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Explanatory models and help-seeking for symptoms of PTSD and depression among Syrian refugees

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ABSTRACT

Objective: This study investigates how Syrian refugees explain and prefer to seek help for symptoms of post-traumatic stress disorder (PTSD) and depression.
Methods: We conducted five semi-structured focus group interviews based on a vignette-technique with Syrian refugees (n = 21 men, n = 10 women). The vignettes describe a fictional person suffering from symptoms of PTSD or depression in line with DSM-5 and ICD-10 criteria.
Results: Despite never mentioning PTSD, participants in the PTSD-interviews recognized the symptoms. They perceived them as a common reaction to extreme situations, mainly the war, the flight, and post-migratory stressors. Depression was labeled as either depression or feelings caused by social problems, and the participants were more hesitant to identify with these symptoms. Despite some differences, both the PTSD and depression vignettes were explained in terms of situational explanatory models and externally caused stress. The main finding is how participants described changing stressors resulting from migration and resettlement leading to a difference in how they would seek help in Syria and in Norway. Specifically, we found that preferred help-seeking and coping strategies are contextual.
Conclusions: These findings point to the need to consider transformations following forced migration when studying aspects of explanatory models, preferred help-seeking, and coping strategies in refugee groups.

1. Introduction

Explanatory models of illness influence how individuals interpret the signs and symptoms of a disease, including psychiatric disorders, and how they seek help for and attempt to cope with their conditions (Kirmayer, 2001; Kirmayer and Bhugra, 2009; Kleinman, 1980). Less is known about how the process of forced migration may influence these explanatory models. To provide resettled refugees with adequate mental health services, more knowledge is needed about how they conceptualize and prefer to cope with common mental health problems. In this study, we explore explanatory models and preferred help-seeking for symptoms of PTSD and depression among Syrian refugees.

The ongoing war in Syria has led to more than 6.7 million Syrian refugees worldwide in addition to the over 6 million Syrians who are internally displaced (UNCHR, 2020). Exposure to pre-migration risk factors in conflict-affected populations is associated with elevated risk for psychological health problems such as post-traumatic stress disorder (PTSD) and depression (e.g. Charlson et al., 2019; Tinghög et al., 2017). Similarly, experiences during flight and post-migration stressors can negatively affect mental health (Jankovic- Rankovic et al., 2020; Miller and Rasmussen, 2017; Porter and Haslam, 2005) and is significantly associated with the risk or severity of conditions such as depression and PTSD (Miller & Rasmussen, 2010, 2017; Tinghög et al., 2017).

PTSD and depression are highly prevalent in refugee populations (Charlson et al., 2019), also among refugees resettled in high-income western countries (Fazel et al., 2005; Tinghög et al., 2017; von Haumeder et al., 2019), but it is important not to portray all refugees as traumatized (Renner et al., 2020). Symptoms may not necessarily indicate mental disorders (Hassan et al., 2016), and many who have been exposed to traumatic events do not develop psychopathology (Charlson et al., 2019). However, refugees tend to underutilize mental health services (Kirmayer et al., 2011; Satinsky et al., 2019). This has been

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attributed to structural and cultural barriers, among them differences in explanations of symptoms and preferred sources for help-seeking that deviate from the majority population (Satinsky et al., 2019). However, while we know that the life situation in exile may influence the mental health of refugees (Fazel and Silove, 2006; Montgomery, 2014), we know less about how explanatory models may be influenced by life in a new country of settlement. This statement rings particularly true in receiving countries such as the Nordic welfare states with their extensive public services and universal health care systems which may be radically unfamiliar to refugees arriving from war-torn countries. Thus, to provide knowledge that may ensure adequate and inclusive health care services, our focus is on explanatory models and help-seeking preferences among Syrian refugees settled in Norway.

1.1. Explanatory models

Kleiman defines explanatory models (EMs) as "notions about an episode of sickness and its treatment that are employed by all those engaged in clinical processes" (Kleinman, 1980, p. 105). EMs are sets of beliefs specifying the cause of an illness, its symptoms, pathophysiology, and treatment (Dein, 2016). EMs also encompass perceptions of relevant coping and help-seeking strategies (Kleinman, 1980). As a result of increased awareness of how people in various cultures perceive mental health problems, the Diagnostic and Statistical Manual of Mental Disorders was revised to include cultural concepts of distress to distinguish cultural traits of mental health experiences (DSM 5; American Psychiatric Association, 2013). This includes cultural explanations or perceived causes, as well as cultural idioms of distress, and cultural syndromes. The Cultural Formulation Interview has been established as a tool for clinicians to take these aspects into account in diagnosis and assessments.

