

The Influence of Social Networks on Mental and Emotional Health Resource-Seeking
Behaviours Amongst Women who are Refugees from Syria

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Background and Objectives: While the arrival of migrants into Canada from foreign countries is not a new phenomenon, recent years have seen a larger than usual influx of individuals come into the nation. Between 2015 and 2017, Canada saw a surge of Syrian people who are refugees coming onto its soil; over 24,000 of which were women. The increasing number of individuals who are refugees directly impacts health equity for Ontario's population and it has been reported that this group is vulnerable to declining health. Migrant women, including those classified as refugees are two to three times more likely than native Canadians to suffer from some form of depression. Other mental health challenges reported by refugees include loneliness, diminished social networks, isolation, and stress. These mental health challenges can negatively impact emotional stability as well. The focus in the present research is the role of social networks, a dimension of and opportunity afforded by social capital, in shaping the mental and emotional health of Syrian women who are refugees – specifically, resource-seeking behaviours in the treatment of mental and/or emotional health problems that they employ in improving their own mental and emotional health.

Methods: This study employs a qualitative research design to explore the stories and experiences of this relatively newly studied population. I sampled twelve participants who were adult women from Syria who were living in Canada as refugees at the time of data collection. Telephone interviews were conducted using a semi-structured approach. Eight of the twelve interviews had an Arabic interpreter present, who was able to translate English into Arabic and vice versa. Interviews were audio-recorded and transcribed using NVivo 12. Thematic coding was also done using NVivo 12 software.

Results: Findings identified that social networks can play both direct and indirect roles in influencing mental and emotional health service-seeking behaviours amongst women who are refugees from Syria. Namely, (1) families play large roles in teaching and providing information about Canada's health system; (2) providers prevent use of resources, while family, friends, and sponsors help; and (3) women feel more welcomed into social networks in Canada than in interim countries. Additionally, (4) social networks act as alternatives to seeking formal mental and

emotional health care; and (5) comparing environments from Syria and interim countries helps some women build resilience.

Conclusion: The findings of this study explored the stories and experiences of women's transitions into Canada in relation to their mental and emotional health and social networks. This study explored the importance of considering who women seek out for support and how these groups and individuals can impact women's decisions to seek out mental and emotional health care resources. Avenues for further investigation may answer questions such as: Where should resources be invested? What can be done to foster and facilitate social networks that promote mental health?

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Dedication

To my parents; for without them I could not have had the courage to start this journey.

To my husband; for without him I could not have gracefully completed this journey.

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Chapter 1: Introduction and Literature Review

While the arrival of migrants into Canada from foreign countries is not a new phenomenon, recent years have seen a larger than usual influx of individuals come into the nation. Between 2015 and 2017, Canada saw a surge of Syrian people who are refugees coming onto its soil; over 24,000 of which were women (Statistics Canada, 2017). The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as “someone who has been forced to flee his or her country because of persecution, war or violence.” In terms of the drivers and effects of fleeing, UNHCR states that “a person who is a refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group (2018). Most likely, they cannot return home or are afraid to do so. War, ethnic, tribal, and religious violence are leading causes of refugees fleeing their countries.” (UNHCR, 2018).

The increasing number of individuals who are refugees directly impacts health equity for Ontario’s population and it has been reported that this group is vulnerable to declining health (Toronto Public Health & Access Alliance Multicultural Health and Community Services [TPH & AAMHCS], 2011). For example, research from 2011 identifies that those who are refugees are at risk of poor and deteriorating mental health and that they self-report poorer health than other immigrant populations (TPH & AAMHCS, 2011). Migrant women, including those classified as refugees are two to three times more likely than native Canadians to suffer from some form of depression (Kirmayer et al., 2011). Other mental health challenges reported by refugees include loneliness, diminished social networks, isolation, and stress (Makwarimba et al., 2013; Hynie, Crooks, & Barragan, 2011). These mental health challenges can negatively impact emotional stability as well. To mitigate the negative mental and emotional issues that these women have, a call to action may involve better research to understand how to meet the needs of these women, and if current efforts are meeting their needs.

The focus in the present research is the role of social networks, a dimension of and opportunity afforded by social capital, in shaping the mental and emotional health of Syrian women who are refugees – specifically, resource-seeking behaviours in the treatment of mental and/or emotional health problems that they employ in improving their own mental and emotional health.

Overview of Social Capital

Social capital plays a role in mental and emotional health as well as individuals' health resource-use. Social capital is an umbrella term for resources that are available to individuals and groups to achieve a desired goal (Sanchez, 2016). This includes any form of social interaction through communities, group gatherings, and socially-centered institutions. Engagement with these resources fosters trust and reciprocity, so that women feel safe to continually partake in society and take advantage of resources that are available to them (Sanchez, 2016).

Social capital has been defined differently by scholars in sociology, in economics, and more recently in public health. Common across definitions of social capital is the notion that networks, norms, and trust are the main principles upon which social capital is built, as well as exhibited (Sanchez, 2016). Additionally, when analyzing the role of social capital in migrant integration, it is important also to mention the definition by Coleman who states that social capital constitutes "resources that can be used by the actors to realise their interests" (1990). For example, in the context of women who are refugees from Syria, the proposed research hypothesizes that social networks act as a resource that may help these women to realize their interest of bettering their mental and/or emotional health. Migrant integration refers to the process by which those who are refugees integrate into society emotionally, economically, and socially. Coleman's definition is best utilized for the purpose of this research because it considers the idea that individuals use social networks, a resource afforded by social capital, to better their mental and/or emotional health. He defines social capital by its function, which is to facilitate a certain group (in this case refugees) to act in ways that allow them to be contributing members of society. However, refugees face barriers as newcomers to Canada because they have to rebuild social capital (Coleman, 1990). In order to rebuild social capital, which in turn will produce social networks, a relationship with at least one other individual or group has to be established in which information is exchanged. In the exchange of information, reciprocity is exercised, thus increasing comfort and trustworthiness amongst a refugee's social network (Coleman, 1990). Overall, the way in which Coleman defines social capital as a concept that provides avenues for trusting social networks is central to being able to see the effect it has on the resource-seeking behaviours for mental and/or emotional health problems.

The public health sector draws on the concept of social capital to better understand various social factors that affect mental health and physical health (Sanchez, 2016). Specific to this

research is their focus on the role of social networks, a dimension of social capital, that fosters physical and mental health and wellbeing. It is argued that social networks provide an opportunity to confide in and share common experiences in relation to mental and/or emotional distress. Indeed, numerous studies demonstrate an association between mental and emotional health status and access to social networks (Vigod et al., 2017). Trust in others and a feeling of belonging has been shown to increase mental well-being, where feelings of trust and a sense of belonging are afforded by social capital (Vigod et al., 2017). For example, the presence of social capital can impact the trust individuals have in health-related knowledge shared with them by others thus propelling them to use mental and/or emotional resources that they need. Conversely, a lack of social capital is correlated with mental illness (Sanchez, 2016).

The general associations between social networks and mental/emotional health can be applied to our understanding of the mental health of refugee women. Data suggest that social networks (or lack thereof) in a host country (in this case, Canada) affects the mental health of refugees. For example, the absence of social networks can limit opportunities for social support and a safe space for women to open up about their emotional and mental health troubles (Anderson et al., 2017). However, central to the proposed research is the lack of understanding regarding how social networks affect resource-seeking behaviours by women who are refugees (Sanchez, 2016). Social capital consists of resources that are available to individuals to have more advantageous lives. These resources include social interaction through communities, group gatherings, and socially-centered institutions where their main components foster trust and reciprocity (Sanchez, 2016). Further, Coleman explains that social capital increases when the creation of networks, norms, and trust are typical results of the social experiences one has and are part of the tenets by which well-being is judged, therefore further suggesting that mental and emotional health and the availability of social networks are connected (1990).

It is important to consider how mental and/or emotional health resources are defined and understood. For the purpose of the present study, resources extend beyond those identified in Canada as treating or responding to mental health and emotional crises – namely health services. Indeed, previous literature has proposed that treatment is not limited to medical treatment (Vigod et al., 2017). Treatment, or the provision of resources rather, may be defined as any activity that betters the mental or emotional health of women who are refugees from Syria living in Canada. From previous studies it may be assumed that in addition to medical services, resources to improve

mental and/or emotional health may include church or religious groups and community groups (Sanchez, 2016).

The focus in the present research is the role of social networks, afforded as a consequence of social capital, in shaping the mental and emotional health of Syrian women who are refugees – both their experiences with mental and emotional health, as well as their use of resources they deem relevant to improving their own mental and emotional health and wellbeing.

The present research will explore the role of social networks in Syrian refugee women’s resource-seeking behaviour for mental and/or emotional health problems.

Overview of Social Determinants of Mental and Emotional Health

The definition of the social determinants of health has evolved as new scholars and organizations have studied, conceptualized, and made determinations about what it means to be healthy; however, the social determinants of health can broadly be described the prerequisites for being healthy or unhealthy (Raphael, 2006). As an extension of the social determinants of health, the Office of Disease Prevention and Health Promotion has outlined the social determinants of mental health, specifically. The social determinants of mental health include “race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location. Other social conditions—such as interpersonal, family, and community dynamics, housing quality, social support, employment opportunities, and work and school conditions—can also influence mental and emotional health risk and outcomes, both positively and negatively” (healthypeople.gov, 2018). The data presented in this study speak more to the other social conditions outlined the definition.

Literature Background

Previous literature has identified and investigated many of the barriers to health care service use by refugee populations in Canada. For example, research has identified that culturally appropriate social networks, such as family, do act as moderators for resource-seeking behaviours (Andermann, 2010; Godoy-Ruiz et al., 2015). Resource-seeking behaviour is moderated when “social supports include the use of refugees’ mother-tongue languages by professionals and women being able to meet other women that have been through similar situations. Families also play a large role in how women seek care; this lack of social support in the form of decreased family presence was found to affect the motivation women have to seek care, especially when women have children to care for without alternative childcare arrangements” (Andermann, 2010;

Godoy-Ruiz et al., 2015). These findings were present in South Asian, Caribbean, and Southeast Asian societies (Andermann, 2010; Godoy-Ruiz et al., 2015; Anderson et al., 2017). What warrants further investigation is exploring how social networks moderate resource-seeking behaviours in women who are Syrian refugees as they are becoming more prevalent in Canadian society. In a narrative review conducted by Dr. Meyer and myself, we identified a gap in research regarding how social networks influence how women who are refugees from Syria seek treatment for mental and/or emotional health problems (Mahajan & Meyer, 2019). The narrative review followed Rosella Ferrari's narrative review framework and unveiled the complexities of refugee status, discrimination and stigma, the social experience of gender, and previous health experiences in relation to how they influence mental health service use (Mahajan & Meyer, 2019). Additionally, culture and cultural competency as they are regarded in health care offered insightful explanations for understanding the relationships between patients and physicians which ultimately influences use of services. Finally, this paper uncovered policies and power divides between patients and doctors that impacts how mental health care is welcomed by women who are refugees (Mahajan & Meyer, 2019). Overall, data suggested that social support innovations are desirable by refugee women in Canada but that further research is required to mitigate social and structural barriers to seeking care (Mahajan & Meyer, 2019). Recognizing that social and structural barriers exist, I decided that it would be interesting to explore specifically how social networks (as an opportunity afforded by social capital) would work to influence mental and emotional care seeking behaviours by women who are refugees from Syria.

Understanding the Syrian Refugee Crisis

Since the onset of the Syrian civil war in 2011, 13.5 million citizens have been displaced from their homes and were forced to seek refuge in neighbouring countries (Al Rifai, 2017). These countries began with Turkey, Lebanon, Iran, Jordan, and Egypt (Al Rifai, 2017). Major reasons for fleeing came from violence, collapsed infrastructure, and women and children being in danger (World Vision, 2018). As of January 2017, over 40,000 refugees were resettled into Canada under the Government of Canada's resettlement initiative. Syrian women have faced unique challenges in fearing the loss of their children and families through violence and illness (World Vision, 2018; Al Rifai, 2017). Challenges for successful settlement into Canada include limited ability to communicate in English, lack of accessibility to affordable childcare, culturally inappropriate healthcare, and lack of financial stability (Senate of Canada, 2016).

