SUPPORTING THE MENTAL HEALTH AND WELLBEING OF SYRIAN ADULTS WITH REFUGEE EXPERIENCES: CONSIDERATIONS FOR THE NURSE PRACTITIONER IN CANADA

by

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ABSTRACT

Synthesizing the findings from diverse methodologies, this integrative review aimed to guide nurse practitioners (NPs) in supporting the mental health and wellbeing of Syrian adults with refugee experiences in Canada (Syrian Adults). A comprehensive search strategy was conducted in three databases (APA PsycInfo, MEDLINE with Full Text (EBSCO) and Web of Science), Google Scholar and Google Search Engine to identify relevant literature. Twelve publications met the inclusion criteria and were critically appraised. The analysis of these publications led to the identification of four key themes: (1) Correlates and Social Determinants of Mental Health, (2) Cultural and Linguistic Considerations (including the subthemes of Stigma and Perceptions of Mental Distress; and Screening and Self-Report Tools), (3) Non-Clinical Facilitators of Mental Wellbeing, and (4) Trauma and Provision of Trauma-Informed Care. The findings of this integrative review highlight the importance for NPs to build their foundational knowledge to provide comprehensive, culturally appropriate, and trauma-informed care. Key strategies include the use of validated mental health screening tools tailored for Arabic-speaking and/or refugee populations, fostering trust and safety through an awareness of the role of stigma and trauma in mental health care, utilizing interpreters and cultural brokers where appropriate, and assessing social determinants of health during routine assessments. This review also emphasizes the importance of interagency collaboration and ongoing professional development in cross-cultural mental health to support access to care and mental wellbeing for Syrian Adults.

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ACKNOWLEDGEMENT

"Perhaps home is not a place but simply an irrevocable condition" – James Baldwin

Thank you to my dear parents, Manizheh and Kevin, and siblings, Shaida and Adrian, for your unconditional support in everything I pursue. Thank you, Mom and Dad, for raising us to see *all* humans as inherently noble and worthy of compassion and dignity. Thank you for your willingness to evolve and grow and welcome conversations that are difficult but necessary.

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Dedicated to RS, MZ, BW and EW. I miss you.

CHAPTER I: INTRODUCTION

According to The United Nations Refugee Agency (formerly United Nations High Commissioner for Refugees [UNHCR], 2024), Syria has experienced the "largest displacement crisis in the world" due to nearly 14 years of civil unrest and internal and international conflict (para. 1). While most affected Syrians have been displaced internally or to neighbouring countries (including Egypt, Lebanon, Iraq, Jordan and Türkiye) (UNHCR, 2024), over 100,000 Syrians have resettled in Canada since 2016 (Government of Canada [GOC], 2024a). Syrians seeking refuge in Canada are either government-assisted, privately sponsored, or they arrive via a blended visa officer-referred status. These newcomers to Canada have resettled in 350 communities across the country (GOC, 2024b).

Conflict, displacement, and uncertainty, combined with challenges of resettlement such as isolation, language barriers and discrimination, can harm the mental health of Syrian adults who have resettled in new countries (Hassan et al., 2015). This may lead to emotional, cognitive, and physical symptoms, as well as interpersonal difficulties (Hassan et al., 2015). However, such distress is not always a diagnosable disorder unless it is significantly disruptive and meets certain diagnostic criteria (Hassan et al., 2015). Supporting the mental wellbeing of resettled Syrian adults requires a consideration of pre-existing conditions, experiences of displacement, and the realities of starting their lives over in a new country (Almoshmosh et al., 2020; Hassan et al., 2015).

In Canada, there are many barriers that hinder the provision of adequate mental health care to those Syrian adults who have refugee experiences, including limited transcultural provider knowledge, gaps in client knowledge about available services, communication challenges, and stigma associated with mental health concerns (Wylie et al., 2018). The

inconsistency of current practices regarding transcultural mental health assessment stems from a lack of standardized tools, varied provider knowledge and comfort levels, and systemic barriers such as financial and time constraints (Wylie et al., 2018). These constraints often result in healthcare providers making ad hoc adaptations to their current practices, and this often leads to fragmented and inadequate evaluations that fail to fully address diverse cultural and linguistic needs (Wylie et al., 2018). Presentations of psychiatric distress or psychological disorders tend to be deeply culturally embedded; therefore, attempts to simply apply Western-based screening tools or assessment parameters, without adequate consideration of cultural differences, can lead to bias and inaccuracy when diagnosing and caring for these patients (Wylie et al., 2018).

Included in their role as primary care providers, NPs are educated and responsible to assess, diagnose and help manage mental health concerns throughout the lifespan; however, far beyond mental health diagnoses, NPs are responsible for providing comprehensive care that is culturally sensitive, understanding social determinants of health and advocating beyond clinic settings (British Columbia College of Nurses & Midwives [BCCNM], 2024).

The aim of this integrative review (IR) is to synthesize findings from diverse methodologies to guide NPs in supporting the mental health and wellbeing of Syrian Adults. Specifically, it aims to identify the considerations and strategies that NPs should consider using to support the mental health and wellbeing of this population. This IR seeks to equip both entry-level and seasoned NPs with insights into the effects of trauma, chronic displacement, cultural and linguistic differences, and other influences on the provider-patient relationship and individual mental health outcomes. When NPs lack awareness of these influences on mental health, they are unlikely to appropriately screen, identify or manage the mental wellbeing of

Syrian Adults and the care they provide may ultimately be inadequate or inappropriate to the actual need (Wylie et al., 2018).