In the Syrian context, explicit labeling of concepts referring to mental health problems may carry negative connotations and can constitute a source of stigmatization (Hassan et al., 2015). More indirect expressions are often used when describing psychological states, such as *ana ta'ban* (I am tired), or *nafsiyti ta'banah* (my psyche is tired) (Hassan et al., 2015, p. 22). However, Renner et al. (2020) describe how Syrian refugees settled in Germany reported several emotional consequences of war, fleeing, and resettlement, even explicitly talking about *depression*. Symptoms of PTSD were never labeled as PTSD. Participants stressed *resource-oriented coping mechanisms*, particularly the importance of having work and opportunities to study. In addition, the *social network* was identified as the most significant source of coping and support (Renner et al., 2020). However, war and displacement have in many cases disrupted social support structures (Alzoubi et al., 2017; Hassan et al., 2015), which may in turn, affect Syrian refugees' preferred help-seeking paths.

EMs can affect preferred sources for help-seeking (e.g. Kirmayer and Bhugra, 2009; Kleinman, 1980), treatment (e.g. Dinos et al., 2017; Erdal et al., 2011; Hagmayer and Engelmann, 2014) and coping strategies (e.g. Markova and Sandal, 2016). Importantly, EMs are not fixed representations, but fluid, dynamic, complex, and changeable (Dinos et al., 2017; Ghane et al., 2010; Kirmayer and Bhugra, 2009). Irrespective of cultural background, individuals may simultaneously hold different explanations for the same condition, rather than a coherent set of beliefs (Kirmayer et al., 2004; Williams and Healy, 2001). Explanatory models develop from people's experiences in life and vary across time and living environments (Dein, 2016; Dinos et al., 2017; Kleinman, 1980), including migration stories (Dinos et al., 2017). For example, Mölsä et al. (2010) showed how traditional explanatory models among Somali immigrants in Finland both persisted and changed as a result of new sources of suffering and new ways of interpreting them. This exemplifies how the process of acculturation and familiarization with the cultural practices, beliefs, and common help-seeking strategies in the country of settlement also affects the EMs of immigrants. However, few other studies are exploring how the process of forced migration may influence explanatory models of mental health problems after settling in a western country.

In the present study, we explore how Syrian refugees explain and prefer to seek help for symptoms of PTSD and depression, and how their conceptualizations of these disorders and preferred help-seeking are affected by the migration-and resettlement process.

2. Methods

2.1. Design and vignettes

We conducted semi-structured focus group interviews using a vignette technique. The vignettes (see Supplementary Material) display a fictional person suffering from symptoms of either PTSD or depression, in line with the criteria of the DSM-5 and the ICD-10. The vignette character was gender-matched to the respondents to facilitate identification. The PTSD-vignette was inspired by vignettes used by Markova and Sandal (2016), Erdal et al. (2011), and Yaser et al. (2016). It was developed in cooperation with clinical psychologists- and adjusted for cultural appropriateness by a Syrian medical doctor who assisted the research group. The depression-vignette is similar to the one applied Markova and Sandal (2016), which again is adapted from Erdal et al. (2011). The vignettes were translated from English to Arabic by a professional translation service, and back-translated to Norwegian by interpreters participating in the focus group interviews.

2.2. Interview guide

An interview guide was developed based on the work by Markova and Sandal (2016), which in turn builds on the Short Explanatory Model Interview (Lloyd et al., 1998) inspired by Kleinman (1980). The interview guide was further adjusted in cooperation with the Syrian MD/research assistant. After eliciting the groups' initial reactions and thoughts about the vignette, the main follow-up questions were: *What, if anything, do you think is wrong with Karam/Ghazal? What could be the reason why Karam/Ghazal is feeling the way he/she does? If you were his/her friend, what would you recommend him/her to do? And why? Does he/she have a disease? Do you think Karam/Ghazal can get help from the public health sector? If yes, how? If no, why not?* Closed questions were followed up with more open questions.

2.3. Participants

Participants were recruited by purposive sampling and had to meet the following inclusion criteria: 1) Being a refugee from Syria, 2) above the age of 18, 3) lived more than 6 months in Norway, and 4) currently enrolled in the mandatory Introduction Program. The program is offered by Norwegian municipalities to refugees and their families who have been granted residence permits. It aims to provide the qualifications necessary for refugees to obtain subsequent training, education, or employment (The directorate of integration and diversity, 2019).

Participants were recruited by the staff at the Introduction Program in two municipalities in collaboration with the research team. Participants received information a week prior to the interview. At the first school, the information was given by the staff, while the first author organized an information meeting at the second school.

A total of 31 Syrian refugees participated in five focus-group interviews: two based on the PTSD-vignette and three based on the depression-vignette. The groups were divided by gender. The participants varied in age and educational background (see Table 1). Data collection was conducted from September 2018 to May 2019.

2.4. Procedure

The first two interviews (using the PTSD-vignette) took place at an activity-center for refugees next to the introductory school they

Table 1
Sample features.