Regarding service navigation, six different health plans for refugees have been instated and revoked since 2014, increasing the challenges faced by individuals trying to settle in Canada (CBC News, 2016). Before the reinstatement of the Interim Federal Health Program (IFHP), a refugee health care benefits plan funded by the federal government, refugees were unable to access routine medical services, thus forcing them to fill up in emergency departments with non-emergency health concerns (CBC News, 2016). In light of constant cuts to medical care funding for refugees, church groups who sponsored social programs to help refugees integrate into Canada were fearful that they would not have the ability to direct refugees to health services that they needed. Therefore, they began to cut down funding for these social programs, further reducing services that could be beneficial for refugees in making a home in Canada (CBC News, 2016). Now, with the country going into its eighth year of the civil war and the reinstatement of the Interim Federal Health Program, the Canadian government's efforts to bring Syrian refugees to the nation will continue to grow and churches have restarted support groups (Al Rifai, 2017). Given the current availability of resources, it is critical that women know of their access to these services and central to the proposed work, that women use these resources.

Barriers to Seeking Mental Health Care

The following sections discuss barriers to seeking mental health care as explained in existing literature.

Overview of Barriers

There are a host of factors identified as shaping the resource-use patterns of those who are refugees. Utilizing available mental health services is impacted by “the lack of culturally and linguistically appropriate care, complexity of the Canadian healthcare system, and a fear that service use would jeopardize the outcome of immigration or refugee claimants” (Kirmayer et al, 2011). Further, research indicates that discrimination, stigma and gender socialization influence mental and emotional resource-use rates amongst female refugees (Mahajan & Meyer, 2019) Additionally, existing literature identifies that a person's culture may moderate how she seeks care. Finally, the overarching idea that the presence of culturally appropriate social support is associated with service-seeking patterns is demonstrated in existing literature. As identified below however, it remains unresolved the extent to which social

networks play a role in the degree to which women seek out resources or supports for mental and/or emotional health problems.

Discrimination and Stigma Stop Women from Seeking Treatment

Discrimination and stigma have been well-studied in migrant health behaviour studies and are identified as barriers to seeking treatment amongst refugee populations, in Canada and globally (Beiser & Hou, 2017; Brown-Bowers et al., 2015; Stewart et al., 2015; O'Mahony et al., 2012). Specifically, women report different accounts of discrimination than men (Beiser & Hou, 2017). For women, discrimination exists in layers in which emotional and gender-role discrimination impacts women's mental health the most of all types of discrimination (Brown-Bowers et al., 2015; Stewart et al., 2015; O'Mahony et al., 2012). These reports are unique to women and can play a role in how they realize the social experiences that lead to their health-seeking behaviours. Additionally, self-stigmatization of medical conditions also occurs, especially in women who have a general lack of knowledge about treatment options. For example, this has been noted to be a problem for women in seeking treatment for postpartum depression (Chen et al., 2015).

Women who have had previous negative health care experiences regarding depression tend to shy away from seeking them in their home country, which may lead us to assume that help-seeking may be a problem in host countries as well (Anderson et al., 2017; Kiss et al., 2013). This is especially common in women who have been diagnosed with postpartum depression or HIV/AIDS (O'Mahoney & Donnelly, 2013; Chen et al., 2015; Brown-Bowers et al., 2015; Stewart et al., 2015; Donnelly et al., 2016; Logie et al., 2016; O'Mahoney & Donnelly, 2010). Feelings of fear and shame associated with a diagnosis of these illnesses acts as a double-edged sword, in that fear and shame prevent individuals from seeking care while continuing to fester, ultimately negatively impacting their mental health (Anderson et al., 2017; Vigod et al., 2017; Kiss et al., 2013). However, studies have shown that individuals reported that social groups would decrease their feelings of isolation and discrimination, and would help normalize the experience of living with HIV and postpartum depression (Brown-Bowers et al., 2015).

Gender Socialization

The experience of being a woman in today's world is different than being a man due to gender socialization (Godoy-Ruiz et al., 2015). "Gender socialization refers to the process by which

individuals learn the social expectations and attitudes that are to be associated with one's sex. Gender socialization of women works by the notion that they are homemakers, caretakers, and that their inability to execute these roles for any reason renders them illegitimate (Godoy-Ruiz et al., 2015; Yohani & Hagen, 2010).” Declined mental and/or emotional health can interfere with execution of these roles. By this thought process, women may fear seeking mental and/or emotional health care and publicly deny the possibility that they suffer from mental and/or emotional health problems. Other authors, however, explain that women are becoming increasingly resilient and do not allow the norms of gender socialization to stop them from seeking mental and/or emotional health treatment (Godoy-Ruiz et al., 2015; Yohani & Hagen, 2010). Resiliency can be built from the social networks provided by social capital, in that social networks can empower women to make healthy decisions (Godoy-Ruiz et al., 2015; Yohani & Hagen, 2010). The combination of social networks and the empowerment that comes from these social networks can influence how women seek out resources to improve their mental health. Examining the way in which women who are refugees experience how gender socialization, shifting cultural norms, and social networks affect their resiliency may explain their attitudes towards seeking help for emotional and mental health in Canada.

Culture Influences Attitudes About Health and Health Care

The culture that refugees identify with can impact their experience when seeking refuge in Canada, especially in using health care services and resources (Andermann, 2010). Being pulled away from loved ones and put into a country where their first language is not spoken by the majority of the population and having cultural identities that differ from native Canadians can impact their ability to seek appropriate health resources, both mental and emotional (Anderson et al., 2017). Further, “culture acts as a moderator in women refugee’s mental health by influencing how enthusiastic a woman may be about using available mental and/or emotional health services as a refugee in Canada.” (Andermann, 2010). Specifically, South Asian, Southeast Asian, Middle Eastern, and Caribbean cultures are argued to not accept mental [or emotional] health support for issues that may be seen as fixable or resolved through medicines and treatment (Andermann, 2010; Anderson et al., 2017). The lack of willingness to use conventional treatment in their home countries, often impacts their willingness to use them in host countries (Anderson et al., 2017). Further, culture serves as a framework to build a community that leads to the development of social capital and thus, social networks. Therefore, looking at the role of culture to increase social

networks in relation to its influence on resource-seeking behaviours may be useful in understanding how to appeal to women who are refugees that need mental and/or emotional health care.

In summary, the barriers that have been identified in the literature include discrimination and stigma, gender socialization, and culture. In addition to the identified research objectives, this literature provides insight into the various concepts that may allow us to better understand if and how social networks play a role in shaping resource-seeking behaviours for mental and emotional problems amongst women who are refugees from Syria. For example, studies have consistently shown that discrimination and stigmas hinder women from seeking care out of fear of being chastised by their communities. Additionally, gender socialization can create negative attitudes towards seeking mental and/or emotional health services in women due to the communities they are a part of and the attitudes that are expressed within of these communities. Moreover, culture is a social construct that leads to the development of social capital and social networks, thus influencing the way in which health care services are sought out. However, little information exists about how social networks, as a result of social capital, works to influence the social networks women have, how they engage with them, and whether these engagements make a difference in using needed resources. Thus, listening to the first-hand accounts of Syrian refugees will help to broaden the understanding of how social networks influence the use of mental and/or emotional health care resources, thus adding valuable knowledge about another group that is a part of Canada's mosaic.

The Role of Social Capital in Health Service Utilization

Central to the proposed research is literature identifying social capital as a determinant of positive refugee health (Strang & Quinn, 2014). As individuals who are refugees leave their home countries, they leave behind family and friends, therefore disrupting the perceived normalcy and familiarity of their social ties, ultimately decreasing their social capital. Arriving in a host country, such as Canada, can put them at risk of being isolated, therefore being detrimental to their overall mental and physical health (McMichael & Manderson, 2004). Previous studies demonstrate a link between mental health levels given the availability of a social network (Sanchez, 2016). Social networks are one aspect of social capital and are the focus of the proposed work because social networks change for women who are seeking refuge in Canada as a result of being uprooted from

their home country of Syria. Studies also demonstrate that migrating as a refugee from one country to another can worsen already diminished mental and emotional health, and the presence of social networks and social capital in a new country may mitigate these negative effects (Brown-Bowers et al., 2015; Anderson et al., 2017; Kiss et al., 2013). However, investigations into the effects of social networks on the use and seeking of mental and/or emotional health resources are not well-articulated. The assumption that social capital plays a role in individuals' mental and/or emotional health comes from the numerous studies identifying that positive social relations are shown to positively affect health (Brown-Bowers et al., 2015; Anderson et al., 2017; Kiss et al., 2013; Godoy-Ruiz et al., 2015).

Social networks are known to be an opportunity that arises from having social capital (Coleman, 1990; Sanchez, 2016; Kindler et al., 2015) and social capital explains that social networks are created in various ways (explained in the next section). Social networks impact the ways in which refugees communicate and interact with each other, their environments, and health care professionals. Ultimately, this has the ability to influence the ways in which they seek mental and/or emotional health care resources (Coleman, 1990; Sanchez, 2016). Thus, in order to understand why and how female refugees seek mental and/or emotional health care in the ways that they do, it is imperative to ground what we learn about their experiences in the concept of social capital and the opportunities for social networks that arise from it. These experiences refer to the social networks they have, how they engage with them, and whether social networks make a difference in using needed resources.

Concept of Social Capital

Social capital is conceptualized as having various domains and sub-domains; domains include individual capital, ecological capital, cognitive capital, and structural capital, whereas sub-domains include bridging capital, bonding capital, horizontal capital, and vertical capital. The domains relevant to the proposed research are cognitive and structural social capital, with the relevant sub-domains being bridging, bonding, horizontal, and vertical capital. Broadly, social capital is used in health contexts to determine how different types of social capital can positively impact health (Sanchez, 2016). Social capital can be broadly broken up as cognitive or structural, where cognitive capital focuses on the quality of social relationships, while structural capital focuses on the quantity of relationships and frequency of interactions (Sanchez, 2016). Ultimately,

structural social capital concerns itself with participating in a group or community, collective action, and links to groups with resources, otherwise known as what people ‘do’ (Sanchez, 2016; Harpham et al., 2002). On the other hand, cognitive social capital includes general, emotional and instrumental social support, trust, a sense of belonging to a community, perceived fairness and responsibility, reciprocity and cooperation, and social harmony, otherwise known as what people ‘feel’ (Sanchez, 2016; Harpham et al., 2002). Often, sub-concepts known as bonding networks and bridging networks can be classified in social capital. Bonding networks occur between groups and individuals with similar demographics such as ethnicity and immigration status, socio-economic statuses, ethnicities, and other experiences. Bridging networks occur when individuals or groups come together that have different characteristics, regarding ethnicity, immigration status, or socioeconomic status. Further, these networks can then be broken down again into horizontal and vertical classifications (Sanchez, 2016). Horizontal social capital, both structural and cognitive, occurs when people come from similar strata. Vertical social capital (structural and cognitive) is a form of social capital that occurs when individuals describe social relationships with others whom they perceive to be more or less powerful than them. These social relationships can include professionals such as immigration officials or policy makers (Sanchez, 2016). It is these various forms of social capital that they engage with that are determinant of their social networks’ characteristics. Identifying the various types of social capital that women experience and how they are conceptualized may provide insight on their resource-seeking behaviours which will be important to report in my findings.

Reflecting on conceptualizations of social capital have led scholars to question the extent to which social capital leads to inclusion/exclusion and advantage/disadvantage. In considering the idea of inclusion/exclusion, Anthias and Cederberg wonder whether the bonding form of social capital in which migrants and non-migrants strengthen community groups actually prevents them from forming the bridging version of social capital, thus threatening their inclusion in society (Anthias & Cederberg, 2009). Bridging social capital is seen as critical for true integration into society both from an economic and a health standpoint as individuals interact with the broader community (Kindler et al., 2015). Comparatively, Coleman and Sanchez focus on the idea that increased forms of both bridging and bonding forms social capital will always lead to more inclusion as well as increased advantage. The contrasting ideas between authors force researchers to examine whether the population they investigate is able to forge connections with those outside

their ethnic group, therefore demonstrating bridging form of social capital which focuses on the ways in which migrants interact with those heterogeneous to them. Understanding how refugees interact with those outside of their ethnic group can be important in understanding how they view their mental health and engage in resource-seeking behaviours (Sanchez, 2016). The examination of the type of connection (bridging vs bonding and social vs cognitive) that is formed is important because being part of a larger society may impact the comfort levels of these individuals to share their feelings and experiences thus impacting their social networking, and resource-seeking behaviours.