The synthesized findings of this IR address a range of mental health predictors, spanning individual, social, and societal factors. It will also bring attention to several validated screening and assessment tools and highlight culturally sensitive and trauma-informed management and care strategies. This review therefore identifies practical strategies and broader considerations relevant to the Canadian NP scope of practice and is guided by the research question: *what strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?*

CHAPTER II: BACKGROUND

This chapter provides context to explain and clarify key concepts contained within the research question. It begins with a brief overview of the global and political realities that led to increased numbers of Syrians having to flee their country, followed by possible pathways to resettlement for refugees to Canada. Subsequently, a review of mental health and psychosocial wellbeing as a concept is provided as well as an explanation of the primary care framework. A brief discussion is provided about the potential mental health outcomes for persons who have experienced displacement, conflict and trauma. Finally, the breadth of the NP role is reviewed next, including their responsibilities in the mental health and psychosocial domain, their competencies as both clinicians and advocates and why NPs are conveniently situated in primary care settings to identify and manage many of these outcomes (BCCNM, 2024).

Syrian Crisis

Situated in West Asia, the Syrian Arab Republic (Syria) is bordered by the Mediterranean Sea and several countries, including Iraq, Jordan, Türkiye, Lebanon, and Israel. As a result of the ongoing unrest, violence, and instability in their home country, millions of Syrians have been displaced internally, sought asylum in neighbouring countries, and resettled throughout the globe (UNHCR, 2024).

Using authoritarian control, the al-Assad family shaped the Syrian political landscape for over 50 years as they attempted to balance economic interests, sectarian dynamics and regional alliances (Bin Saleem et al., 2024). After 30 years in power, Hafez al-Assad's death in 2000 lead to his son, Bashar, coming into power, with national hopes that he would reform and modernize Syria (Bin Saleem et al., 2024). Tragically, instead of reform and modernization, Bashar al-Assad intensified his father's leadership style, leading to one of the most tragic civil conflicts of

the century (Bin Saleem et al., 2024). For decades, Syria has had a tumultuous history, with the most recent 14 years marked by significant political, civil and international unrest involving multiple domestic and international parties (Bin Saleem et al., 2024). While the al-Assad regime was durable, it relied on powerful security forces, widespread patronage relations and deep interconnectedness between the state and segments of Syrian society (Bin Saleem et al., 2024).

As part of the broader political and economic uprisings in the region (i.e. Arab Spring movements), peaceful protests broke out in Syria in 2011 marking a turning point in the country's relative stability (Bin Saleem et al., 2024). Syria descended into a civil war marked by increased militarization, violent suppression of dissent, widespread destruction, over 500 000 deaths and the displacement of over half the population (Bin Saleem et al., 2024). Proxy wars, backed by Russia, Iran and Western and Arab nations further destroyed Syria's economy and amplified the humanitarian crisis (Bin Saleem et al., 2024).

Although the December 8, 2024, overthrow of Syrian President Bashar al-Assad, and the subsequent toppling of a decades-long family rule, led to eruptions of celebrations across the nation, it remains unclear what the future of Syria will look like (Al Jazeera, 2024).

Paths to Resettlement in Canada

There are three possible paths to resettlement for refugees who wish to resettle in Canada:

1. the Government-Assisted Refugees (GAR) program;
2. the Private Sponsorship of Refugees (PSR) program; and
3. the Blended Visa Office-Referred (BVOR) program (UNHCR, n.d.).

Under the GAR program, UNHCR or stated-registered refugees (while still in their country of asylum) are referred for resettlement by UNHCR or other partners and, if accepted,

receive government support and financial assistance for up to one year in Canada (UNHCR, n.d.). As a GAR, the GOC delivers support through non-governmental agencies called service provider organizations (GOC, 2024c). Under the PSR program, Canadian citizens or permanent residents can privately sponsor individuals or families who qualify under the Canadian refugee and humanitarian program (UNHCR, n.d.). Resettled refugees admitted to Canada under the PSR program are also supported for up to one year following arrival; however, the financial support and settlement assistance is provided by the private sponsors (UNHCR, n.d.). The BVOR program is a shared sponsorship in which refugees identified for resettlement by UNHCR are matched with private sponsors, but the financial cost is then shared between the Canadian government and private sponsors (UNHCR, n.d.).

Operation Syrian Refugees

In November 2015, the GOC commenced Operation Syrian Refugees (OSR) which led to the resettlement of 25 000 Syrian refugees over the course of 100 days (GOC, 2017). Resettled Syrians were welcomed to Canada through all three paths to resettlement, with the majority using the GAR program (GOC, 2017). Registered refugees in Jordan and Lebanon were initially contacted by the UNHCR and offered resettlement (GOC, 2024d). Privately sponsored refugees with submitted applications were subsequently approached and then, in collaboration with the Government of Türkiye, registered refugees in Türkiye were also offered resettlement opportunities in Canada (GOC, 2024d).

Syrians resettled through OSR received support comparable to provincial social assistance, intended to cover the cost of necessary items such as clothing, food, shelter, boots, winter coats, furniture, linen and basic household items (GOC, 2024e). Like all resettled refugees, Syrians could receive help with essential services (e.g. opening a bank account or

obtaining a Social Insurance Card) through the Resettlement Assistance Program and receive medical coverage under the Interim Federal Health Program (GOC, 2024e). Additionally, language training, vocational searches, and community support could be accessed through regular settlement services (GOC, 2024e). Refugees settled through the PSR program lived in their sponsors' communities and were reported to receive similar levels and types of support as those who resettled through the GAR program (GOC, 2024e).

Mental Health and Psychological Wellbeing

The World Health Organization (WHO, 2022) describes mental health as a necessary part of wellbeing, shaping the way in which we form relationships, make decisions, manage stress, learn and work, and contribute to our communities. Additionally, greater mental health is often associated with improved self-esteem, better coping skills, and resiliency (GOC, 2020).