	Women ($n = 10$)	Men ($n = 21$)
Age (range)	25–47	19–56
Married (percentage)[a]	90%	61.9%
Residence permit	100%	100%
Education		
University/college[b]	3	4
Worked in Syria	2	21
Homemaker	7	–
Time in Norway		
0.5–1 years	2	3
1–2 years	3	5
2–3 years	3	5
3–4 years	1	3
Missing	1	5

Note. Focus group composition by gender, number of participants, and vignette.
[a] All married participants had spouse and family members in Norway.
[b] Because of the war, most of the participants who attended university or college did not finish their degree.

attended. The rest of the interviews (depression-vignette) were conducted at a different introductory school. All participants were enrolled in the respective schools and were familiar with the locations. Certified interpreters of the same gender as the participants took part in all interviews. Before the interviews, the interpreters explained their role and assured that everything to be discussed would be kept confidential. Three members of the research team (author one, two, and four) were present during the interviews. Authors two and four conducted the first four interviews, whereas author one and two conducted the fifth interview. All interviews lasted 1.5–2 h. The interviews were videotaped and audio recorded. Prior to the interviews, participants were provided with an Arabic consent agreement which was read aloud by the interpreter, making sure that the content was understood by everyone. All except one agreed to participate, and this person left the site. Written informed consent was obtained from all participants.

The vignettes were orally presented by the interpreter at the start of the interviews. The interviewers encouraged free discussion, still ensuring that all groups covered the main topics, that all participants were to some extent active, and that the conversation was focused. The participants were never asked personal questions, instead, they were encouraged to take the position as the friend of the vignette character.

2.5. Transcription

The interviews were transcribed verbatim masking the identity of the participants. The quotes presented are translated from Arabic to Norwegian by the interpreter during the interviews, and later from Norwegian to English by the first author.

2.6. Ethics statement

Approval for the study was obtained from the Regional Committee for Medical and Health Research (REK) (2016/32) and the Norwegian Centre for Research Data (NSD) (602214). Focusing on psychological health problems runs the risk of reactivating distress and trauma. Therefore, we specifically asked the participants not to disclose personal stories. They were further urged to respect the confidentiality of other participants. Clinically trained psychologists conducted the interviews, trying to avoid going into themes or personal stories that could be experienced as painful. The participants had contact persons at their introductory schools who were available after the interview.

2.7. Analysis

Our analytic starting point was that concepts such as health and healing are constructed, incorporating the notion that there is no universal conceptualization of depressive disorders (Marsella, 2003) or PTSD. The interviews were analyzed using template analysis (King, 2020). Before the analysis, six a priori themes were defined: *identification with the vignette, explanatory models, help-seeking, coping strategies, barriers,* and *potential interventions.* The next steps were transcribing and familiarization with the data, reading and re-reading the text, generating initial codes representing the a priori defined themes, producing the initial template, developing the template, and writing up the findings (King, 2020). The codes were organized hierarchically from broader to more focused themes and reviewed through careful reading of the data until we were confident that the data was described sufficiently.

The development of the template and the initial coding were carried out by the first author. Next, author four developed codes separately from author one, and we then compared the two code sets. This served as a quality check and sparked discussions about the validity of our initial interpretations. Author two and three read the transcriptions and discussed codes with author one, making sure that the codes satisfactorily captured the data. Feedback on the analysis was provided by a reference group consisting of health personnel working at the introductory program, general practitioners with immigrant backgrounds (including from Syria), people working with refugees in the Red Cross, the Church City Mission, and representatives from the local municipality. The transcription from each focus group was first analyzed independently. Next, transcriptions from the groups with the same vignette were compared, and finally, all interviews were compared. The transcriptions were coded using the software Nvivo12 (NVivo qualitative data analysis software, 2018). An outline of key components of the analytic process is presented in Fig. 1.

3. Results

During the analysis, our a priori themes were restructured, merged, and expanded upon. The final analysis resulted in three broad themes which were labeled "*The nature of the problem*", "*Preferred help-seeking and coping strategies*" and "*Context sensitivity*."

3.1. The nature of the problem

"This is a result of experiences in Syria" (PTSD). Participants primarily drew on explanations related to *external situations and stressors* to interpret the symptoms displayed in the PTSD-vignette. They normalized the character's situation by interpreting experiences of distress as a common reaction to extreme situations. Identifying with the vignette character's situation, participants interpreted the difficulties considering their own and other Syrians' communal war experiences, and experiences pre- and post-migration:

> "Oh yes, we have gone through this as well when we fled our home country from the war, and we walked to the neighboring country. It took us two years before we could settle down properly. We were scared. The children were kind of unstable and scared all the time and suffered from everything happening around us" [Female participant].