However, Amin (2005) offers a different perspective by stressing that rather than deciding whether bridging is better than bonding (or vice versa), the emphasis should be placed on how ‘community’ takes on different meanings to individuals when they are in new environmental and institutional settings of the host country. Amin’s thought is important to carry on in my research and analysis. This is because I am exploring how individuals engage in social networks that arise from social capital such that they influence the individual’s ability to recognize emotional and/or mental health problems and seek appropriate treatment in a host country. Coming to Canada forces an overnight change in social situations as well the institutional/organizational bodies that said individuals interact with. In light of these changes, the meaning of community may change for these women and thus can impact their behaviours related to health resource-seeking. Specifically, a change in physical community may mean a change in their place within its respective social community, therefore impacting who they engage with and how they open up about mental and/or emotional health problems. Patterns and characteristics of changed social engagement could prevent individuals from seeking treatment for mental and/or emotional health problems. By exploring the social experiences of these women in my research in relation to their health-seeking behaviours, Amin’s view becomes a prominent source of analysis framework, through which I may be able to make important connections to better understand the social actions and behaviour of Syrian refugee women in Canada that may ultimately affect their healthcare decisions.

Investigating whether women who are refugees from Syria exhibit bridging or bonding behaviours will add to the understanding of the ways in which women use social experiences to elicit their need for relevant resources. Bridging social capital and bonding social capital separate people by who they interact with and the characteristics they look for in their peers in social settings. Understanding what type (bridging or bonding) of social groups women want to be part

of will provide interesting insight into who they feel most comfortable around and what they may share with others, given their own situations, emotionally, mentally, or even financially. The social networks they seek out may influence their resource-seeking behaviours and their attitudes towards mental and/or emotional health traumas, thus revealing the degree to which social support influences treatment-seeking decisions.

Chapter 2: Study Design

Methodological Approach and Theoretical Framework Used

In light of previous findings and current research gaps, examining and understanding the effects that social networks can have on resource-seeking behaviours and recognition of need is important. Doing so helped to understand whether social networks propel an individual to seek mental health resources and why this may or may not moderate and mediate resource-seeking behaviours.

The present study had 4 objectives:

1. Understand the nature of women's current social networks
2. Identify if the experience of social networks in Canada are different than what it was in a refugee woman's home country
3. Understand the role of social networks in the recognition of mental and emotional problems
4. Explore the extent to which women identify social networks as facilitating or impeding mental/emotional health resource use

In addition to the primary research objectives, data were collected which identified the roles of discrimination and stigma, gender socialization, and as determinants of recognizing mental and emotional problems and behaviour with regards to seeking out resources. These lines of inquiry were driven by gaps in existing literature regarding barriers to resource-use and directly related to the notion of social networks. These concepts were used to identify the mechanisms and motivations for seeking mental and/or emotional health resources, as related to social networks.

The methodological approach for this study was a qualitative approach, specifically theoretical thematic analysis, using Braun and Clarke's guide (2006). Braun and Clarke note that doing thematic analyses of data involve many choices on the part of the researcher, depending on the type of research questions, epistemological position, and the goal of the answered research questions and objectives (Braun & Clarke, 2006). Given the fact that the area of health resource-seeking behaviours in relation to social networks is an under-researched area, I wanted to achieve a rich thematic description of the data collected (Braun & Clarke, 2006). Further, theoretical thematic analysis posits that data are to be analyzed deductively or from a top-down approach (Braun & Clarke, 2006). Deductively analyzing data allowed me to abide by the epistemological position I committed to – the idea that my analysis is driven by the theoretical interest around understanding how social networks influence mental and emotional health resource-seeking behaviours. However, inductive coding was also conducted which allowed me to discover information in the interviews that was rich, descriptive, and provided important information that was relevant to my research question and objectives. Using both inductive and deductive coding methods were helpful in gathering information that demonstrated the unique voices and experiences women had in regards to how their social networks influenced their mental and emotional health-resource seeking behaviours. Further, coding through a theoretical approach helped me to code for my specific research objectives and doing some inductive coding provided for the ability to unravel deeper understandings of how social networks play a role in mental and emotional health-resource seeking behaviours.

A thematic analysis consists of six main phases when collecting and analyzing data (Braun & Clarke, 2006). The phases and each of their explanations are as follows (Braun & Clarke, 2006):

- (1) Familiarizing yourself with the data – transcribing data, read and re-read data, note down initial ideas
- (2) Generate initial codes – code interesting data in a systematic way across the entire data set and collate data relevant to each code
- (3) Search for themes – collate codes into potential themes, gathering all data relevant to each theme
- (4) Review themes – check if themes work with collated codes and entire data set to generate thematic map of analysis

- (5) Define and name themes – ongoing analysis to refine the specifics of each theme and the overall story the analysis tells to generate clear definitions and names for each theme
- (6) Produce report – final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relation back of the analysis to research question and literature to produce a scholarly report of the analysis

Study Generalizability

Further, the aim of this research reflects the social constructionist ideology that “researchers construct categories of the data [rather than new theories]. Instead of aiming to achieve exact explanations and generalizations regardless of context, social constructionism aims for an interpretive understanding of the studied phenomenon in its own context. As opposed to giving priority to the researcher’s views, social constructionists see participants’ views and voices as integral to the analysis—and its presentation.” (Charmaz, 1996). The goal of my research was not to generalize findings to a whole population, but rather identify nuances of participant experiences in contexts that may be transferable to similar situations.

Ethics

This study received ethics clearance from the University of Waterloo’s Ethics Review Board on January 24th, 2019. Further amendments to allow for an Arabic interpreter were approved on June 29th, 2019 (ORE # 40284). Data collection involving women who were comfortable speaking English commenced after January 24th, 2019 and those who required an interpreter were interviewed on or after June 29th, 2019. All data collection was conducted in compliance with the approved protocols for research including human subjects.

Each participant signed a consent form after fully understanding what it entailed. Those who were comfortable with reading and speaking English read and signed the consent form on their own, while those who required help from an Arabic interpreter were given the consent verbally in Arabic and then provided their signature on the consent form. The consent form along with the personal information form outlined the purpose of the study, their roles as participants, how their information would stay confidential, that their participation was voluntary, that they could withdraw from the study or part of the study if desired, the types of questions they would be asked, and that if they had phone interviews, that they would be audio-recorded. Additionally, the

forms had the contact information of both myself as well as that of my supervisor in case participants had any further questions about the study.

Interview data were collected and audio-recorded with the consent of both the participants and the interpreter in applicable cases. All interviews were transcribed using NVivo and only used the initials of participants. In the descriptions of results, each participant was given a unique identification number ranging from 1 through 12. These same identification numbers were used to log interview times and dates as well as the date of remuneration.

Sampling, Recruitment, and Inclusion Criteria

The focus of my study was not necessarily to be generalizable, but rather to elicit deep understandings of participants' experiences. Charmaz states that ideally 10-15 participants are sufficient for small qualitative research studies (1996). Taking this into consideration along with the discussion about sample sizes with my committee, I decided that 12 interviews would be helpful in representing the stories and experiences of the concerned population given the scope and time and financial constraints of the study.

Women over the age of 18 years were included in this study. All 12 women had come to Canada as refugees either sponsored by the government or through private sponsors. Initially, my study was only set to include women who spoke enough conversational English to answer the interview questions. The first four interviews were conducted in English, where the participants were recruited through YWCA Toronto. Rich data were extracted from these interviews and recruitment continued. Recruitment was done through recruitment posters, cold calling and emailing settler organizations, women's health clinics in the Greater Toronto Area. Recruitment posters did not elicit any response. Email templates were sent out that outlined who I was, my purpose for emailing specifically about my research project, along with my contact information along with that of my supervisor. In instances where I made cold calls, a telephone script expressing the same information was used. I got in touch with YWCA through a call where I explained my study and my purpose to one of the program coordinators who turned out to be my first participant.

After providing interested organizations with organization information forms, they reached out to me for participant information forms. Organization information forms explained why I thought they would benefit from the study, how I think they could help, and confidentiality of any of the participants that chose to take part in the study as a result of learning about it through their

organization. After speaking with the program coordinator at YWCA and providing her with the information forms, she decided that she wanted to take part in the study herself and also gather other women for the study. Through this contact, I was able to arrange three more interviews. After this round of interviews, I did another round of emailing and calling to organizations that I thought would have access to the study population. I then got in touch with a settlement and community organization that focuses on delivering services to diverse communities called Culture Link. Here, I was able to get in touch with the program coordinator who was able to provide me with eight more women who wanted to participate. However, these women expressed that they had so much to say and speak about and that trying to do so in English would not be sufficient. This is when I decided to alter my ethics to allow for interpreters.

Initially, I proposed that I would only speak to women who were comfortable with conversational English because their experiences and challenges would differ from someone who had English as a limitation. However, in both cases, struggles, challenges, and experiences were similar, therefore not hindering my research, but rather illustrating that the notion of language is not always a moderator in experiences of transition; challenges and transitions span further than speaking the majority language in a country. Ensuring that I was able to properly communicate with non-English speakers through an interpreter as well as with conversationally comfortable English speakers helped to get a more holistic understanding of what different types of women experience during their transitions, their social networks and how they change, and how these social networks influence mental and emotional health resource seeking behaviours.

Interviews

Twelve interviews were included in my study and interviews were analysed according to the six phases explained above and coded. The constructionist approach best allowed the voices of the women I interviewed to come through in my findings, as deductive and inductive coding was conducted based on how women answered the interview questions proposed (Braun & Clarke, 2006). It is important to note here that emergent themes do not mean that the data presented the themes explicitly, and I just had to identify them; rather, emergent themes were presented because of my ability to semantically analyse the data and make meaningful interpretations of them as well as understand their implications in relation to my overall research question (Braun & Clarke, 2006).

Additionally, data were analyzed at the semantic level, and allowed me to unpack the deeper meanings behind what participants said about their social networks. Braun and Clarke (2006) explain that the analytic process involves a progression from description, where the data have simply been organized to show patterns in content, and summarized, to interpretation, where there is an attempt to theorize the significance of the patterns and their broader meanings and implications in relation to the posed area of inquiry. Therefore, this methodological approach allowed me to identify and explain conceptual relationships that exist between women and how their social networks influence their use of mental and/or emotional health care.

All 12 interviews were over the phone and audio-recorded using a subscription-based, private call recorder available through the Apple App Store. All women and the interpreter were aware that the call was being recorded prior to starting the interview. The first four interviews were conducted directly with the participants in English. The last eight interviews were conducted via telephone on conference call with an interpreter present in the following stages:

1. I would read the question in English
2. The interpreter would then repeat the question in Arabic to the participant
3. The participant would answer the question in Arabic
4. The interpreter would then translate the answer back in English to me

Given the possibility that some information could have been lost in translation, I summarized the overall answers I got from the Arabic interviews and had the interpreter say them back in Arabic to the participants to ensure that I sufficiently understood their experiences and stories. At this point, participants could make clarifications or add on to their stories if necessary. Each interview lasted an average of about 1 hour and included questions such as: what does family mean to you? Can you tell me about a person that you have a strong bond with? What challenges have you faced in moving to Canada? How do the people around you react if you talk about your feelings? (see Appendix for more). The interview questions focused on participant's personal feelings and experiences and required no knowledge of any factual information related to coming to Canada. Ensuring that the interview focused on personal experiences helped to gather a deeper understanding of what women really think about their social networks and their mental and emotional health. All interview questions remained open-ended and included probes in the case that data had the potential to be richer.

Remuneration

After completion of the interview, each participant received an electronic gift card to Walmart at the denomination of \$25 to use in store or online. All women confirmed receipt of remuneration via self-declaration forms and online notice that they had viewed the email with their gift card attached.

Coding of Data

Additionally, I coded the data deductively to answer my specific research question and inductively to allow for themes to come up that spoke to my research in a novel way. Thematic analysis emphasizes the importance of being aware of assumptions and making them clear (Braun & Clarke, 2006). Knowledge of social capital, its components, and its characteristics built the foundation of the way in which I defined social networks. Additionally, the characteristics of social capital were identified as the building blocks for the social interactions which women who are refugees from Syria partake in. The emerging themes that I was looking for related to social capital and its components. Also, a semantic approach was taken to identify themes in the data and code as well as summarize the data. After summarizing the coded data, I interpreted them to explore broader meanings and implications of social networks on mental and emotional health resource use, thus creating themes (Braun & Clarke, 2006).

When considering epistemology, Braun and Clarke note that it guides what you say about your data and informs how you theorize meaning (2006). A constructionist epistemology states that meanings are produced socially and are not inherently in each individual, thus a constructionist framework asserts that experiences and how they are analyzed are rooted in sociocultural contexts and structural conditions which shape the experiences that are had by individuals (Braun & Clarke, 2006). In relation to my own research, interviewing refugee women using the appropriate questions and probes allowed me to analyse and make sense of their responses and behaviour based on the epistemological position of constructionism that emphasizes the realities experienced as a result of their sociocultural and structural context (Braun & Clarke, 2006; Charmaz, 1996). Interviews were semi-structured, on the phone and audio-recorded with participant consent. Doing this helped to identify factors and themes that met the objectives of my study and answered the research question, semantically.