Far more nuanced than the absence of mental illness, mental health and wellbeing exist on a spectrum and are experienced uniquely by each person (WHO, 2022). Individual, social and structural factors can act as either barriers or facilitators to positive mental wellbeing and, collectively, these factors affect one's position on the mental health spectrum (WHO, 2022).

Displacement, Conflict, and Mental Health

Exposure to conflict, singular or repeated displacement from one's homeland, and "profound uncertainty about the future" (Hassan et al., 2015, p. 14) have known negative effects on mental wellbeing and these effects may be worsened by the challenges of settling in a new country, including poverty, lack of social supports, isolation, linguistic and cultural barriers, loss of identity and discrimination from host communities. Struggles with mental and psychosocial wellbeing may manifest in a variety of: (a) emotional concerns, including sadness, fear, and anxiety; (b) cognitive challenges including worry, hopelessness, and helplessness; and/or (c)

physical symptoms including fatigue, sleep disruptions, loss of appetite, and/or other somatic complaints (Hassan et al., 2015). Additionally, distress may manifest in increased interpersonal challenges, withdrawal from others, and/or aggression towards others (Hassan et al., 2015). The experience of distress and its associated emotional, cognitive, physical, and behaviour struggles may be identified in Syrian Adults but will not always equate to a diagnosable disorder unless the distress has manifested in a significant, notable impact on daily activities and the signs and symptoms have met mental illness diagnostic criteria (Hassan et al., 2015).

Understanding the pre-existing mental health status of Syrian Adult clients, the impact of their migration and resettlement journey, and their post-migration realities in Canada is essential to providing appropriate and adequate primary healthcare services to this population. This can be challenging for primary care providers in particular given that distress can arise from (1) pre-existing diagnoses, (2) the violations and abuses of conflict and the hardship(s) of the displacement journey, and/or (3) the challenges and current realities of resettlement in a new country (Almoshmosh et al., 2020; Hassan et al., 2015) or it can result from a combination of these factors that will be unique to each person's journey.

Primary Care

In Canada, primary care refers to the first-contact care provided by NPs, family physicians, and other general practitioners (Canadian Institute for Health Information [CIHI], n.d.). It involves provision of a range of care services, including routine or episodic care, chronic disease management, perinatal and childcare, urgent but minor presentations, home-care liaising, disease prevention, health promotion, nutritional advice and, notable, mental health care and psychological services (CIHI, n.d.). Principles of primary care emphasize continuity of care and a comprehensive approach to care that includes preventative, promotive, protective, curative,

rehabilitative, and palliative services (WHO, n.d.). Primary care also typically includes coordination between health services and people-centred approaches, thereby ensuring that clients have the information needed to participate meaningfully in their own care (WHO, n.d.).

Nurse Practitioners

NPs are registered nurses who have pursued additional education at the master's level, providing them with the theoretical knowledge and clinical skills to autonomously manage health care throughout the age span (BCCNM, 2024). As part of evidence-informed practice and within primary care settings, NPs are responsible for conducting mental health assessments and understanding contributors to the wellbeing of their clients, including social, psychological, and emotional factors (BCCNM, 2024). Concurrent with their roles as clinicians, NPs engage in education, scholarship, leadership, and advocacy for the wellbeing of their clients and positive public policy (BCCNM, 2024).

As clinicians, NPs assess, diagnose, manage, counsel and coordinate clinical care (BCCNM, 2024). As advocates, the NP role may extend beyond the clinical setting as they work to improve the health and wellbeing of their clients, focus on health inequities, and lead efforts to influence policy in a positive manner (BCCNM, 2024). NP practice calls for cultural humility, an assessment of one's biases and positionality, and efforts to create a practice environment that is sensitive to the unique needs of each client (e.g. culture, lived experiences, and personal expression) (BCCNM, 2024). As part of providing care to their clients, NPs promote equitable service delivery, work to mitigate systemic barriers, challenge social structures that enable oppression, and advocate for resources that enable cultural safety (BCCNM, 2024). Because they are typically the first point contact for Syrian Adults within

Canadian healthcare, primary care providers, such as NPs, are particularly well-placed to recognize distress symptoms early and intervene more quickly than other practitioners.

CHAPTER III: METHODS

Study Design

An IR, guided by the framework of Whittemore and Knafl (2005) and the step-by-step guide of Toronto and Remington (2020), was completed. IRs allow for a broad sampling of diverse research and methodologies, including experimental and non-experimental studies, theoretical literature, and empirical literature, leading to a more comprehensive understanding of a phenomenon (Whittemore & Knafl, 2005). Similar to a systematic review, an IR requires a transparent and systematic approach, and this IR was guided by a five-stage methodological approach (Toronto & Remington, 2020). These stages are: (1) formulation of a review question or purpose statement; (2) design and performance of systematic and comprehensive search strategy leading to the selection of relevant literature; (3) critically appraising the methodology of the chosen literature; (4) comparing, analyzing and synthesizing data extracted from the chosen literature; and (5) presenting review findings, discussing their implications for practise, policy, and research, and then presenting the limitations and strengths of the review itself (Toronto & Remington, 2020).