A few of the participants, both male, and female, used labels associated with psychological problems to describe the character's reactions, but PTSD was never named. Even though the participants never explicitly mentioned PTSD, they not only recognized the vignette character's situation, but also specifically identified with the outlined symptoms. These included nightmares, difficult memories, and thoughts of homeland and family.

One of the men explicitly stated that the PTSD-character was depressed, and a few others recognized that part of the problem was psychological. However, one of the men emphasized that "*the problem is not only psychological. It should not get that label.*" He stated that Karam's problems stemmed from his experiences in Syria: "*It looks like Karam has*

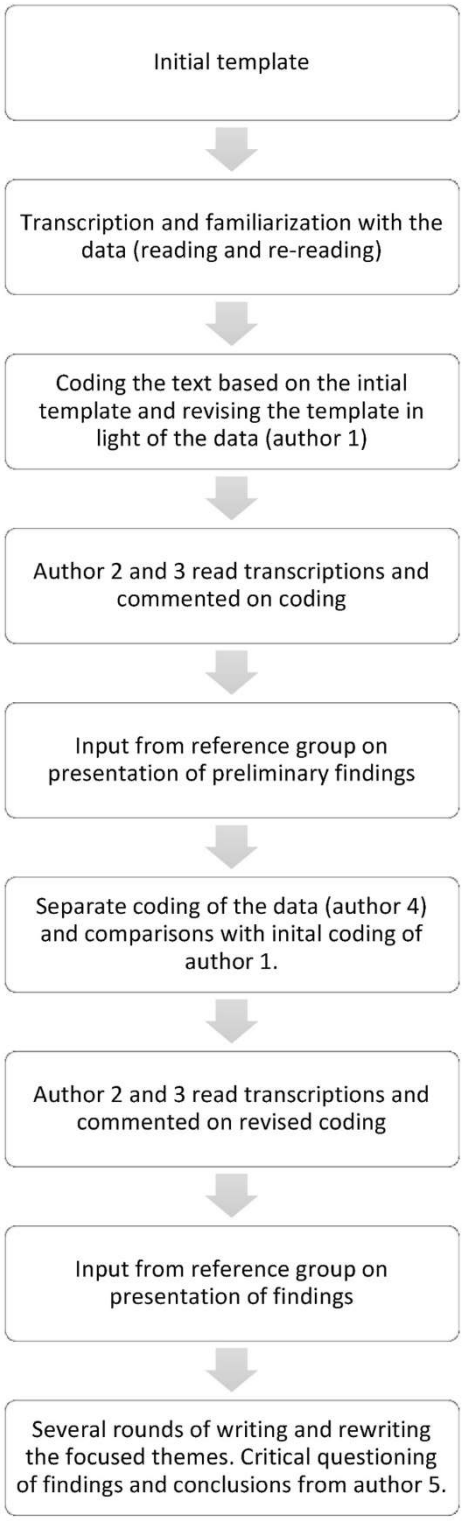

Fig. 1. Outline of key aspects of the analytic process.

many psychological strains. He has become depressed already and this is a result of what he has experienced in Syria. Karam's situation looks like our situation – the situation of most Syrians here." Hence, normalizing symptoms of PTSD does not necessarily entail a de-emphasis on the character's psychological pain. Some of the men saw the character as perceiving everything in a negative way, and that he kept "*the bad feelings in his body*," which in part could be the reason for his reactions.

Based on their own experiences, participants discussed how post-migration stressors could cause the character's symptoms to persist or increase over time. Important stressors were degradation or loss of social networks, culture-related difficulties, and problems with the bureaucracy. Difficulties getting a job, economic challenges, and language barriers also came up.

The male group focused primarily on pressures related to being enrolled in the introductory program and navigating in the new society. When talking about the Norwegian system (e.g., introductory program, governmental bureaucracy), the men described a feeling of "*always meeting a closed door in the face*", and "*that the rules are followed so strictly that it is like they are written by God or Allah.*" This experience of stress and lack of flexibility in the first years in the new country made it harder to establish a new life. In this context, the men kept turning back to how much they missed their old life:

> *"I feel that I am in the same situation* [as the vignette character]. *Because in the time after I came to Norway, I got the same feeling. In the first months, I could not go to school. I always thought of what I had left in Syria, and all my memories are in Syria"* [Male participant].

The many challenges navigating in the system were also a topic in the female group. Particularly problematic was accessing general practitioners:

> *When you see the doctor for example because of back pain in the homecountry, you get an appointment with a specialist on the same day, not after seven months. When we go to the doctor* [in Norway] *and we are sick, we must wait for ten days, one month, two months. What am I supposed to do in these two months?* [Female participant].

They also related the vignette character's situation to their own worrying about problems with finding a job or their husbands' unemployment.