Primary codes that were created while going through transcribed data included the deductive codes of: changed meaning of community, cognitive bridging and bonding, cognitive social capital, culture, discrimination and stigma, gender socialization, migrant integration, structural bonding and bridging, and structural social capital. Inductive codes included: Canada provided a new life, fear, god, ideas of family, independence, positivity and optimism, and self-reflection

Primary codes were combined and re-combined, thus introducing new themes further detailed in the discussion section of the thesis.

Chapter 3: Findings

Contextualizing Women's Experiences of Leaving Syria

During the interview process, each woman explained her experiences in how she came to Canada as well as the experience of leaving Syria. Challenges in moving as well as excitement about moving were discussed. Explaining the overall experiences of these women was important to help contextualize some of the trends and themes lending themselves to answering the research question. Additionally, it was important to lay out the social determinants of mental and emotional health as they were prevalent in the stories of each of the participants and influenced their mental health service use and interactions with their social networks.

Overarching themes that existed in women's accounts of leaving Syria and coming to Canada tended to be stories of upset before happiness. This was because all but one of the interviewees went from Syria to another Arab country before finally settling in Canada. Interim countries included Lebanon, Jordan, and Turkey. Five women lived in Lebanon, three women lived in Turkey, and three women lived in Jordan. Time spent living in the interim countries spanned anywhere from ten months to six years. Data showed that regardless of which interim country or amount of time spent there, women's experiences were similar. Most women described their times living in these countries as "difficult", "depressing", and "unwelcoming". One woman expressed feeling like each day in her interim country felt like a year and that she could not wait to come to Canada.

Most women came to Canada through private sponsors and cited their sponsors as "helpful", "friendly", "so good", and "just like family". Adjustment to Canada was mainly difficult due to language barriers in English. However, women felt that they were never discriminated

against for not speaking or fully understanding English. The majority of women, moved to Canada during the winter and were faced with harsh weather conditions to which they had never been exposed. Thus, some women expressed this as another challenge they experienced in their resettlement into Canada. Albeit, this challenge was quickly mitigated by the women's private sponsors through providing them with warm clothing, driving them to appointments and school, and providing them with public transit tickets. Even in the face of these challenges, however, women still noted feeling like Canada provided them with a new life or that seeking refuge in Canada was "like rebirth".

Additionally, women identified social networks as including sponsors, family members in and outside of Canada, health care professionals, and individuals they met in the community through social and settlement events/organizations.

Contextualizing the overall experiences of leaving Syria and resettling into Canada helps to set up the experiences women have regarding social networks and the role they play in their mental and/or emotional health-resource seeking behaviours.

The General Role of Social Networks

The data collected in this study has shown that social networks can play both direct and indirect roles in whether or not women seek mental and emotional health care.

Social networks can directly impact women's decisions about seeking mental and emotional health resources in two ways:

1. Social networks can encourage the use of services and/or
2. Be used to help overcome some of the issues facing women in relation to transitions into Canada, thus reducing the need for services, or providing alternative forms of help.

On the other hand, social networks can indirectly influence the use of services by providing narratives to the women on which they reflect, thereby driving them to be resilient. For example, one woman reflected on her husband's statement which expressed the idea that she did not have to face the same kind of discrimination in Canada that she did in Syria and her interim country about the way she chose to dress. Her husband's words helped her to realize her freedom from discrimination and to act resiliently in the face of transition into Canada. This sense of resilience employed by this woman, as well as by other women allows them to deal with their mental health and emotions internally, meaning that they do not necessarily have to actively seek out mental and/or emotional health resources, rather they can help themselves.

Both direct and indirect uses of social networks lend themselves to the comparison of mental states from life in Syria to life in Canada, supporting the use of or providing an alternative to typical mental health services, alleviating some of the worries that come with transitioning into Canada, helping women take charge of their situations, influencing the labels placed on women, and who women choose to share information with.

Data Interpretation

Five central themes rose from the thematic analysis of the study: Comparison of mental states from Syria to Canada; Social networks as supporting the use of, or providing an alternative to mental health services; Social networks alleviate some of the determinants of mental health problems that arise in moving out of Syria; Social networks influence assumptions about mental health services; and Resilience and strategies for overcoming the determinants of mental health issues.

Theme 1: Comparison of mental states from Syria to Canada

Women tended to compare their mental states in Syria to what they are in Canada – just feeling a little bit better made women feel that seeking out resources to improve mental and emotional health was not necessary.

“When I came to Canada, it changed my life completely because we had so many hopes for our future here in Canada.” (Participant 9)

Participant 2 reported:

“trying to compare between what happened and how I live now and think I am safe. I can get over all of this stuff because I am here in Canada, I try to think of the future. I am trying to not let my brain think a lot.” Participant 2 also reported that having her “complete family” with her was all she needed to feel more relaxed to create a good future – and that “nothing else is needed”.

Participant 9 identified that:

“Sometimes I don’t go [to seek mental health resources] because I think that time will solve my problem - so I ignore my feelings. Because I compare myself to before, like I am not the same as when I first came from Lebanon so I feel better than that time, so I think with more time I will feel even better -- so I don’t go to any place for help.”

Participants also made comparisons between their home country and Canada in terms of the determinants of mental health. For examples, Participant 10 spoke about her experience with acceptance in Canada in comparison to the discrimination she experienced in Jordan. By acknowledging that she felt safe in Canada, compared to her lack of safety in Jordan implicitly illustrates that her mental health in Canada has improved:

“The people are all so nice here so it made me feel a bit better. They don't say things or think about whether I am Muslim or if I wear a hijab or don't wear a hijab. They are good people; they don't discriminate and that makes me feel safe.”

In relation to the role of social networks, discussions with others about the improvements to their life, and former traumatic experiences, again allowed them to reflect and reinforce the idea that their lives in Canada are better despite some of the challenges of settlement.

For example, as Participant 8 put it:

“Also, everyone that I meet who is Syrian has been through a similar experience, so we know that if we had the same bad things happen to us then good things can also happen so we focus on that. I feel bad when I hear other people's stories, I feel that I am much safer and in a better situation than all the people that are still in danger. This helps me to think and go forward to improve my life.”

In this example, Participant 8 very clearly demonstrates that having a group of people that have gone through similar experiences can help to feel positive about a good future, thereby suggesting that social networks themselves can help to relieve mental and/or emotional stresses related to settling in Canada.

Theme 2: Social networks as supporting the use of, or providing an alternative to mental health services

Social networks were found to play a role in resource seeking behaviours because they were suggested support the use of mental and emotional health services and/or act as an alternative for helping women face their mental and emotional health issues. Specifically, some women identified situations in which they found trust in others and some participants talked about those who helped them to seek out services. In both situations, women felt happy that they had other individuals to turn to for support and guidance.

Participant 1 explained that her social networks provided and alternative to seeking

formalized mental health services. She demonstrated a great ability to be considerate in the thoughts of sharing her experiences with others in her social network, including medical professionals. Her aim was to continue on in life and be happy, not to harp on the negative things and hurt herself and others. She stated:

“I never wanted to go to therapy, I always wanted to stay by myself because I believe that energy can go like an infection. It can go to other people, I can affect their mood or their health. So, I would stay by myself until I felt better and then go talk to people and smile with them. So, I was trying to solve my issue by myself.”

Additionally, Participant 1 spoke about her family in Syria by saying:

“for me when they are safe, this makes me feel safe and I feel that they help me because my biggest fear in my life is to lose one of them. I was someone who was independent and I didn’t need help or something but I just wanted to see or feel that they are safe.”

She identified her family in Syria as the ones who she can always count on and that they should feel that they can also count on her, thus negating the need for mental health services. Participant 1 noted that she saw her family as a proxy for justifying the non-use of mental health services – their safety also makes her feel safe and comfortable which allows her to live her life without seeking external help for any mental or emotional health issues that she may have.

Participant 6 too explained that her family serve as a surrogate for services, stating:

“if I have anxiety or stress, I can talk with my sister and brother in law because we have so much trust.”

In another interview, Participant 11 spoke about her daughter and expressed

“I feel close to her. For a long time, we have had a friendship with each other. I am so lucky to have her in Canada with me because she is positive and helps me stay happy.”

The same participant said that while nobody else encouraged her to go back to school, her daughter always told her to “do her thing for school or her health”. Going back to school, for her a determinant of mental health, was important for Participant 11 to feel that she had done something to further her self-development and to make her intrinsically mentally and emotionally satisfied In Participant 11’s case, her daughter acted as both a confidante and encourager. Both Participant 6

and Participant 11's explanations of how their social networks played a role in improving their mental health speaks to the idea that they used their siblings and daughter, respectively, as an alternative to seeking formal care. The role of an encourager was also explained by other participants.

Participant 7 explained the role of one of her encouragers. She spoke about her sponsor by saying:

“Mariella has helped me get in touch with a good psychiatrist who is also supportive and does not make me feel crazy. Instead she teaches me ways to feel better.”

Here Participant 7 suggested that her social network, in this case her sponsor, was supportive of the idea that she could benefit from mental health services and was therefore a motivator for seeking services.

Theme 3: Social networks alleviate some of the determinants of mental health problems that arise in moving out of Syria

Evidence shows that women see that their social networks have alleviated the worries and stresses that women have about moving to Canada. The alleviation of worries by social networks proved to be an alternative to mental health service use. Determinants of mental health that were evident in the data include education level, intrapersonal relationships, as well as family and community dynamics. Social networks were shown to help reduce these determinants of mental health problems. Social networks include friendships, sponsor relationships, parental relationships, and relationships with doctors.

EDUCATION LEVEL

Participant 5 recognized her need to be part of community organizations and make friends in order to feel happier and to recognize that she was in a better place in regards to safety, security, and success of the future. Her community engagement was directly related to increasing her education, thereby improving her English. She describes her experience by stating:

“Now I am very happy here because I have lots of friends and I am part of many organizations, like Culture Link. People are always there to help me - Sandra is there. I am better in English and I can communicate with my neighbours. Even my kids have joined school so they are studying. We are in a way better place so I am happy.”

She uses the term “now” in comparison to before coming to Canada to illustrate that she was not happy, safe, or secure before her transition, thus decreasing her mental health. Additionally, a secure school environment for her children also makes Participant 5 happy, which is another determinant of mental health. Overall, Participant 5’s mental health problems were alleviated by increasing her education through community engagement to improve her English and also, slightly from knowing that her children are able to go to school safely, both of which are determinants of mental health.

INTRAPERSONAL

In multiple instances, social networks were shown to influence a participant’s relationship with themselves. Intrapersonal relationships or a relationship with oneself is explained as being a determinant of mental health. In the following situations, intrapersonal relations were focused on and demonstrated that they can alleviate issues associated with mental health.

Participant 2 explains how her doctor made her realize that she could not do everything and be healthy. He made her recognize the importance of self-care and taking care of the relationship she had with herself. Participant 2 stated the following:

“I already had so many health problems so I thought that if I can be patient with this, I have to solve another thing. And when I think about it all now, I think that doing this did affect me - I had a disk in my back. We did not have a car yet, so we were carrying everything. And even the doctor said I had an addiction to doing too much, because even in Lebanon I was alone and doing all the work myself, so he helped me get over the idea that I need to do everything. I had to train myself to be gentle with myself. I did not care about myself when I came here at first and then I realized that I would not be able to take care of my children if I did not take care of myself. So, I went to the doctor to learn how to improve my attitude and find out about more services.”

In this example, Participant 2 reflects on how she has been treating herself throughout the transition process and recognizes that unless her mental and emotional health improves, she will have increased difficulty in prospering in Canada and looking after her family. In this case, her doctor helped her to acknowledge the notion that she was neglecting her own mental and emotional needs. Additionally, she acknowledges that ignoring the pain of a disk in her back was negatively

affecting her mental health because she was not “being gentle” on her body, illustrating that for some people mental health and physical health are linked. Therefore, the social network of her doctor helped to reduce a determinant of mental health problems.

FAMILY/COMMUNITY DYNAMICS

A third social determinant of mental health is family and community dynamics. Study data revealed that mental and emotional health burdens could be relieved by positive family and community dynamics.

Participant 2 leaned on her sister for great support during the initial stages of her resettlement. She describes feeling:

“so disappointed and really sad...it was like I was in a coma all the time and she [sister] really tried to help me - at that time I had a blood disease so she would always try to make me smile or something small just to get my blood to flow a little bit, because I was getting blood clots. She was trying to do everything for me.”