Literature Search Strategy and Results

The databases APA PsycInfo, MEDLINE with Full Text (EBSCO) and Web of Science were searched in October 2024 using a combination of search terms to identify literature that explored the mental and/or psychosocial wellbeing of Syrian refugee adults in Canada. APA PsycInfo was chosen for its indexing of vetted publications in behavioural and social sciences and is considered a credible source for psychology research (American Psychological Association [APA], 2025a). The MEDLINE database was searched because of its comprehensive inclusion of journal articles exploring life sciences and biomedicine (Lawless &

Foster, 2020). Web of Science was chosen due to its extensive inclusion of multidisciplinary journal articles, covering a range topics, including psychological, medical and social sciences (Lawless & Foster, 2020). Both Google Scholar and Google Search Engine were strategically included in the search strategy to allow the search to be comprehensive and capture potential articles not indexed in the above databases.

With guidance from an experienced University of Northern British Columbia (UNBC) librarian, the search used various combinations of the following terms: 'Syria*', 'refugee*', 'asylum*', 'displaced*', 'mental health', 'mental wellbeing', 'psychological', 'mental wellness', 'Canada', 'Canadian' and all province names. The included studied were restricted to English language publications and work published between 2016 and present day (see Table A1 in Appendix A for complete search terms). Results were uploaded into an open-source reference management tool, Zotero, screened according to inclusion and exclusion criteria and cleared of ten duplicates. Publications met inclusion criteria if they were the result of qualitative or quantitative empirical studies, expert-led practical guidelines or systematic reviews, focused on Syrians adults in Canada with refugee experiences and had a focus on mental or psychosocial wellbeing (full inclusion and exclusion criteria, with rationale, can be found in Table A2 of Appendix A). One article (Kassam et al., 2023) was obtained through direct contact with O'Mahony who co-authored O'Mahony et al. (2023) with Kassam. Using a flow diagram (Figure A1 in Appendix A), the search strategy is depicted, narrowing from the initial 142 publications identified from searches of the databases, Google Scholar, and Google Search Engine, to the 12 that were ultimately selected for inclusion in this IR. After identifying the 12 articles to be included in the IR, a reference search of each article was performed, and no further relevant articles were identified.

Data Evaluation and Appraisal

The overall quality of each publication was appraised using a modified combination of tools from Joanna Briggs Institute (JBI) (McArthur et al., 2022), Critical Appraisal Skills Programme (CASP, 2024a, 2024b) and Johns Hopkins Evidence-Based Practice Critical Appraisal Tools (Dang et al., 2022). A subjective score of strong or moderate was assigned to each publication by the author based on an assessment of the clarity of purpose and findings, methodology, ethics, rigour of analysis, generalizability or transferability of findings, and relevance to the IR research question. In particular, publications were appraised based on the appropriateness of their method (e.g. qualitative vs quantitative, semi-structured interviews vs questionnaires vs surveys), the expertise of the authors (i.e. the authors of the expert-led guide), sample sizes and recruitment strategies. Additionally, the ethics of each publication was appraised, looking specifically at whether the authors considered the relationship between researchers and participants and whether informed consent or ethical approval was explicitly addressed (see Appendix B for full critical appraisal matrix). Transferability or generalizability to populations beyond the study population was also considered in the appraisal of each study. Six studies were given a strong score (Kuo et al., 2020; Kuo & Rappaport, 2024; Bridekirk et al., 2021, Ahmad et al., 2021; Newaz & Riediger, 2020; Almoshmosh et al., 2020) and six were given a moderate score (Abi Zeid Daou et al., 2024; Al-Hamad et al., 2023; Kassam et al., 2023; Mahajan et al., 2022, O'Mahony et al., 2023, Nakeyar & Frewen, 2016). In order not to exclude potentially relevant data, no articles were excluded based on their critical appraisal score; however, limitations of these studies have been identified within the Findings chapter and the Discussion chapter.

Data Extraction

Data was extracted from the 12 publications that were selected for inclusion in this IR. The relevant data extracted from each article was organized into matrices, with a separate matrix created for each type of study methodology (i.e. quantitative, qualitative, expert-led guide, and systematic review). Each primary source was reduced to a one-page summary that included the study's purpose or objective, any relevant conceptual or methodological frameworks used, study method and design, characteristics of participants, sample size, sampling method, main findings, and finally strengths, limitations and relevance to the IR research question. The guiding principle for this phase of the IR was to extract any data that would assist in answering the research question: *what strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?* All of the full data extraction matrices are shown in Appendix C.

Data Analysis

Once data extraction was complete, the author read through the completed matrices and colour coded the content by highlighting related subjects in the same colours. After two complete reviews of the data matrices with simultaneous colour coding, six themes emerged. Further analysis of this content resulted in several of the initial themes being merged together, leaving a total of four distinct themes that arose out of these 12 publications.

CHAPTER IV: FINDINGS

The purpose of this IR is to explore how NPs can support the mental wellbeing of Syrian Adults. Through a focused search of the literature conducted in accordance with the process set out in Chapter Three, 12 publications were identified as relevant to the research question and were included in this IR. One systematic review (Nakeyar & Frewan, 2016), seven qualitative studies (Abi Zeid Daou et al., 2024; Ahmad et al., 2021; Al-Hamad et al., 2023; Kassam et al., 2023; Mahajan et al., 2022; Newaz & Riediger, 2020; O'Mahony et al., 2023), three quantitative studies (Bridekirk et al., 2021; Kuo et al., 2020; Kuo & Rappaport, 2024), and one practical expert-led guide (Almoshmosh et al., 2020) that was intended for healthcare providers in high-income countries. These 12 publications were analyzed for the purpose of identifying the key considerations and strategies that can be used by NPs to support Syrian Adults in their care.

