services that support mental health and wellbeing for other youth like yourself?
13. Where and when should programs be offered? (Prompt: in school, outside of school, during school hours, after school hours)

Final Comments

14. Do you have any additional ideas/comments you would like to add that I have not asked about?

Thank you very much for your participation!

Appendix H: Service Provider Interview Guide

Understanding Syrian Refugee Adolescent's Conceptualization of Mental Health:
An Exploratory Analysis
Semi-Structured Interview Guide (Service Providers)
Adapted from Khanlou et al., 2015

First, thank you again for your willingness to participate in my study. I would also like to remind you to let me know if there are any questions you would prefer not to answer or any answers you would like to have removed from the record.

The purpose of the interview is to gather your insights on how Syrian refugee youth conceptualize mental health and wellbeing and to identify risk and resilience factors that contribute to their mental health.

For this study, mental health is defined as the ability to function and cope in everyday life and deal with challenges you face every day.
Everything disclosed here is private and confidential. Before we begin, do you have any questions?

Demographic questions:

1. What is your occupation?
2. What kind of organization employs you?
3. How long have you been doing this kind of work?

Open Ended Questions:

1. In what context do you have contact with Syrian refugee adolescents? (Schools, community centres, etc.)?
2. In your experience, what do you think Syrian refugee adolescents know about mental health?
   - What are their thoughts and ideas about mental health?
   - What do they think it looks like to have good mental health? Poor mental health?
3. What words do you use to define mental health and wellbeing when speaking to these youth?
4. On a whole, how do these youth seem to you (facing challenges/ showing resilience/both)?
5. In the sector in which you work/practice, what do you perceive would be of most help to these youth in understanding and learning about mental health?
6. What factors do you think foster resilience in Syrian refugee youth?
   - Prompts: community programs, school, family, friends, language

7. What factors do you think contribute to mental health challenges in Syrian refugee youth?
    - Prompts: Prompts: community programs, school, family, friends, language
8. Can you tell me about what supports offered through your workplace are offered to maintain or improve mental health and wellbeing for Syrian refugee youth?
    - What works well?
    - What changes may you like to see?
9. Do you have any additional ideas/comments you would like to add that I have not asked about?

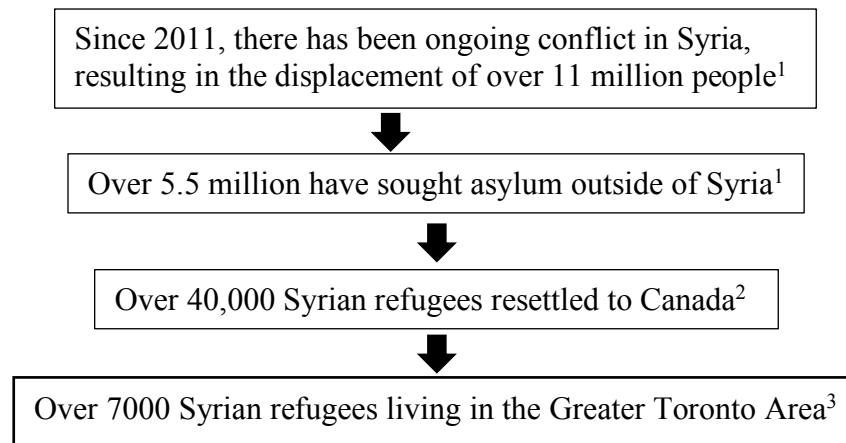*Thank you very much for your participation!*

Appendix I: Service Provider Information Sheet

Understanding Syrian Refugee Adolescents' Conceptualizations of Mental Health: Key
Findings
Tali Filler, MSc Candidate, Global Health, McMaster University

Background

Conflict in Syria and Resettling to Canada

Since 2011, there has been ongoing conflict in Syria, resulting in the displacement of over 11 million people[1]

↓

Over 5.5 million have sought asylum outside of Syria[1]

↓

Over 40,000 Syrian refugees resettled to Canada[2]

↓

Over 7000 Syrian refugees living in the Greater Toronto Area[3]

Adolescents and Mental Health
- Of the Syrian refugees that resettled to Canada, approximately 52% were under the age of 19[4]
- Adolescence (ages 10-19) is a critical stage for physical, psychosocial and cognitive development[5]
- As a result, adolescents are at an increased risk for mental health challenges[5]
- Refugee adolescents are a particularly vulnerable group, as normal adolescent stress is compounded with pre-migration, migration and resettlement stress[5]

Study Objective
- The aim of this study is to explore how Syrian refugee adolescents conceptualize mental health through the perspective of older adolescents and service providers

Key Findings

Finding 1
- Most adolescent participants were unfamiliar with the ***term*** mental health
- Fear and stigmatization associated with the term
- Perceived negatively

Finding 2
- When other words were used by the interviewer to describe mental health, adolescents expressed a deeper and more nuanced understanding of the *concept*
  - These words included **stress, pressure** and **comfort**

Finding 3
- A number of factors that influence mental health were identified by service providers and policy makers
- *** indicates where adolescent and service provider opinions differed, followed by a brief explanation**
- Individual factors
  - Sense of optimism and thinking about the future, positive mental health outcomes
  - Achieving full potential – through volunteer and employment opportunities, positive mental health outcomes
  - Assuming adult role – adolescents taking on too many responsibilities, negative mental health outcomes
- Social Factors:
  - *Cultural background of social supports
    - Service providers thought social supports should be of the same cultural background as the adolescents, yet adolescents did not believe so
  - *Family
    - Service providers discussed the difficulties in parent-adolescent relationships, but adolescents spoke of their parents very positively, influencing good mental health
  - Friends and peers
    - Good relationship can influence positive mental health outcomes
    - Bullying, frequently experienced by peers
  - Community Members
- System-level factors
  - Navigation challenges
    - Understanding systems in Canada, difficulties with transportation, leads to disengagement and poor mental health
  - Education system challenges and benefits
    - Challenges: for adolescents who come from Syria, they are typically in the middle of high school, and have to very quickly transition out of high school, without necessary supports
    - This leads to poor mental health
    - Benefits: extracurricular programming and homework help in schools

Recommendations
1. Appropriately frame mental health when designing programs and services for Syrian adolescents

      a.   Use terms such as stress, pressure and comfort
2. Increase parental engagement in programs and services for adolescents
3. Increased employment and volunteer opportunities for Syrian adolescents

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For more information, please email Tali Filler at fillerte@mcmaster.ca