Participant 2’s sister played the role of the encourager by trying to appeal to her sister’s sense of humor and what she thought might improve her mood, emotionally.

Participant 3 found comfort in multiple places and also identified that her siblings were able to make friends too. For her, she felt better emotionally when she met people at church and experienced a positive dynamic in this community:

“First at English class and then the circle grew. Like my landlord, even in the places I go shopping, the cashiers are familiar, they are used to me. We start to talk. English class most-- like Most of my friends are from English class. We went to United Church in Richmond Hill, I met people there. They were so welcoming, they didn't help us buy stuff but they helped us emotionally. Even though I just wanted to depend on my husband, I did not want to depend on anyone else, they still helped me. They welcomed us and invited us to their home. And then -- after like 2 years, my husband made friends from his job. My siblings made friends in the community - like from their job and volunteering, school like everything - the circle becomes bigger and bigger.”

In this example, Participant 3's social network was an alternative to seeking traditional mental health care services through the determinants of family and community, which helped her to feel a sense of belonging.

Unique to Participant 6 was the acknowledgement that raising her children as they became teenagers was difficult. Other parents who are also raising teenagers, similar to that of Participant 6 can be explained as a community of parents who are at similar stages in life.

The participant cited the difficulties of raising teenagers as one of the causes for her mental distress and found that speaking to her friends who were also raising teenagers was beneficial:

“The most important topic we discuss is mainly our kids and especially teenagers because we have problems with them in this stage of life... I get good ideas because everyone talks about what happens with their kids and then you can get whatever is relevant to your situation.”

In Participant 6's situation, her social network addressed the determinants of family, and community dynamics. When Participant 6 explains that she can take what is relevant to her situation and apply it in rearing her teenage children, illustrates the idea that the experiences of her social network alleviate some of her mental and emotional distress and that she can learn from these experiences to help her children grow while staying mentally healthy herself.

Participant 7 illustrates that her previous family dynamic diminished her mental health in Syria, but the privacy of having her own house in Canada and a positive relationship with her sponsors has improved her mental health. In Canada, she has a safe shared space, whereas in Syria, that was not the case. Participant 7 recognized that she was able to open up to her sponsors and tell them the truth about how she was feeling. Doing this propelled her sponsors to advise that she seek psychiatric counselling, which ended up being helpful for her future success. Moreover, this example demonstrates the need for acute care in some cases and the role of social networks in providing the support and encouragement for women to do so.

In another interview, Participant 3 spoke about the time that she told her parents that she was leaving Syria. She waited until the last minute to tell them because she did not want to be persuaded to stay and she was most nervous to tell her father, who is very attached to her. She recounts her story as the following:

“ So, my parents are still there, all my siblings are out, but for my parents they wanted to stay. Yeah, they will come in June to visit us. They will not move, I want them to move. They are like trees you can't change them. I was used to seeing them so often so it is hard for me now because I miss them. My dad was really hurt when we left because he is a very sensitive. It was the end of the world when I told him. I never told my parents until I was actually called for an interview at the embassy. That was one and a half years - then I told them 'I have to leave to Lebanon tomorrow', he asked why and I told him I have an interview in the Canadian embassy and I am moving to Canada. It was like the end of his life because all of my siblings are out of Syria and I was the only one who stayed there. Even when I moved back to their city, he was so happy. The only time in my whole life I saw my dad crying was when I left for Lebanon. I struggled at first, so at first, I always wanted to show them that I was winning and made it. I didn't want them to know it was hard.”

In this example, Participant 3's family dynamic prevented her from revealing all her plans to her parents until the last minute. As a result, her family dynamic had to be suddenly adjusted to suit her decision to leave Syria. Due to the displeasure from her father about moving, Participant 3 did not want her parents to know that she was having a difficult time adjusting to Canada, so she only ever told them the good things that were happening. Without knowing the reality of her struggles, her parents could only believe that she was solely experiencing happiness. Not wanting her family to know she was struggling forced her to act emotionally and mentally happy even when she was not. Further, while she was using tools to help improve her mental and emotional health, she could not speak with her parents about it, which for some other participants was very important to be able to do.

Comparatively, Participant 6 credits her parents for giving her so much mental and emotional support that it helped shape her to become a person who seeks mental and emotional health support when she needed it. Her family dynamics fostered an environment where it was safe to speak about mental and emotional feelings and where life choices were supported through encouragement and financial means:

“Okay so when I had a difficult time, my parents stood by me and supported me a lot. They supported me mentally, like strengthening my personality and they

supported me financially. This affected me by changing my mental state. How I looked at life - like my opinion of life in general.”

Participant 6’s “opinion of life” was an underlying theme in her whole interview. She had no shame of her experiences in Syria, and felt that there was nothing wrong with needing to seek mental and emotional comfort, based on the support and encouragement always given to her by her family.

Additionally, sponsors were identified as a part of participants’ social networks. In all cases, sponsors were aware of the general stories of the women that they helped, they understood the transitions women went through in terms of home cities, family size, family members that came with them to Canada, interim countries and length of stay in the interim country, as well as amount of time in Canada. Given the fact that sponsors were the first point of contact for many of these women, relationships developed into ones that were quite deep and long lasting, therefore playing a role in addressing mental and/or emotional health issues related to the women. Many women even referred to their sponsors as “family”, therefore introducing a family dynamic.

Participant 7 recalled her time in Syria as being “hell” because she was living with her husband’s family who was “demanding, unwelcoming, and mean”; she explained that she was isolated from everyone she knew and everything she loved while she was in Syria and often felt rejected by her husband’s family. As a result, she never spoke about how she felt or what she wished for. She came to Canada with the hope of escaping both Syria and her in-laws and stated:

“I am so thankful to my sponsors for encouraging me to go to the psychiatrist because I would miss so much school and could not learn. I am so thankful for living here, I would not have this life in Syria because the government does not support us, my husband’s family would shame me, and I would not ever have privacy. I think the privacy part alone has helped me so much.”

Also, Participant 6, compared the familiarity of her surroundings in Syria to Canada and recognized her need to be a part of the community in order for her mental and emotional health to improve:

“When I first came here, I felt so strange. I felt alone - I left my country, I left all my brothers and sisters so I felt really alone. But then I met some others in the community - I met some Syrians and other people in the community and that reduced this feeling a lot.”

By engaging with community, Participant 6 is introduced to another positive dynamic, thereby reducing her feeling of loneliness, which could have led to decreased mental and emotional health.

Theme 4: Social networks influence assumptions about mental and physical health services.

Social networks were identified as providing women with confidence to be independent and take charge of their situations because they can learn from other women that have come to Canada and act according to what they have learned. Independence can result in taking charge of their own health through self-advocacy, thereby propelling them to make choices that are bettering their mental and emotional health. For example, Participant 1 reflected on the differences between her experience with mental unrest and that of others. Within her social network and the individuals whom she met, she recognized:

“that people who go to the family doctor, most of them have depression. So, he was judging me as a person who just came from a war and he assumed that because I was going to him and walking in front of him like a healthy person -- I told him not to judge me now because I don’t like to show my pain to others, so he was looking for somebody who looked very physically sick and he saw a healthy person because I was walking. Maybe he judged me because of this.”

Her ability to realize that she may have been judged based on the comparison a doctor could have made between her and other patients gave her the foresight to confront him about how he viewed her and self-advocate for how she needed to be treated, thereby making him aware of the fact that he was doing this and to change his style of treating Participant 1.

Participant 9 explained that seeking mental health help made her feel uncomfortable because of the protocol that the psychiatrist used. The uncomfortable situation made her decide that she did not want to go to that psychiatrist at all:

“I also had a difficult time at the beginning so I went to my family doctor to tell her how I was feeling and she sent me to a psychiatrist so I went for the first time and I did not feel comfortable so I did not go back because I expected someone to listen to me and help me find ways to feel better. But instead she brought a social worker and an interpreter and there were 5 people in the room, so they were just discussing my problems with me in the room and acting like I was not there, I didn’t like that so I did not go back.”

Participant 9 expected that there would just be one person that she could talk to about her feelings because her family doctor along with others in her social network always told her that going to a psychiatrist just meant talking to a professional who could help her talk about her feelings; she never expected that there would be a group of doctors speaking about her as if she was not in the room. Acknowledging her discomfort gave her the confidence to decide that she did not want to go back to the psychiatrist. By recognizing that she was uncomfortable in that position with the psychiatrist, she took charge when it came to her choice of who she was willing to share her feelings with.

Some women also expressed that social networks helped them to develop independence in general, that did not necessarily propel them to seek or deny help. Rather, the newfound independence made women feel confident about adjusting to life in Canada. Participant 4 expressed finding independence. In the first instance she says,

“Like I do not drive, so my sister or brother in law always would drive, but now I take the bus because my brother in law taught me so I can do things on my own schedule - I can stay busy. I do not like being lazy or only at home all day because I have worked my whole life so now I feel independent. I am okay, I can do what I want.”

Participant 4 saying “I’m okay” speaks to the idea that she is fine and that she feels mentally and emotionally stable.

In a second instance, Participant 1 explains:

“your unconscious mind is a huge world - an ocean, it is really an ocean and all you do is throw things inside it so at least...you know my psychiatrist helped me but in reality, he didn't help me in a perfect way, because he is not in my brain. Even I can't fully help myself, but now I picture myself on the beach, not in the middle of the ocean, so I am not going to sink. I will help myself, I will study, I will be successful...you know that feeling when you are successful back home and you leave that country and lose everything? Yeah, this is very very...especially when all this happens at 32. You build everything there, I had three jobs and all big companies and then I came here and had nothing.”

Specifically, she identifies that while her psychiatrist could not help her completely overcome her mental health problems, he helped her develop the ability to change her thoughts and to have the confidence to know that she will build herself back up to study and be successful. This interaction with her psychiatrist, who is part of her social network has given her the independence to make plans for her future.

Theme 5: Resilience and strategies for overcoming the determinants of mental health issues

Women revealed that they began to see themselves in different lights after escaping Syria. All women cited that they had good lives before in Syria before the war and that after the war, their lives changed, leaving them feeling lost. However, once in Canada, many women felt that they could feel happy again and that they were capable of more and less tolerant of situations that made them feel demeaned. Many of these demeaning situations involved feeling as though they needed to act in a certain way that would label them as ‘good’ women, or god fearing (making decisions based on the way they perceive god will view them). However, coming to Canada and interacting with the new environment and new social networks after facing harsh realities in Syria and interim countries propelled the women to show their ability to be resilient.

Participant 2 explained that her children were getting older and finding themselves in situations where they felt ridiculed at school or left out of social activities because of what they had gone through in Syria. She responded to their fears with:

“be brave, do everything successfully and try to be a hard worker. And what we dealt with there and if we are still alive after it, we can do anything. We had all of that to deal with and still made it out.”

She emphasizes the idea that her children are capable of success regardless of what they had been through – she places her own confidence and feeling in them. Former adverse events that she went through in Syria and her interim country gave her the confidence to know she can also overcome this hurdle (hence the resilience developed at an earlier stage).

Another instance of Participant 1 utilizing resilience comes from the implicit thought that she had of being an outsider and the consequences associated with this thought. She stated:

“if I was negative, I would not be able to have a job like I have now because the whole time I would say this is not my country, this is not my home, so I would

not have gotten a chance here. So, to be thankful for everything around you is important.”

Her reflection explaining the thought of “this is not my country, this is not my home” is an expansion on the idea of being an outsider. Giving herself the label of “outsider” would prevent her from being able to adjust into Canada. Instead Participant 1 becomes resilient in her quest to adjust to life in Canada and thrive.

Participant 2 explained:

“I do admit I do need to go to the doctor. My husband tries to remind me that that was in the past, you have left that place so you can be safe, so that the kids can be safe, you can live normally, nobody looks at you because you don't wear a hijab.”

In this case, the Participant’s husband was her voice of reason – he made her realize that she did not have to tolerate being shunned for not wearing the hijab, she could experience truly being safe in Canada as she was. In addition, her husband helped her realize that she was focusing on the past too much and needed to see a doctor in order to heal mentally and emotionally. In this case, Participant 2’s husband helped her to address the worries that were causing her to feel mental and emotional unrest.

Participant 9 speaks about using religious thought as a mental strategy in her adjustment to Canada. She states:

“I am not that attached just to Islam, but religion in general. I believe that any religion can help you feel better. We can love accept and communicate with people of religion in general”.