The three quantitative studies had sample sizes ranging from 235 to 1,805 adult participants, with all three including both men and women (Bridekirk et al., 2021; Kuo et al., 2020; Kuo & Rappaport, 2024). Participants in the studies by Kuo et al. (2020) and Kuo and Rappaport (2024) were living in Windsor, Ontario, at the time of their participation, while those in the Bridekirk et al. (2021) study were from locations all across Canada. The mean age of participants in the studies by Kuo et al. (2020) and Kuo and Rappaport (2024) was 36.6 years, whereas Bridekirk et al. (2021) reported participants as being "18 years or older" (p. 292).
The sample sizes among the qualitative studies ranged from 8 to 1,924 adult participants, with an average of 18 to 19 participants after removing the outlier study with 1,924 participants (Abi Zeid Daou et al., 2024; Ahmad et al., 2021; Al-Hamad et al., 2023; Kassam et al., 2023; Mahajan et al., 2022; Newaz & Riediger, 2020; O'Mahony et al., 2023). Six studies engaged only women (Abi Zeid Daou et al., 2024; Al-Hamad et al., 2023; Kassam et al., 2023; Mahajan

et al., 2022; Newaz & Riediger, 2020; O'Mahony et al., 2023), and among these, four specified that participants were also mothers (Abi Zeid Daou et al., 2024; Kassam et al., 2023; Newaz & Riediger, 2020; O'Mahony et al., 2023). Abi Zeid Daou et al. (2024) did not collect demographic information from participants "out of respect to their wishes" (p. 114); however, the authors noted that all participants were living in Quebec at the time of the study.

The Ahmad et al. (2021) study had equal representation of men and women, with participants from across Canada. The age distribution was as follows: 18–29 years (29.7%), 30–49 years (49.4%), and 50 years and older (20.9%). Participants in the study by Al-Hamad et al. (2023) were all living in Ontario for a minimum of one year and were between the ages of 21 and 60 at the time of participation. Kassam et al. (2023) and O'Mahony et al. (2023) conducted the same study, leading to two publications; this study engaged Syrian mothers living in British Columbia, aged 18 to 50 years. Mahajan et al. (2022) sampled Syrian women who had been living throughout Canada between 18 months to six years and were required to be "at least the age of 18 at the time of consent" to participate (p. 703). Finally, Newaz and Riediger (2020) interviewed adult Syrian women living in Winnipeg, Manitoba, though their ages and duration of stay in Canada were not specified.

The expert-led guideline, developed by Almoshmosh et al. (2020), was created by five experts in the fields of transcultural psychiatry and refugee health psychiatry. This guideline did not involve direct participant data collection or reporting. The expert authors had either completed PhDs in psychiatry or refugee health psychiatry, coordinated mental health responses in refugee crises, or had multiple publications on Syrian and/or mental health subjects.

The single systematic review included in this IR, conducted by Nakeyar and Frewen (2016), examined 17 manuscripts concerning Syrian, Iraqi, or Kurdish refugees in developed

countries (i.e. Australia, North America, Western Europe, Scandinavian countries). Additional inclusion criteria for the systematic review required manuscripts to: (1) convey data on PTSD according to DSM-IV criteria, (2) be published in English, (3) include only primary research, systematic reviews, meta-analyses, or literature reviews, and (4) be written after 2011 (noted as relevant to the currency of the Syrian crisis at the time of the study) (Nakeyar & Frewen, 2016).

A comparison and synthesis of the content of these 12 articles led to the identification of four themes: (1) Correlates and Social Determinants of Mental Health, (2) Cultural and Linguistic Considerations, (3) Non-Clinical Facilitators of Mental Wellbeing, and 5) Trauma and Provision of Trauma-Informed Care. The Cultural and Linguistic Considerations theme was further divided into two subthemes: Stigma and Perceptions of Mental Distress; and Screening and Self-Report Tools.

Theme 1: Correlates and Social Determinants of Mental Health

Much of what has been synthesized in this theme relates to post-resettlement stressors and positive and negative correlates of mental health (Ahmad et al., 2021, Almoshmosh et al., 2020; Bridekirk et al., 2021; Kuo et al., 2020; Kuo & Rappaport, 2024; Mahajan et al., 2022; Newaz & Riediger, 2020). Collectively, these findings confirm that mental wellbeing is deeply influenced by the interaction between individual factors and broader social and structural determinants of mental health. Newaz and Riediger (2020) encouraged providers to be aware of the range of individual, community, societal, and relationship factors that may place clients at risk for lower mental health and wellbeing. The authors highlighted social determinants such as level of education, employment stability, social status, and community or peer support as areas of focus for improving refugee women's mental health services (Newaz & Riediger, 2020).

Social determinants of mental health refer to a person or community's living and working circumstances that may shape or influence mental health outcomes (Alegría et al., 2018). The WHO and Calouste Gulbenkian Foundation (2014) report that social determinants of health may include parental and family factors, life course events, sex/gender, social isolation, housing and built environment, and national and policy contexts. Other social determinants associated with mental health include employment conditions, discrimination, familial relationships, race/ethnicity, sexual orientation, migration status, social support and community belonging (Alegría et al., 2018). Social determinants are understood to have a deep influence on mental health inequities, by impacting both the risk of developing mental health disorders and one's ability to access quality mental health services (Alegría et al., 2018).

Using correlation analyses in a quantitative study, Kuo et al. (2020) studied correlates of mental health in a sample of 235 Syrian Adults living in Windsor, Ontario. The authors found that higher levels of mental health were related to the following protective factors: younger age, male, married, higher level of education, English language proficiency, sufficient finances to cover food costs, stable employment, perceived control over circumstances, lower reported stress, satisfaction with housing and healthcare services, and greater quality of friendships (Kuo et al., 2020).