"One cannot exclude multiple reasons for explaining what is happening to Karam now" (Depression). Participants in the depression interviews also recognized the symptoms described, but in contrast to the participants in the PTSD interviews, they were hesitant to express personal identification with the character's situation. Some of the participants said that they knew people who suffered from similar symptoms. Others fully distanced themselves and people their network from the symptoms displayed. Like in the PTSD-interviews, participants in all depression interviews drew on explanations related to *external situations and stressors* when interpreting the vignette character's symptoms. However, they emphasized other situational factors as likely causes than those discussed in the PTSD interviews. This may be because the depression-vignette did not display a flight-scenario. Participants emphasized that the characters' symptoms derived from a complex situation in which a multitude of factors could be affecting their mental health, and the fact that the characters live alone is not enough to explain their situation:

> *"He means that one cannot exclude multiple reasons for what is happening to Karam now. He means that there can be many reasons for that. He* [Karam] *is unmarried, he lives alone, and he has some bad experiences from before. It could be many factors at the same time, and it could be an accumulation of those factors that has this result for Karam. Because there is not enough reason for Karam to be depressed. He* [the participant] *uses himself as an example. He lives alone, and he has a normal life"* [Male participant, the interpreter translates in "he"-form].

We observed a generational gap in the labeling of symptoms. Younger participants explicitly used the term *depression* when talking about the vignette character's symptoms, whereas the older participants to a greater extent discussed it as *reactions to social problems*. Participants using the term depression in the male group were further divided. Some talked about depression as being sick: "*He is of course sick. He has an abnormal life. So, something is wrong.*" Others used the label *depression* but

emphasized that it does not mean that the character is sick - depression is something everyone can experience: "[…] *he* [the character] *does not have a disease. Depression does not require a doctor."*

Participants drew on their personal experiences in their reflections; however, they attributed the character's symptoms less to refugee-related explanations such as war and flight, and instead focused on the experience of coming to a new country. Especially social consequences of resettlement and displacement, such as loneliness, having no one to talk to, separation from family members, and living alone, were seen as contributing to the character's problems. In the participants' situation, one must start from scratch: *"It's another culture here. We come from a different society […] We feel that we are born again here. We have to start from scratch"* [Female participant].

In contrast to the PTSD-vignette, the character in the depression-vignette is not married. This came up as an important explanatory factor among the women. One woman stated that *"I think that this woman needs love. Because she is 27 years old."*

3.2. Preferred help-seeking and coping strategies

The preferred help-seeking behaviors were similar across the two vignettes but varied between men and women. Participants discussed several different help-seeking strategies, including challenges and barriers to seeking help. In addition, there was also some discussion of different individual coping strategies.

Individual coping strategies. Male participants focused more than the women on individual self-help strategies and active coping strategies such as exercise, "be a man," heal your own wounds, and change the tempo in life: "*We have an Arabic expression that says that nobody can heal your wounds*[…] *You have to heal your own wounds"* [Male participant, PTSD-interview]. Similarly, some of the women in the PTSD-interview discussed that the character needs to be willing to play an active part in the process of changing her life. If not, no one can help her. Moreover, forgetting the past and positive thinking were important strategies mentioned in the PTSD-interviews:

> *"I would advise her to forget everything from the past, and only look at the positive things for her – at the children, the future of her children, to help the children. Only focus on all that will happen to her in the future. Forget about everything"* [Female participant, PTSD-interview].

Paralleling the finding that post-migration stressors such as economic challenges and unemployment were viewed as causing the characters' symptoms to persist or increase over time, we found that both men and women talked about *participation in the society of settlement* (Renner et al., 2020), in the form of integration into the new society, as an important coping strategy regardless of the vignette. For instance, all groups emphasized how getting a job was an important coping strategy: "*If you manage to find a job, the financial problems are solved, and the stress and the psychological problems are solved simultaneously"* [Male participant, PTSD-interview].

Moreover, engaging in sports was emphasized as a coping strategy for symptoms as those described in the vignettes. One of the men explicitly described how he used exercise to cope with nightmares:

> *"[…] When I think of something before going to sleep, I get nightmares. So, for example, I do physical activity to get very tired. When the night comes, I am so tired and sleep very well"* [Male participant, PTSD-interview].

Doing sports such as walking or going to the gym was discussed in all groups as helpful strategies for individual coping.

None of the participants mentioned Allah or God or any other religious issues as either explanatory factors or coping strategies. The only time this issue was mentioned, was when the interviewers specifically asked about it. It was described as belonging more to the past, their parents' generation, the rural areas of Syria, and certain other Arab countries.

Seeking support ***in the social network.*** In all interviews, family and friends were described as constituting the first circle of support. Social support in the form of talking to family members or friends was perceived as essential and the main source of preferred help-seeking. Some mentioned the extended family. A friend was described as someone that listens to you, helps you to "*take the weight of your heart*", and help you to change- and get control over - your thoughts.