This sets up the idea that she subscribes to the belief that religion can help to heal. She followed up on this statement by saying that she had many friends from different religions and was appreciative of this fact:

“what is good about my friendships with people from other religions or cultures is that we accept each other as we are. Nobody tries to impose any ideas or feelings on anyone else and that makes me feel safe to be myself. I know they won't give me an opinion if I don't want it. That is why we can have good relations. It has affected me in positive way. I love life now, and I see life in a

better way.” (Participant 9)

In this passage, Participant 9 acknowledges that her social network accepts every religion how it is, that nobody tries to label another person based on their religious practices or their views of religion. Further, her social network facilitates acceptance of differences, which increasingly promotes her engagement with religion to overcome mental health issues. Additionally, it is the appreciation of her religion along with that of others that provided her with strategies to overcome her mental and emotional health issues. Her mental and emotional health are improved because of this, and she admits to being more positive about her life and more loving of it as well.

Chapter 4: Discussion

Research Rationale and Findings: Refugees and Social Networks

With the growing levels of refugee women in Canada, it is critical to understand their mental health resource-seeking behaviours. Various factors such as patient-provider trust, refugee status-type, discrimination, and previous health care experience have been identified in the literature as contributing factors to the use of mental health resources for refugee women (Gagnon et al., 2013; O’Mahony & Donnelly, 2010; Yohani & Hagen, 2010). Though research shows that social networks play a role in mental and emotional health status, there is a lack of research regarding the role of social networks in influencing the use of mental and emotional health resources. Specifically, previous data suggest that social support innovations are desirable by refugee women in Canada but that further research is required to mitigate social and structural barriers to and motivators of seeking care (Mahajan & Meyer, 2019).

Given the previous investigations as explained above, I was interested in exploring the concept of social capital and more specifically, social networks. Social capital is an umbrella term for resources that are available to individuals and groups to achieve a desired goal, in this case mental and emotional health-related; social networks are an element that is part of social capital. In turn, this led to the following research question for further investigation: What role do social networks play in the mental and/or emotional health resource-seeking behaviour of women who are refugees from Syria?

Given the four primary research objectives along with consideration of what previous literature identified as influential in mental and emotional health, there were six key findings to illustrate

concepts that are novel in this area of research. The following key findings that emerged are as follows and will be discussed in detail:

1. Families play large roles in teaching and providing information about Canada's health system
2. Providers prevent use of resources while family, friends, and sponsors help
3. Women feel more welcomed by social networks in Canada than in interim countries
4. Social networks act as alternatives to seeking formal mental and emotional health care

Families play large roles in teaching and providing information about Canada's health system

In a study conducted by The Mental Health Commission's, data suggest that family and friends play a large role in refugees learning about the Canadian health system when there is an absence of appropriate information. Moreover, the need to consult with friends and family intensifies when considering mental health services, as the stigmas attached to mental health and mental illness may prevent women from wanting to use mental health services (Hansson, 2009). This is consistent with my data suggesting that social networks can influence individual thoughts that a woman has about mental health services. These thoughts influence how women react to receiving care, either propelling them to engage or disengage in services. Specifically, women began to deeply consider what type of specialist doctor she needed, whether she needed to just talk to a doctor or felt that prescription medications would suit her, and the competencies of doctors to appropriately treat women who are refugees. This illustrates that social networks may play an indirect role in the use of mental health resources because individuals within a social network speak of their experiences with mental health resources. The preconceived notions of mental health treatment as a result of social networking make women have different expectations than what is actually provided to them in treatment or by the provider. Data from this study revealed that for many women, family members also acted as a proxy source of help for mental and emotional distress. I discovered that women who are refugees in this context did not always seek out help from family to understand the typical Canadian health system, but rather saw their family members and social networks as a health system within itself.

Providers prevent use of resources while family, friends, and sponsors help

Findings also suggested that each social network plays a role either indirectly or directly in a woman's quest and decision to get mental health help, where providers were noted to deter women from seeking professional help. My study revealed that providers may contribute to non-

use of resources and that while not always suggested to be intentional, providers may make women feel less desire to seek out formal mental health treatment or to visit the doctor for advice on their mental health as they do not provide treatment in a way that aligns with the woman's values or beliefs about health care. Other studies supporting my findings have shown that immigrants are less likely than Canadians to use mental health services in both primary or specialist care settings in part because of their own perceptions of how doctors and other health professionals may diagnose and treat them rather than the actual experiences with these health care professionals (Hansson, 2009). While the stated study discussed immigrants in general, the authors found that results from refugees were similar. Further exploration of attitudes towards mental health care professionals in my study helped to reveal that women felt that mental health and primary providers actively created situations and gave advice which unintentionally resulted in women not wanting to get medical treatment for mental health distress, such as misdiagnosing an injury or having a "panel" approach to conducting therapy sessions, where multiple professionals are asked to sit in. Consequently, women became hesitant to seek out primary and specialty mental health. Additionally, my study explored the relationships women have with physicians from the viewpoint that these physicians are part of their social networks and identified that some women felt as though the physicians lacked an understanding regarding the determinants of mental health for refugees compared to individuals born in Canada. Indeed, previous research has identified mental health care as inconsistent with the values, expectations, and patterns of help-seeking of immigrant and refugee groups (Gagnon, 2002; Durbin et al., 2014; Andermann, 2010; Green et al., 2006). Therefore, it is imperative for mental health care professionals to recognize key differences in experiences of women who are refugees and be able regard their values and comforts highly in order to tailor their practice accordingly.

However, family members, friends, and sponsors were noted to reduce some of the determinants of mental health problems by acting as a resource to teach them that they may need acute mental health services in some instances. Study data revealed that social networks, in the forms of family, friends and sponsors, can help women to recognize that there may be a need for acute services by encouraging them to seek help for periodic mental stress that is related to the adjustment of life in Canada. Additionally, social networks encourage women to see care for physical pain which in turn helps them to uncover mental and emotional health issues as well. This finding is important in that it demonstrates that the role of social networks can be large in the

decisions which women make about seeking care. Their presence, sharing of experiences, and general friendship can serve importance in women's recognition of mental health and the need to get care. In some cases, women said that they seek acute treatment for physical injury in addition to mental health distress as they identify that many of the chronic physical conditions they face pose a great deal of mental stress for them as well, as they are unsure of how to self-treat and are nervous about how they will receive treatment in the health system. Previous research has demonstrated that refugees are at risk for deteriorating mental and physical health soon after arriving in Canada. These studies suggest a course toward increasing the efficacy of the health resources in place to help refugees gain their health back. In addition to the pre-existing health problems before migration, such as injuries and chronic illnesses, after they resettle in Canada, refugees are more likely than the general population to experience socioeconomic barriers, which may also contribute to deterioration of their health status (Oda et al., 2017). This is interesting to consider given that women in my study identified physical pain and injury as a cause for their mental distress. My data suggest that physical pain and mental distress are not necessarily mutually exclusive and that having social networks act as guides for seeking acute health services, both in the realms of mental and physical health.

Women feel more welcomed by social networks in Canada than in interim countries

Data illustrated that women generally feel welcomed into social networks in Canada, unlike their experiences in interim countries whereby they described the initial transition from Syria negatively. This finding speaks to the idea that the experiences of social networks differ from what they were in Syria in regards to ethnic similarity, cultural similarity, stage of life, and future chances of success. Further, data suggest that women's social networks change multiple times through the transition process and therefore, their experiences with constantly changing social networks should be accounted for when considering possible determinants roles in creating or relieving mental and emotional health issues. Previous studies also explore and present the issues faced in interim countries, namely Lebanon. Authors explained that "Syrian refugee women are disproportionately affected by the situation in Lebanon, due to the increase in gender-based violence (particularly intimate partner violence, early marriage, transactional sex, sexual assaults), as well as lack of access to emergency obstetric care, limited access to contraception, forced caesarean sections, and the high cost of healthcare services" (Yasmine & Moughalian, 2016). The recognition of difference in experiences between interim countries and Canada is interesting when

social factors are taken into consideration. Specifically, leaving Syria to go to an interim country often results in leaving behind family and friends. Compounded with this sense of loss is a feeling of unsureness of what the future will look like, especially given the fact that women faced a loss of community and increased discrimination in the interim countries. The act of leaving Syria along with the sense of loss and insecurity about the future works to reduce women's mental health. Studies have shown that the effects of displacement and war on a woman's mental health are detrimental and that fear and stress are exacerbated by society's views and expectations of women (Yasmine & Moughalian, 2016). Examinations in my study further confirmed this by emphasizing the discrimination participants faced in their interim countries for being women. While not directly related to the role of social networks, this finding is nonetheless important for providers because it suggests that Canada and Canadian healthcare providers should consider a woman's entire journey as relevant to her mental health, rather than just looking at current aspects of her environment that can be considered as stressors. If the entire journey of a woman is considered regarding her transition to Canada, providers may be able to better understand the nuances of her experiences and how they may contribute to her mental and emotional health.

Social networks act as alternatives to seeking formal mental and emotional health care

Study data revealed that determinants of mental and emotional health and their associated problems are often alleviated by social networks who act as alternatives to seeking formal care services. This means that the extent to which social networks encourage or impede use of mental health services is not always black and white. Since social networks can alleviate the determinants for mental health problems by providing social support, feelings of community, and financial help among others, they may also alleviate the need for formal services. This does not necessarily impede the use of services, as it does not serve as a negative block in a woman's process to improve mental health. Rather, it acts as a mental health resource in itself by ways of decreasing mental and emotional distress that women may experience as refugees and in their transition to Canada. Previous research explains that when vulnerability, life events, and stress are greater than a person's ability to deal with them, they move away from the path of good health. However, by summoning their resources, this same person can move back towards a balanced level of health. These same authors explain that mental health issues are an "interaction between forces that promote balance and those which promote mental health problems and illnesses. Risk factors for the development of mental health problems and illnesses such as unemployment or migration may

work by increasing stress and life events or decreasing resilience and social support” (Hansson, 2009). This idea was further confirmed in my study as social networks were used as a resource to help bring balanced health back to many of the women’s lives. The women included in this study saw increased levels of vulnerability, changes in their daily life courses, as well as heightened stress as a result of having to leave Syria during dangerous times. Due to these negative experiences, mental and emotional health was impacted and social networks were part of the resources used to improve their health.

Many women in the study cited the importance of having their husbands to lean on during their transition. This is important as spouses were often named and spoken about first when women explained what family meant to them, thus setting the scene for their ideas of social networks. Other studies explain that the availability of a significant other can mitigate the stresses and vulnerabilities that can come along during a transition and affect the mental health of some newcomers in their initial years. Further on in the resettlement process when negative memories of traumatic experiences may arise and feel threatening, it is the support of the significant other that can reduce the feeling of being threatened by past memories. The critical element of ensuring that spouses would be helpful is stability and longevity of an intimate relationship (Beiser, 2009). While the mentioned research concerns itself mainly with the presence of a romantic partner and my study also confirmed this idea, women also spoke about their sponsors and siblings in a similar way by acknowledging that they felt welcomed, heard, and understood by these types of social networks.

Comparing environments and experiences helps build resilience for some

Important in the study data explored in my work is that during the experience of transitioning from Syria to an interim country and then finally to Canada, women compared their environments and experiences from country to country. Doing this helped some women to build resilience in the face of adversity. This resilience prevents the need to seek comfort in social networks and encourages independence. While the need for social networking is not involved in being resilient, there is a sense of balance that comes back to a person, which in turn will help them to build their social network and community in order to thrive in other walks of life later on in the resettlement process. Specifically, The Mental Health Commission explains that as people move from distress back to balance, it is the result of their internal resilience as well as other aspects of good mental health such as community or social support (Hansson, 2009). Therefore, it

is important to consider the idea that social networks alone cannot be responsible for bettering mental health or encouraging the use of mental health resources. Understanding the role of resilience in addition to the role of social networks can help illustrate a holistic image of the pathways to improve mental and emotional health in women who are refugees from Syria.

Chapter 5: Where do we go from here?

Narratives provided by the participants in this study are important because they suggest areas where policy makers, researchers, and clinicians may invest resources to assist in both improving the mental health of Syrian women who are refugees, as well as addressing the broader determinants that might arise after settlement. Addressing the determinants of mental health, and providing social networks that facilitate the addressing of them (or conditions under which this happens naturally, like resettling people in communities for example with other immigrants) is a better use of money than providing more acute care services that are more of a band aid solution.

Where do we invest resources?

Given the data revealed and explored in my study along with the results of other studies, it is important to consider where resources would be best invested to benefit women who are refugees that make decisions about mental and emotional health support based on their social networks. In my study, social networks were categorized into types, each with their own ability to affect the decisions women made about their mental and emotional health care. Further, mental and emotional health have unique determinants that differ slightly from the general determinants of health. Recognizing through multiple studies, including mine, that explore the importance of social networks in a person's transition back to mental and emotional health along with the unique determinants of mental and emotional health, resources that actively speak to decrease some of the determinants of mental health and emotional health problems should be invested in. Additionally, health care providers and immigration officials should be better educated on how to provide appropriate care to women who are in Canada as refugees – their experiences are often different from Canadian-born individuals or naturalized Canadians that did not arrive as refugees.