Engaging the same participants as the study above, Kuo and Rappaport (2024) measured the temporal effects of depressive symptoms on stress, anxiety, perceived control over environment, perceived social support, and anxiety at baseline and then again at a one-year follow-up. The researchers found that participants who had depressive symptoms at baseline were also more likely to have lower self-efficacy, stronger feelings of helplessness, and lower levels of perceived control at baseline (Kuo & Rappaport, 2024). At follow-up one year later,

baseline depressive symptoms were correlated with lower self-efficacy, lower perceived control and social support, and higher anxiety (Kuo & Rappaport, 2024). The authors concluded that their findings support early depression-targeted screening and the urgency of early detection for newly arrived Syrian Adults given that depression is considered both an outcome of displacement and an "antecedent risk factor" in the settlement process (Kuo & Rappaport, 2024, p. 590).

Complementing the predictors identified in the Kuo et al. (2020) study, Ahmad et al. (2021) found the following factors to correlate with moderate or severe depression at both baseline and year two of their study: female, fewer friends, lower level of education, financial struggles, unemployment, lower English proficiency, being Muslim, living in Ontario, being resettled through the GAR process (versus PSR) and being divorced, widowed, or separated from a partner. The strongest predictor of depression at year two was baseline depression; participants with moderate depression at baseline were ten times more likely to experience moderate depression in year two (Ahmad et al., 2021). Further, moderate to severe depression at year two in the study was associated with lower satisfaction in housing and health services, lower levels of perceived control and social support, and having lived in Canada longer (Ahmad et al., 2021). These findings aligned with Kuo and Rappaport (2024) as they both identified baseline depression as a predictor or correlate of future depression and levels of satisfaction with multiple important areas of adult life.

In addition to the correlates mentioned above, Almoshmosh et al. (2020) noted that, when Syrian Adults presented in the primary care environment with somatic symptoms such as nausea, dizziness, headaches, appetite changes, and insomnia, this could provide an opportunity for practitioners to assess the mental wellbeing of Syrian Adults in their care.

In their practical guide for healthcare providers, Almoshmosh et al. (2020) outline the potential settlement stressors that practitioners should consider when caring for Syrian Adults. Pre-settlement stressors may include isolation, loss of cultural or linguistic identity, and discrimination; post-settlement stressors may involve social isolation, unemployment, lack of vocational or educational opportunities, discrimination, and language barriers (Almoshmosh et al., 2020). Almoshmosh et al. (2020) encouraged providers to consider potential barriers to services that may otherwise seem readily available, including linguistic barriers, challenges with acculturation, or difficulty covering the direct or indirect costs of mental health services (e.g. transportation or medications) (Almoshmosh et al., 2020).

A lack of familiarity with Western perspectives on mental health, the process of making appointments, therapy as a concept, the process for specialist referrals, and mental illnesses being illness like “any other diseases” were identified as knowledge gaps among refugee women in the qualitative study by Newaz and Riediger (2020, p. 3).

Unemployment was mentioned numerous times as a source of stress for the participants as income was considered intricately connected with social status and mental wellbeing (Newaz & Riediger, 2020). Being on social assistance made many participants feel like a burden as they did not want to rely on social assistance programs; at the same time, their language abilities or unrecognized education and skills were barriers to stable, meaningful employment (Newaz & Riediger, 2020). Service provider participants in this study added that finding employment would serve multiple purposes, since job opportunities could provide Syrian women with the opportunity to strengthen their English language proficiency, another correlate of better mental health outcomes (Kuo et al., 2020; Newaz & Riediger, 2020).

Naming isolation and loneliness as significant sources of stress, the participants in Newaz and Riediger's (2020) research identified socialization and networking as beneficial to mental wellbeing. Although making connections in the greater community was identified as important to mental health, the refugees in this study still found comfort in gathering with other Syrians, speaking one's native language, and sharing common struggles (Newaz & Riediger, 2020). Furthermore, being able to speak with peers who had arrived in Canada earlier was identified as a source of guidance and support during the participants' settlement period (Newaz & Riediger, 2020).

The role of social networks was also explored by Mahajan et al. (2022). In their study, social networks included friendship, family, sponsors, and service providers (Mahajan et al., 2022). Beyond the role of stigma that was previously discussed, social networks such as long-time friendships or sponsors were identified as an alternative to formal mental health care for some participants (Mahajan et al., 2022). Some participants noted that social networks could encourage women to identify their mental and physical health needs and seek help when they needed it (Mahajan et al., 2022). Of note, social networks were also identified as a potential contributor to non-uptake of mental health services due to a lack of cultural competence (by providers), stigma (within and from any social network), or simply not considering these services because of the informal support found through social networks (Mahajan et al., 2022). The authors reflected on the importance of fostering social networks and emphasized the value of Syrian Adult women speaking directly with other women refugees as a way of assessing their needs and desires pertaining to mental health services (Mahajan et al., 2022).

Level of education and quality of employment were also associated with measures of mental and psychosocial wellbeing, although not always in a linear fashion (Bridekirk et al.,

2021). Interestingly, Bridekirk et al. (2021) found that, among employed participants, those with moderate to high levels of education reported higher levels of stress, compared with participants with lower levels of education. The same moderate to highly educated participants reported lower perceived control and lower general health, using the RAND-36 scale (Bridekirk et al., 2021). Bridekirk et al. (2021) attribute these correlations to a 'relative deprivation' explanation, suggesting that refugees with higher levels of education might have had greater expectations for their employment in the new country, leading to dissatisfaction when their jobs do not align with their education qualifications. Expounding upon their findings, the authors reported that general mental health was positively correlated with perceived control over life circumstances, job appropriateness, job satisfaction, and wage satisfaction, and negatively correlated with reported levels of stress (Bridekirk et al., 2021).