> *"We have lost our entire families; we have lost contact with our families. We are all alone, without people we know, without emotional closeness. It is vital that you get a friend here. Always have people around you […]. Because then you get a chance to talk with them – to tell them what you feel. That helps"* [Female participant, PTSD-interview].

Regardless of who the person to talk to is, the main criterion was trust:

> "*He must contact someone he trusts. He is capturing all the bad feelings in his body and brain. So, he must find out how to tell someone about it. He must express this feeling. Because the feeling must not remain inside the person"* [Male participant, PTSD-interview].

Despite this emphasis on seeking social support, cultural stigma connected to mental health issues affected the way, to whom, and to what extent participants considered it appropriate for the vignette characters to communicate their emotional distress:

> The interpreter sums up what has been said in the group: "So, everyone agrees that Karam can talk to a friend, but it is not very good that everyone else knows about it [the problem]."
>
> Interviewer 1: "Why?"
>
> Male participant: "If Karam is an Arabic person, he will of course be very embarrassed if everyone knows about his situation" [Male participant, depression-interview].

The character in the depression vignette is unmarried and does not have children. Both male and female participants suggested that getting married was a way of improving the situation, both because the character was "too old" to still be unmarried, and because a spouse could provide the character with the support he/she needed. One of the male participants suggested marriage as one of several solutions: "*There could be several solutions. For example, Karam must find a new job* (…). *He could get married and get a new life."* The female participants emphasized that the vignette character needs love, someone to take care of, and to share her thoughts and feelings with.

Professional support**.** The women in both the depression- and PTSD-interviews discussed how going to a psychologist often has a negative connotation in the Syrian culture: *"It is not good. It is not nice in our culture."* Yet, the women agreed that the vignette character should see a psychologist, and not care about what other people may say, because she needs to talk to someone outside the family: "*Psychologist. She needs to see a psychologist. That is the best way for her to get help"* [Female participants, PTSD-interview]. The female PTSD-group highlighted that it is the responsibility of the vignette character's closest network to encourage her to see a psychologist. Because once her problems hinder her from being positive towards her family and children, she needs to act to change.

Generational differences characterized all the male groups' discussions on preferred help-seeking strategies. The younger men suggested seeking formal support such as psychological treatment to a larger extent than the older men, who expressed more skepticism. Those who were skeptical towards seeking professional help in the depression-interviews, also described the symptoms as being caused by social or relational reasons, as one participant described it: "*Karam does not need a doctor. Karam has some kind of void in his life and he just needs a friend to talk to, and then the problems will be solved"* [Male participant, depression

interview]. However, other men suggested seeing a doctor if Karam had tried to talk to a friend first:

> "*The doctor has experience with treating conditions like this* […]. *It could happen that Karam might get medicine, for example, a calming medicine. It could also be a conversation between the doctor and Karam, and Karam will get a very nice feeling when someone is listening to him"* [Male participant, depression-interview].

A few of the oldest participants in the PTSD-interview said that you can become sick, or sicker, if you see a psychologist, and highlighted that there is nothing a psychologist can do in a situation like the one displayed in the vignette.

Challenges with the health system were highlighted as barriers to seeking professional support. Navigating in the system, miscommunication with doctors, language barriers, and the many challenges connected to seeking help using an interpreter were mentioned as important:

> Participant a: "A third thing that I would like to point out is that I have some friends who have psychological problems. They want to go to a psychiatrist, but what hinders them are concerns about the interpreter because they do not speak Norwegian."
>
> Interviewer 2: "Is that in Norway?"
>
> The interpreter [explains]: "Yes, it is in Norway. They do not trust the interpreter. They do not want anyone who speaks Arabic to hear them talk. So, this is a barrier for treatment."
>
> Interview 2: "So, the interpreter is a hinder?"
>
> Participant b: "Yes!"
>
> Many participants: "Yes, the interpreter is a barrier."
>
> Participant b: "Some people are afraid that the interpreter knows about their story" [Male participants, depression interview].

In this quote, we see both the importance of trust and the fear of being stigmatized among one's community members as a barrier towards the use of interpreters.

3.3. Context sensitivity – *"she has this problem here in Norway, and that means that we have to find the solution in Norway"*

An important finding is how the help-seeking and coping strategies discussed by the participants seemed to be affected by the migration and resettlement situation. Participants indicated that there is a difference between how they would seek help in Syria and in Norway for a problem like the one presented in the vignettes. In Syria, relying on the social network would be the preferred strategy: *"The treatment is the people around you like friends, relatives, family, and such"* [Male participant, PTSD-interview]. Seeking social support was the first preferred strategy in Norway as well. However, some participants explained that because social support structures are not present in their original form in Norway and that the cultural stigma connected to professional help was perceived to be very different in Norway and Syria, they found it easier to seek professional (mental) health services in Norway if needed. In both the PTSD and depression-interviews, participants' reflections indicated that their preferred help-seeking and coping strategies are geographically and culturally situated.