Currently, at the national level, the Canadian government describes the following as support services that they provide for government-assisted refugees:

- greeting at the airport,
- temporary housing,

- help with finding permanent housing,
- help with registering for mandatory federal and provincial programs,
- orientation to the community, a service that includes
 - providing contacts for safety and emergency services,
 - introducing refugees to the city where they have settled,
 - explaining
 - public transportation,
 - Canada's education and health care systems,
 - Canadian laws and customs, and
 - the local climate,
- personal finance help in areas such as
 - budgeting,
 - setting up a bank account and
 - using debit and credit cards,
- basic "life skills" support for high needs clients, and
- referrals to other refugee programs.

Canada provides income support under the Refugee Assistance Program (RAP) to eligible refugees who cannot pay for their own basic needs. Support can include a:

- one-time household start-up allowance, and
- monthly income support payment.

It is important to note that these federal services are only available to those who have come as sponsors of the government. Many women from Syria who come as refugees are privately sponsored by Canadian families or community organizations and are not entitled to the same support resources automatically, rather privately sponsored refugees gain permanent residency in Canada and depend on sponsors for most types of support (Government of Canada, 2019¹; Government of Canada, 2019²). Permanent residents of Canada are expected to find jobs quicker, and thus be quick-producing members of society, which is often difficult to do for many of the women who come to Canada with little knowledge of the English language and little familiarity of North American working culture, compounded by the demands of looking after their children and spouses. In light of having less government-based resources, privately sponsored refugees

may require more community-based resources to turn to. Some of these organizations include Culture Link, the Multicultural Mental Health Centre, Crossroads Clinic, and other online sources. All of these organizations work to provide different kinds of support including employment workshops, physical healthcare, and social support from a patient or person-centred standpoint. This is particularly important in today's Canadian health care system climate as the *Charter for Patient-centred Care* is considered a strong foundation for teaching health care professionals, government bodies, and patients about patient-centred care but does not have fully developed mechanisms to ensure accountability from these groups (Canadian Medical Association, ND). Given this information, more attention should be given to maintain and grow community and grassroots organizations like these in order to benefit women who are refugees in Canada.

What can we do to foster or facilitate social networks?

In order to understand how to facilitate social networks that can be helpful in the process of engaging in mental and emotional health care, researchers must be able to speak directly to women who are refugees in order to understand what they feel is missing from the Canadian social health system and what they wished they had. My study serves as a foundation to help unravel some of the experiences that women go through during their transition so that other researchers can use it as a stepping stone to approach the situations of these women respectfully and sensitively. Additionally, it is important to remember that it is not the responsibility of one governing body to implement policies and programs, rather it needs to be a collective effort from all levels of government, including community level authorities to create and maintain social resources for women who are refugees to use in their transition and maintenance of good mental and emotional health. Community groups and gathering places have resulted in women feeling safe about sharing their experiences and excited about building prosperous futures in Canada – feelings of safety and excitement are important in being mentally and emotionally healthy.

Considering Differences in Populations and Demographics

While all refugees face negative experiences in their home countries and new experiences in a host country, not all refugees face the exact same experiences in terms of mental and emotional health, social support including family members, friendships, and community support organizations. My study considered only situations of women who are refugees from Syria, where women have experienced trauma and transition uniquely. This is not to say that their experiences may not be similar to those of other refugees, but it is important to consider the differences in areas

of culture, attitudes towards mental and emotional health and health care that may warrant other populations their own studies in this area.

Chapter 6: Strengths, Limitations, and Conclusion

Strengths and Limitations

Research regarding Syrian women, especially in regards to their health is essential to improving the ability for Canada to properly care for its habitants. Given the exponential growth of Syrian refugees since 2012 coming into Canada, it is important to understand their stories, their struggles, and to hear their voices to clearly understand what is missing, what they need, and what they hope for in Canada in order to lead healthy and productive lives.

By conducting a qualitative study with in-depth interviews as a sole source of data collection allowed the data to be rich. Rich data came in the forms of true stories, experiences, and emotions of Syrian women about their challenges, social networks and experiences throughout their transition, and the effects of these social networks and experiences on their mental and emotional health. While not necessarily generalizable to another population of refugees, including men who are refugees, this study considers a population of great importance in Canada's current context and history. Additionally, the sample size of this study may not be fully representative of the entire Syrian refugee population regarding religion and religious beliefs, methods of obtaining refugee status, and age. However, the scope of the study was specific to investigating mental and emotional health resource seeking behaviours regardless of religion. Further, it was beyond the scope of this study to examine the differences, if any, that exist between the stories of women who came to Canada as government sponsored refugees and those who came by being sponsored privately by families or community organizations. This is because both sets of refugees equally make up the population that was being investigated in this study.

Initially, the plan for the study was that it was only to use English speakers as participants and partway through the study, an interpreter was made available. The slight shift in language allowance may have hindered other potential participants to take part in the study from the beginning of its introduction. However, participants that spoke English and participants that spoke Arabic expressed similar stories and challenges in their interviews. Time and financial constraints resulted in the study having relatively few participants given the size of the population of women who are refugees from Syria living in Canada; more time and financial resources could have

allowed for a larger sample size. Lastly, having an interpreter could have prevented information from being perfectly accurate in translations and may have only captured the overall essence of some stories shared during interviews.

Conclusion

This study aimed to understand the role and influence of social networks on the use of mental and emotional health resources amongst women who are refugees from Syria. The findings reveal that social networks can both positively and negatively impact the use of and decision to use mental and emotional health resources amongst women who are refugees from Syria. Specifically, families play large roles in teaching and providing information about Canada's health system, providers sometimes prevent use of resources while family, friends, and sponsors help, women feel more welcomed by social networks in Canada than in interim countries, and social networks act as alternatives to seeking formal mental and emotional health care. Additionally, comparing environments and experiences helps build resilience for some women.

Many studies focus on the effects of transitioning to host countries on mental and emotional health, where women often cite the levels of diminished mental and emotional health they experience. Overall, studies show that women who come to Canada as refugees are more likely to face mental health issues than Canadian citizens and report lower health levels than other immigrant groups in Canada. Given this vast research and well-studied effects of transition in the mental and emotional health of women who come to Canada as refugees, it was important to consider who these women turn to for support and how these groups and individuals may impact women's decisions to seek mental and emotional health care resources.

This study was designed to be exploratory in nature and has opened up avenues for more investigation such as: where should resources be invested? What can be done to foster and facilitate social networks that promote mental health? And are more formal health care services better, worse, or equal to non-formalized health services? Additionally, focusing on the Syrian population demonstrates some challenges that may be specific to them, such as logistics around the political context in Syria at the time of fleeing and cultural attitudes and beliefs about mental and emotional health. Recognizing the uniqueness in the experiences of Syrian women may open up avenues for more research into women who are refugees from other countries and how their experiences may be similar or different from each other.

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Appendices

Appendix 1: Recruitment Email

Hello,

My name is Shreya Mahajan and I am a Master's student working under the supervision of Dr. Samantha Meyer in the School of Public Health and Health Systems at the University of Waterloo. I am contacting you because your organization may have knowledge of potential participants for my thesis research. The reason that I am contacting you is that I am conducting a research study on the role of social networks in mental and emotional health resource-seeking behaviours amongst women who are refugees from Syria. I am currently seeking volunteers who may be in contact or affiliated with your organization that may want to be participants in this study.

Participation in this study involves meeting for one (1) one-on-one interview with me in person in a public setting, on the phone, or through video chat. Interview questions will focus on women's experiences of resettlement into Canada, their social networks and support systems, and how they express their emotions. Participation in this study would take approximately 45 to 60 minutes. In appreciation of a participant's time commitment, they will receive a \$25 giftcard to Walmart. I would like to assure you and potential participants that the study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.

However, the final decision about participation is in the hands of potential participants.

Time slots are available to participate in this study through the months of May and June.

If you think that my study will be of interest, please send out my information letter to your patient/client list. I also kindly request that you display the recruitment poster for this study in your organization in areas where potential participants will easily be able to view them.

Interested participants will be advised to contact me directly at s23mahajan@uwaterloo.ca. You may also contact my supervisor, Dr. Samantha Meyer at samantha.meyer@uwaterloo.ca or at (519) 888-4567, ext. 39187. You and the organization will not have any knowledge of who or who does not participate in the study. Participants will also be told this if they contact me via email.

Sincerely,

Shreya Mahajan

**School of Public Health and Health Systems
University of Waterloo**

**PARTICIPANTS NEEDED FOR
RESEARCH ON the influence of social networks on *mental and emotional health
resource-seeking behaviours amongst women who are refugees from Syria***

As a participant in this study, you would be asked to: participate in a one-one-one,
semi-structured interview.

Your participation would involve *1* session,
each of which is approximately *30-45* minutes.

In appreciation for your time, you will receive
a \$25 gift card to Walmart.

For more information about this study, or to volunteer for this study,
please contact:
Shreya Mahajan

School of Public Health and Health Systems
at
s23mahajan@uwaterloo.ca

**This study has been reviewed by, and received ethics clearance
through a University of Waterloo Research Ethics Committee.**

Appendix 3: Organization Information Letter

Dear Research Participation Candidate,

This letter is a request for *your organization's* assistance with a project I am conducting as part of my Master's degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Dr. Samantha Meyer. The title of my research project is "The Influence of Social Networks on Mental and Emotional Health Resource-Seeking Behaviours Amongst Women who are Refugees from Syria". I would like to provide you with more information about this project that explores how the opportunities for social networks that arise from social capital helps (or hinder) Syrian women who are refugees in seeking treatment for emotional and mental problems. The purpose of this study is to provide important knowledge about this growing population and may help to further inform resource creation and improvement of the resources that are currently available to women who are refugees from Syria that desire heightened mental and/or emotional health. Knowledge and information generated from this study may help other policy-makers to adjust current and design new programmes for social organizations to take part in that help women who are refugees. Social organizations, such as yours, can put these programmes into practice, and research in the area of social tools to improve mental and/or emotional health can continue to develop.

It is my hope to connect with women who are engaged in the programs of your organization to invite them to participate in this research project. I believe that the participants and women of your program have unique understandings and stories relating to resettlement into Canada as women who are refugees from Syria and how social networks influence that process along with its impacts on health. During the course of this study, I will be conducting interviews with women to gather their stories of social networks and their impacts on health resource-seeking behaviours. At the end of this study the publication of this thesis will share the knowledge from this study with other health researchers, policy professionals, and community members.

Initially, to respect the privacy and rights of your organization and its participants, I will not be contacting the women directly. What I intend to do, is provide your organization with information flyers to be distributed by the [name of organization] at their discretion. Contact information for me and my advisor will be contained on the flyers. If a woman is interested in participating they will be invited to contact me, Shreya Mahajan, to discuss participation in this study in further detail.

Participation of any woman is completely voluntary. Each woman will make her own independent decision as to whether or not they would like to be involved. All participants will be informed and reminded of their rights to participate or withdraw before any interview, or at any time in the study. Participants will receive an information letter including detailed information about this study, as well as informed consent forms.

To support the findings of this study, quotations and excerpts from the stories will be used labelled with numbers to protect the identity of the participants. Names of participants will not appear in the thesis or reports resulting from this study. Participants will not be identifiable, and only described by their participant ID numbers.

All electronic data will be stored for one year on a USB drive and password-protected computer with no personal identifiers. Finally, only myself and my advisor, Samantha Meyer in SPHHS at the University of Waterloo will have access to these materials. There are no known or anticipated risks to participants in this study.

I would like to assure you that this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee. However, the final decision about participation belongs to your organization and the participants.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me by *email at s23mahajan@uwaterloo.ca*. You may also contact my supervisor, *Samantha Meyer* at (519) 888-4567, ext. 39187 or by email *samantha.meyer@uwaterloo.ca*.

I hope that the results of my study will be beneficial to your organization to women, and to the communities of families including women, as well as the broader research community. I very much look forward to speaking with you and thank you in advance for your assistance with this project.