Theme 2: Cultural and Linguistic Considerations

When providers focus on culturally responsive approaches to mental health services, they can help interrupt a series of negative events that could impact mental wellbeing (Kuo & Rappaport, 2024). Many authors outlined the importance of cultural and linguistic sensitivity when caring for Syrian Adults, including the need to create safe environments, to be aware of cultural variations of demonstrating distress and interpreting the meaning of distress, to ensure the availability of professional interpretation services, and to consider cultural brokerage when appropriate (Abi Zeid Daou et al., 2024; Ahmad et al., 2021; Al-Hamad et al., 2023; Almoshmosh et al., 2020; Kuo et al., 2020; Kuo & Rappaport, 2024; Newaz & Riediger, 2020). Cultural brokerage is the act of linking, liaising or bridging gaps between groups with different cultural origins (e.g. between a patient and their provider or patient and the healthcare system) and this brokerage may aid in conflict resolution and system navigation (Cultural Brokers

Network of Canada [CBNC], 2023; Jezewski, 1999, as cited in CBNC, 2023). Almoshmosh et al. (2020) provide cross-cultural principles to consider when working with Syrian Adults, including establishing safe spaces by explaining care settings, clarifying privacy and confidentiality, respecting client traditions and customs, and providing adequate time for clients to share their stories in ways that are comfortable for them. The importance of privacy was also identified by Newaz and Riediger (2020), finding that many Syrian women would not share experiences of physical or sexual abuse or information about general sexual matters in front of a male companion.

Language stressors were identified as a theme in the work of Abi Zeid Daou et al. (2024) while Ahmad et al. (2021) reported that continued need for an interpreter one-year post-settlement was correlated with moderate to severe depression. Syrian mothers who participated in Abi Zeid Daou et al.'s (2024) study reported feelings of stress and exhaustion that were related to an ability to communicate with ease or having to translate for other family members. According to the participants, once the local language was learned, integration was made easier (Abi Zeid Daou et al., 2024). Syrian mothers who participated in O'Mahony et al.'s (2023) study similarly identified language skills as a potential barrier and a potential facilitator to healthcare access and overall societal integration. Engaging professional interpreters and/or cultural brokers was identified as one option that could close communication gaps between Syrian Adults and providers (Almoshmosh et al., 2020; Newaz & Riediger, 2020).

Stigma and Perceptions of Mental Distress

Several studies implicated either stigma, shame, or the pressure to hide negative affect as barriers to Syrian Adults seeking mental health services, speaking openly about their struggles,

or general transparency about personal distress (Abi Zeid Daou et al., 2024; Almoshmosh et al., 2020; Mahajan et al., 2022; Newaz & Riediger, 2020; O'Mahony et al., 2023).

In a collaborative review developed by multiple experts in the fields of mental health, transcultural psychiatry, and refugee mental health, Almoshmosh et al. (2020) cautioned that applying the labels 'psychiatric' or 'psychological' to emotional suffering can lead to stigma being attached to some Syrian Adults, leading to feelings of shame and embarrassment. As such, the authors identified stigma as a potential barrier to Syrian Adults seeking and receiving mental health services and they recommended that practitioners instead integrate mental health assessments into existing medical visits and avoid psychiatric labelling and jargon (Almoshmosh et al., 2020). Furthermore, the authors recommended that, when a health care provider is opening the discussion about mental health concerns, they should first discuss those manifestations of mental distress that carry less stigma, such as appetite, sleep, and concentration (Almoshmosh et al., 2020).

From semi-structured interviews with a small participant group of 12 Syrian women, focused on understanding the effect of social networks on the utilization of mental health resources, Mahajan et al. (2022) identified that a woman's social network(s) (e.g. family, friends, sponsors, healthcare professionals) can influence her perception of mental health services, including the degree of stigma associated with it, and thereby influence her reaction to care. This influence can result in patients either being dissuaded from, or encouraged to, engage in discussions about mental health and accept mental health services (Mahajan et al., 2022). These findings align with those of Almoshmosh et al. (2020), as the latter also highlighted the importance of assessing patients as individuals in order to understand their pre-existing

influences, opinions, or understandings about mental illness and to determine whether or not stigma does play a role for that particular individual.

Through their in-depth interviews and focus groups involving 40 Syrian women, O'Mahony et al. (2023) briefly touched on the concept of stigma, particularly in the context of language interpretation services. One participant shared that she felt she was finally being understood when she sought interpretation from a professional interpreter, with the authors noting that interpretation by a patient's family member during mental health care discussions could pose a potential "cultural risk" if there is a stigma attached to mental illness (O'Mahony et al., 2023, p. 13). The stigma described could also prevent proper mental health care due to improper, incomplete, or misinterpretation by family members (O'Mahony et al., 2023).

The need to overcome stigma, speak openly with one's provider, and request necessary services are some of the key recommendations made by a participant in a qualitative study by Newaz and Riediger (2020). In their thematic analysis of semi-structured interviews with 15 participants (including refugees, service providers, and decision makers), one refugee participant acknowledged the importance of overcoming stigma and asking for help directly, highlighting the fact that providers cannot know if help is needed without a certain level of transparency (Newaz & Riediger, 2020). The authors also noted the responsibility that providers have in providing a safe environment that a patient will believe is truly free of any further stigma or shame (Newaz & Riediger, 2020).

Finally, findings from Abi Zeid Daou et al. (2024)'s study of emotion work and coping in Syrian mothers who resettled in Canada further illustrated how stigma and perceptions of mental distress can act as barriers to emotional wellbeing. For example, the authors highlighted the pressure that many mothers felt to conceal their negative emotions and remain optimistic to

protect their family and friends (Abi Zeid Daou et al., 2024). The participants who concealed their emotions acknowledged that the pressure to present a positive attitude, despite actually experiencing distress, required a significant amount of energy (Abi Zeid Daou et al., 2024). The authors also noted that emotional regulation, such as self-concealment of one's true emotions in an attempt to protect loved ones, is correlated with anxiety, depressive symptoms, and psychological distress (Abi Zeid Daou et al., 2024).