Loss of social network and separation from family members were presented as important stressors. Disruptions of social networks meant that reaching out to family and friends (the help-seeking strategies that participants would have chosen in Syria) was not an option in Norway for some of our participants. They discussed how separation from the Syrian society and network because of resettling in Norway could increase the probability of seeking formal help in Norway for a similar problem to the one described in the vignette:

> Interviewer 1: "So, if you felt like Karam you say that you would wait for it to pass. If it does not pass, would you go to the doctor then?"
>
> Male participant: "If I felt like this in Syria; no, I would not go. But here; yes, of course."
>
> Interviewer 1: "Why would you not go in Syria?"
>
> Male participant: "Because of the community and the cultural barriers" [depression-interview].

The women also stated that there are fewer cultural barriers towards accessing mental health services in Norway.

> Female participant a: "In our home country, we cannot recommend her to go to a psychologist, because that means that she will be isolated since she is crazy. But she has this problem here in Norway, and that means that we must find the solution in Norway because Norway is different."
>
> ***Female participant b:*** *"It is scary, it is taboo in our home country to see a psychologist, or they will say like "what is your problem since you are seeing a psychologist?" But here it is understandable, and people do not think like that* (…). *Maybe she is stressed and needs this."*
>
> […]
>
> **Interviewer 1**: "Is it also more accepted among Syrians in Norway to go to a psychologist than among Syrians who live in Syria?"
>
> ***Female participant a:*** *"Yes, yes, of course"* [depression-interview].

At the same time, it is important to stress that the cultural stigma associated with seeking professional help did not seem to have vanished completely after settlement in Norway. At the end of the female PTSD-interview, some of the women described a contradiction between what they would recommend the vignette character to do, what they would advise their friends to do, and where they would seek help. Whereas they would recommend the character to seek professional help from a psychologist, they seemed more hesitant to seek professional help themselves or recommend the same treatment to a friend.

4. Discussion

The present study explored how Syrian refugees in Norway explain and prefer to seek help for symptoms of PTSD and depression, and how their conceptualizations of these disorders and preferred help-seeking are affected by the migration- and resettlement process. Our results showed differences between the two vignettes in how the participants labeled and explained the condition of the person. Despite not mentioning the term PTSD, the participants identified with and recognized the symptoms. They pointed to external situations as the main explanatory factor including the war, the flight, and post-migratory stressors. PTSD symptoms were perceived as a common reaction to experiencing extreme situations. Depressive symptoms were labeled as either depression or feelings caused by social problems. Participants were more hesitant to identify with depressive symptoms. These results align closely with the results of Renner et al. (2020), who investigated perspectives on mental health and coping strategies among Syrian refugees in Germany.

Despite some differences, the condition of the character in both vignettes [PTSD and depression] was explained in terms of *situational explanatory models* that describe psychological distress in the context of social and interpersonal situations *and externally caused stress.* These are central EMs for depression in many cultural groups (e.g. Hagmayer and Engelmann, 2014; Karasz, 2005). Concerning PTSD, Grupp et al. (2018) found that refugees from Eritrea, Cameroon, and Somalia interpreted a PTSD-vignette in light of their own (traumatic) life experiences before and during their migration trajectories, post-migration stressors, and social problems such as loneliness and isolation. In combination with

our results, this pattern suggests that these aspects are central in refugees' understanding of PTSD. Resettlement related stressors on a systemic level (e.g., governmental bureaucracy, not getting a job, economic challenges, uncertainty about residence permit) were seen as causing, preserving, or worsening mental health problems, as in line with previous literature (Cange et al., 2019; Miller and Rasmussen, 2017; O'Donnell, Stuart and O'Donnell, 2020; Porter and Haslam, 2005; Renner et al., 2020).

Our data do not support biomedical or biopsychosocial EMs of illness. This is in line with Hassan et al. (2015), who emphasized that among Syrians suffering is understood as a normal part of life that does not require medical or psychiatric intervention, except in severe forms. Participants in the PTSD-interviews did not view the symptoms as an expression of disease, and most did not mention that the vignette character needed medicine. Symptoms were not talked about as symptoms, but as "normal" reactions to extreme experiences. However, at the same time, many participants recognized the need for professional help, and participants in the depression group were divided in their interpretation of whether depression is a disease or not. This underlines that EMs are a form of dynamic and contextual cultural perceptions.

Help-seeking and coping strategies were mostly similar between the two vignettes. A broad specter of preferred help-seeking and coping strategies was suggested, including seeking social support. Individual strategies such as sport and exercise were highlighted in all groups, which aligns with preferred coping strategies for PTSD reported in other refugee groups (Yaser et al., 2016). Exercise is an evidence-based treatment for depression (Schuch et al., 2016), and maybe a useful supplement to the treatment of people with PTSD (Rosenbaum et al., 2015).