Yours sincerely,

Shreya Mahajan
Master of Science Candidate
School of Public Health and Health Systems
University of Waterloo

Dr. Samantha Meyer
Associate Professor
School of Public Health and Health Systems
University of Waterloo

Appendix 4: Participant Information Letter

Dear Research Participation Candidate,

You have been invited to participate in a project I am conducting as part of my Master's degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Dr. Samantha Meyer. The title of my research project is “The Influence of Social Networks on Mental and Emotional Health Resource-Seeking Behaviours Amongst Women who are Refugees from Syria”. This project explores how social networks help (or hinder) Syrian women who are refugees in seeking treatment for emotional and mental problems. The purpose of this study is to provide important knowledge about mental and emotional health in relation to social experiences. Findings may help to improve current resources and create new health resources that are currently available to women who are refugees from to better their mental and/or emotional health. Knowledge and information generated from this study may help other policy-makers to adjust current and design new programmes for social organizations to take part in that help women who are refugees. Social organizations can put these programmes into practice, and research in the area of social tools to improve mental and/or emotional health can continue to develop.

It is my hope to connect with women to invite them to participate in this research project. I believe that you have unique understandings and stories relating to resettlement into Canada as a refugee from Syria and how social networks influence that process along with its impacts on health. During the course of this study, I will be conducting interviews with you as well as other women to gather their stories of social networks and their impacts on health resource-seeking behaviours. At the end of this study the publication of this thesis will share the knowledge from this study with other health researchers, policy professionals, and community members.

What will happen during the study?

I'm inviting you to do a one-on-one interview [*telephone, video chat, or face –to-face*] that will take about 45 minutes. I will ask you questions about your social experiences since moving to Canada, your support systems in Syria and after leaving, your knowledge of mental and emotional health, and your reasons for moving to Canada, such as ‘what do you think of when I say family? Tell me about a person you have a strong bond with? And what challenges have you faced in moving to Canada?’. *I will use an audio recorder to make sure I don't miss what you say.* We can set up a time and place that works for us both.

Are there any risks to doing this study?

The risks involved in participating in this study are minimal. These risks are short term and relate primarily to you psychological and social feelings. Psychological risks include talking about social experiences which may bring forward emotions that are associated with loneliness, and remembrance of friends and family still facing strife in Syria. Social risks include a loss of control of information about self and loss of privacy in revealing information about social experiences, age, social group, and characteristics of friends/family.

Benefits:

It is unlikely that there will be direct benefits to you, however, by better understanding Syrian women's social experiences as they relate to mental and emotional health resource use, researchers and others may

be able to increase the availability of health resources which women who are refugees from Syria can use. Knowledge and information generated from this study may help other policy-makers to adjust current and design new programmes for social organizations to take part in that help women who are refugees. Social organizations can put these programmes into practice, and research in the area of social tools to improve mental and/or emotional health can continue to develop.

I will keep the personal information you tell me during the interview confidential. With your permission, anonymous quotations may be used in publications/presentations resulting from this study, this will be done without sharing any personal information. Other data from this research which will be shared or published will be the combined data of all participants, meaning it will be reported for the whole group not for individual persons.

Protecting your confidentiality:

All information that could identify you will be removed from the data we have collected immediately after the interview and stored separately. We will keep identifying information for a minimum of one (1) year and our study records for a minimum of one (1) year. Data will be stored on a password encrypted laptop. You can withdraw consent to participate and have your data destroyed by contacting us within this time period. Only those associated with this study will have access to these records which are password protected. It is not possible to withdraw your consent once papers and publications have been submitted to publishers. All records will be destroyed according to University of Waterloo policy.

When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you.

Remuneration:

If you choose to participate in the study completely, you will receive a \$25.00 giftcard to Walmart. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

Voluntary participation:

- Your participation in this study is voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop we will destroy all data given to us by you up to that point
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- The resource center/clinic through which you learned about this study will not know who has taken part in the study and that participation will not affect the services the participant is receiving.
- By agreeing to participate in the study you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.
- If you have any questions about this study or would like more information you can email Shreya Mahajan at s23mahajan@uwaterloo.ca or Samantha Meyer at samantha.meyer@uwaterloo.ca or (519) 888-4567, ext. 39187

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#40284). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

I would be pleased to send you a short summary of the study results when I finish going over our results. Please let me know if you would like a summary and what would be the best way to get this to you.

If you would like to seek mental health resources upon completion of this interview, please visit Good2Talk, where you will be able to call a confidential hotline. You can also call them at 1-866-925-5454.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me by *email at s23mahajan@uwaterloo.ca*. You may also contact my supervisor, *Samantha Meyer* at (519) 888-4567, ext. 39187 or by email *samantha.meyer@uwaterloo.ca*.

I hope that the results of my study will be beneficial to you and to your community as well as the broader research community. I very much look forward to speaking with you and thank you in advance for your assistance with this project.

Yours sincerely,

Shreya Mahajan
Master's of Candidate
School of Public Health and Health Systems
University of Waterloo
s23mahajan@uwaterloo.ca

Dr. Samantha Meyer
Associate Professor
School of Public Health and Health Systems
University of Waterloo
samantha.meyer@uwaterloo.ca
(519) 888-4567, ext. 39187

Appendix 5: Written Consent Form

CONSENT FORM

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about a study being conducted by Shreya Mahajan, under the supervision of Dr. Samantha Meyer of the School of Public Health and Health Systems at the University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time without penalty by advising the researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#40284). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Shreya Mahajan at s23mahajan@uwaterloo.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

YES NO

I agree to have my interview audio recorded.

YES NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

YES NO

Participant Name: _____ (Please print)

Participant Signature: _____

Witness Name: _____ (Please print)

Witness Signature: _____

Date: _____

Appendix 6: Oral Consent Script

The Influence of Social Networks on Mental and Emotional Health Resource-Seeking Behaviours Amongst Women who are Refugees from Syria:

Principal Investigator: Shreya Mahajan

Co-Researchers: Dr. Samantha Meyer, Dr. Elena Neiterman, Dr. John Garcia

Oral Consent Script

Introduction:

Shreya Mahajan is conducting interviews about how social networks impact how women from Syria seek mental and emotional health resources. I'm conducting this as part of master thesis research at The School of Public Health and Health Systems at the University of Waterloo in Waterloo, Ontario. I'm working under the direction Dr. Samantha Meyer in University of Waterloo's School of Public Health and Health Systems.

You were given information about this study. You were given my contact information through the consent/information form and recruitment poster.

What will happen during the study?

I'm inviting you to do a one-on-one interview *telephone or video chat* that will take about 45 to 60 minutes. The purpose of this study is to provide important knowledge about mental and emotional health in relation to social experiences. Findings may help to improve current resources and create new health resources that are currently available to women who are refugees from to better their mental and/or emotional health. I will ask you questions about your social experiences since moving to Canada, your support systems in Syria and after leaving, your knowledge of mental and emotional health, and your reasons for moving to Canada, such as 'what do you think of when I say family? Tell me about a person you have a strong bond with? And what challenges have you faced in moving to Canada?'. *I will use an audio recorder to make sure I don't miss what you say.* We can set up a time that works for us both.

Are there any risks to doing this study?

The risks involved in participating in this study are minimal. These risks are short term and relate primarily to you psychological and social feelings. Psychological risks include talking about social experiences which may bring forward emotions that are associated with loneliness, and remembrance of friends and family still facing strife in Syria. Social risks include a loss of control of information about self and loss of privacy in revealing information about social experiences, age, social group, and characteristics of friends/family.

Benefits:

It is unlikely that there will be direct benefits to you, however, by better understanding Syrian women's social experiences as they relate to mental and emotional health resource use, researchers and others may be able to increase the availability of health resources which women who are refugees from Syria can use. Knowledge and information generated from this study may help other policy-makers to adjust current and design new programmes for social organizations to take part in that help women who are refugees. Social organizations can put these programmes into practice, and research in the area of social tools to improve mental and/or emotional health can continue to develop.

I will keep the personal information you tell me during the interview confidential. With your permission, anonymous quotations may be used in publications/presentations resulting from this study. This will be done without sharing any personal information. Other data from this research which will be shared or published will be the combined data of all participants, meaning it will be reported for the whole group not for individual persons.

Protecting your confidentiality:

All information that could identify you will be removed from the data we have collected immediately after the interview and stored separately. We will keep identifying information for a minimum of one (1) year and our study records for a minimum of one (1) year. Data will be stored on a password encrypted laptop. You can withdraw consent to participate and have your data destroyed by contacting us within this time period. Only those associated with this study will have access to these records which are password protected. It is not possible to withdraw your consent once papers and publications have been submitted to publishers. All records will be destroyed according to University of Waterloo policy.

When information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you.

Remuneration:

If you choose to participate in the study completely, you will receive a \$25.00 giftcard to Walmart. The amount received is taxable. It is your responsibility to report this amount for income tax purposes.

Voluntary participation:

- Your participation in this study is voluntary.
- You can decide to stop at any time, even part-way through the interview for whatever reason
- If you decide to stop participating, there will be no consequences to you.
- If you decide to stop we will destroy all data given to us by you up to that point
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- The resource center/clinic through which you learned about this study will not know who has taken part in the study and that participation will not affect the services the participant is receiving.

Shreya Mahajan, Oral Consent Script (Version 01/21/2019) Page 3 of 3

- By agreeing to participate in the study you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.
- If you have any questions about this study or would like more information you can email Shreya Mahajan at s23mahajan@uwaterloo.ca or Samantha Meyer at samantha.meyer@uwaterloo.ca or (519) 888-4567, ext. 39187. You can also contact me on WhatsApp at (647) 985-4262.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#40284). If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

I would be pleased to send you a short summary of the study results when I finish going over our results. Please let me know if you would like a summary and what would be the best way to get this to you.

Consent questions:

- • _Do you agree to have your interview audio-recorded?

[If yes, begin the interview.]

[If no, thank the participant for his/her time.]

- • _Do you agree to the use of quotes from your interview, with all personal information removed?

[If yes, begin the interview.]

[If no, thank the participant for his/her time.]

- • _Do you have any questions or would like any additional details? *[Answer questions.]*

- • _Do you agree to participate in this study knowing that you can withdraw at any point with no consequences to you?

[If yes, begin the interview.]

[If no, thank the participant for his/her time.]

Appendix 7: Interview Guide

*** Before questions are asked, participants will be reminded that they can skip any questions that they do not feel comfortable answering ***

1. What do you think of when I say family? (Probes: who is family? Are they all blood relatives?)
2. How has your family helped you in the past? What sort of things have they done for you that made you feel safe?
3. Tell me about a person that you have a strong bond with? Why do you have a strong bond?
4. Do you interact with both men and women? (Probes: where? Why?)
5. Tell me about your experience when transitioning to Canada. (Probes: What was the process you had to go through? What was hard about it? What services did you have access to in order to help?)
6. When did you arrive to Canada?
7. Have you become friends with anyone who is not a Syrian?
8. How do you define friendship?
9. Who did you spend most of your time with in your home country and how did that change when you arrived in Canada? (Probes: who came with you?)
10. What challenges have you faced in moving to Canada? (Probes: have you sought support? Do you have the same/different problems as those around you?) were there resources to learn about the laws and rights in Canada?
11. How do your social supports react when you come to them explaining negative emotions? (Probes: negative/positive, what kind of advice do they give you, if any?)
12. Have you ever spoken about negative emotions in a group setting? How did you feel after? What did you do?
13. Tell me about a time that you told someone about any feelings about transitioning. (Probes: was it hard? Why? Who did you talk to? Why did you talk to them and not others? Did it make you feel better or worse?)

Appendix 8: Appreciation Letter

Dear Participant,

I would like to thank you for your participation in this study entitled “The Influence of Social Networks on Mental and Emotional Health Resource-Seeking Behaviours Amongst Women who are Refugees from Syria”. As a reminder, the purpose of this study is to provide important knowledge about this growing population in Canada. Additionally, the analysis of information collected from this study may help to further inform and improve mental and emotional health-resources that are available to women who are refugees from Syria that desire heightened mental and/or emotional health.

The data collected during interviews will contribute to a better understanding of the appropriate direction of future development of resources and information necessary for the development and implementation of increased mental and emotional health for Syrian women who are refugees in Canada.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#40284) If you have questions for the Committee contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

For all other questions contact Shreya Mahajan by email at s23mahajan@uwaterloo.ca or faculty supervisor, Samantha Meyer at 519-888-4567, ext. 39187 or by email at samantha.meyer@uwaterloo.ca.

Please remember that any data pertaining to you as an individual participant will be kept confidential. Once all the data are collected and analyzed for this project, I plan on sharing this information with the research community through thesis paper and defense, seminars, conferences, presentations, and journal articles. If you are interested in receiving more information regarding the results of this study, or would like a summary of the results, please provide your email address, and when the study is completed, anticipated by August 2019, I will send you the information. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

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