The main finding in our study is that preferred help-seeking sources and coping strategies related to mental health problems seemed to be contextual. Participants described changing stressors resulting from migration and resettlement leading to a difference in how they would seek help in Syria and Norway. There are few previous studies on this, but a study among refugees settled in Finland showed that EMs persisted and changed as a result of acculturation, new sources of suffering, and new ways of interpreting symptoms (Mölsä et al., 2010). Changes in social networks could be one of the reasons for the observed context-sensitivity. Participants discussed how separation from the society and network in Syria could increase the probability of seeking formal help in the new country. Social networks are often disrupted by war and displacement (Alzoubi et al., 2017; Hassan et al., 2015; Renner et al., 2020), which may in turn affect people's preferred help-seeking paths. In Arab Islamic cultures, seeing professional help is usually a decision made by the family as a collective (El-Islam, 2008). Being separated from family members is one factor that could increase the likelihood of seeking professional help. However, it is important to recognize that mental health care services in Norway are more available than in Syria, not only because of cultural stigm, but also at the structural and institutional levels (Hassan et al., 2015). Additionally, as part of the mandatory introductory program, all participants have received information about mental health and formal help-seeking sources, which may have raised their awareness about mental health in general and accessible professional help-seeking opportunities.

5. Limitations

The focus group interviews were conducted in Arabic and Norwegian using interpreters. This implies a limitation in our understanding of the explanatory models discussed in the interviews as cultural frames of reference differ and nuances may be lost in translation. The quality of the translations during the interviews was essential for the acquired data, and any errors or misunderstandings may potentially have resulted in errors in our interpretations as highlighted by Skammeritz et al. (2019). In the present study licensed interpreters were used to reduce the risk for inadequate translations. Moreover, after some interviews, conversations between the researchers and interpreters allowed forestalling or rectifying misunderstandings.

We also need to consider that trust in the interpreter may have influenced the information shared by the participants. Other research has suggested that concerns over confidentiality of professional interpreters may be amplified when there are inter-communal tensions in the country of origin (Bhatia and Wallace, 2007). Moreover, since cultural stigma was discussed as a central barrier for seeking formal help in Syria, it is possible that this may have affected how the vignettes were discussed, and to what extent focus group participants chose to engage in the discussion. Bilingual researchers would be preferable in this type of research, even though the language is just one part of this issue. Additionally, the fact that two of the interviewers are clinical psychologists, may also have influenced the participants' view and answers related to seeking professional psychological help.

6. Implications and conclusions

The refugees participating in this study had relatively short residence time in Norway. The stress in the first years, as described by our participants, can worsen refugees' suffering. The first phase of resettlement may represent a window of opportunity to prevent that premigration trauma and post migratory stressors evolve into more severe diagnoses, for example by community group interventions (Husby et al., 2020). Our findings suggest that the participants were aware of available health services should they themselves or someone they care for, suffer from symptoms of depression or PTSD, although it is important to stress that navigating within the health system was perceived as challenging and stressful. Moreover, as emphasized by Bhui and Bhugra (2002) in clinical contexts both the patient's and clinicians' views should be explored in developing capable mental health practices.

All in all, our results suggest that refugees may prefer sources of help or coping in the country of settlement that may neither be available nor necessary in the country of origin. We refer to this flexible approach for help-seeking and coping as context-sensitive. Bonanno and Burton (2013) introduced this concept as one of three components of regulatory flexibility, which has been studied from an individual-level perspective on coping and emotion regulation. We suggest that the concept of context-sensitivity can also be applied to explain how help-seeking and coping strategies change because of forced migration. In developing mental health services adapted to the needs of refugees, we argue that it is important for mental health care providers to be mindful of how refugees may both adapt their help-seeking and interpretations of illness to the settlement context while retaining interpretations and preferences from their culture of origin at the same time. The results from this study highlight the need to take the systemic transformations following a geographical and social relocation into consideration when attempting to understand aspects of EMs, preferred help-seeking, and coping strategies among refugee groups. More research in this area is needed.

Finally, our study addressed the experiences of Syrian refugees in Norway, but our results align closely with results from studies of Syrian refugees in other countries (Renner et al., 2020) as well as among other refugee groups (Grupp et al., 2018). Thus, our results may have relevance also beyond the Norwegian context.

Author contributions

All authors contributed to the design of the study, in particular author two and four. Author two and four conducted the first four interviews, while author one observed. Author one and two conducted the fifth interview. Author one lead the analysis-process in collaboration with author three and four. Author five contributed to writing up the analysis. Author one, working close with author five, wrote the first draft of the manuscript, getting feedback from author two and three along the way. All authors contributed to editing and revision of the manuscript.

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Declaration of competing interest

None.

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Appendix A. Supplementary data

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