Despite the smaller sample sizes in many of the above studies, the role of stigma and the pressure to remain positive or to conceal negative emotions were consistently identified, highlighting the prevalence of stigma as it relates to mental health.

Screening and Self-Report Tools

There is no shortage of screening and self-report tools available to explore mental health and wellbeing; however, many studies included in this review used tools that had been validated for use among Arabic-speaking communities and/or, specifically, among Syrian Adults (Almoshmosh et al., 2020; Kou et al., 2020; Kuo & Rappaport, 2024; Nakeyar & Frewen, 2016). Trauma-related tools are not discussed in this section as they will be addressed within a later theme. Examples of useful tools are listed below:

1) The WHO-5 Well-Being Index (see Table D1 in Appendix D) is a self-report tool used to measure mental wellbeing (WHO, 2024). Patients rate five statements relating to the previous two weeks on a scale of one to six; a higher final score correlates with better mental wellbeing (WHO, 2024). Almoshmosh et al. (2020) confirmed this tool as being valid for use among Syrian Adults.
2) The DSM-5 Cultural Formulation Interview (see Table D2 in Appendix D) is also recommended for use with the Syrian Adult population as it includes questions that

explore clients' views of mental illness, expectations for care, psychosocial stressors, and supports, as well as pertinent parts of their ethnocultural identity (Almoshmosh et al., 2020). For example, some questions in the interview ask the patient if parts of their background or identity affect the problem being discussed, either positively or negatively (American Psychiatric Association, 2013).

3) Ahmad et al. (2021) prioritized validated Arabic versions of standardized scales in their research, including the nine-item Patient Health Questionnaire (PHQ-9) to measure depressive symptoms (see Table D3 in Appendix D). Kuo and Rappaport (2024) confirmed that the PHQ-9 showed strong psychometric measures among Syrian refugees in Lebanon as well as strong internal consistency within their own study. This is a tool that is commonly used among primary-care providers to aid in the screening, diagnosis, monitoring, and assessment of depressive symptoms (British Columbia Ministry of Health, 2022; Kuo & Rappaport, 2024).
4) The RAND 36-Item Health Survey (RAND Health Care, n.d.) is a 36-item questionnaire, available in Arabic, in which the respondent uses a 5-point Likert scale to answer questions related to personal or emotional health concerns, emotional wellbeing, pain, energy, and fatigue, and role limitations related to health problems (Kuo et al., 2020). This tool has shown validity among Arabic-speaking participants, and subscales within the tool can be isolated for a narrowed focus on mental health (Kuo et al., 2020).
5) The Hopkins Symptom Checklist 25 (HSCL 25) has been validated to exclude non-cases of anxiety or depression (Almoshmosh et al., 2020; Nakeyar & Frewen, 2016). In their systematic review of culturally sensitive psychological services, Nakeyar and Frewen (2016) found that the HSCL 25 (see Fares et al., 2021 for further information) was better

at filtering out those without depression and anxiety rather than identifying those who are depressed or anxious. Nakeyar and Frewen (2016) recommended that healthcare providers begin with the HSCL 25 then *follow it* with structured interviews and the Hamilton Depression Rating Scale (see Table D4 in Appendix D) for anyone who was not excluded via the HSCL 25. A potential drawback of Nakeyar and Frewen's (2016) review is the limited inclusion of Syrian participants in the studies they reviewed; however, they asserted that the geographic proximity of other study participants to Syria (i.e. Iraqi, Kurdish, and Mandaean) made their findings applicable to Syrians.

Theme 3: Non-Clinical Facilitators of Mental Wellbeing

In accordance with what is known about social determinants and their impact on mental wellbeing, non-clinical facilitators of mental wellbeing emerged repeatedly in this IR. For the purpose of this theme, as defined by the writer, non-clinical facilitators refer to wellbeing strategies that take place outside of the clinic setting and that do not necessarily require pharmacotherapy or the engagement of specialists. Potential facilitators are shared below:

1) Emphasizing positive and resilient coping strategies, participation in decision-making, and future-planning to reduce learned helplessness (Almoshmosh et al., 2020).
2) Assisting clients to find employment to prevent marginalization and isolation (Almoshmosh et al., 2020).
3) Assisting clients to engage with community-based parenting groups to improve couple and family dynamics (Almoshmosh et al., 2020).
4) Encouraging clients to lean on their religious faith, if this has been self-identified as a source of strength in the post-migration journey (Kuo et al., 2020). Among Syrian

mothers who participated in their study, Abi Zeid Daou et al. (2024) identified religious faith as a resource for coping and connectedness when life became difficult in Canada. The Syrian mothers who participated in Kassam et al.'s (2023) qualitative study also identified religion as a source of peace during their resettlement. This strategy would need to be generalized with great caution given the specific characteristics of the participants in two of the studies (i.e. women and mothers).

5) Fostering interdisciplinary collaborations with local networks, social services, government agencies, ethnic and cultural communities, and religious and faith-based groups to collectively address the myriad of factors that have the potential to affect mental wellbeing (Kuo et al., 2020).
6) Encouraging Syrian Adults to volunteer and use their experience to help others, which has the potential to give more positive meaning to their own traumatic experiences (Al-Hamad et al., 2023) and create reciprocal relationships (Kassam et al., 2023). Volunteering was also identified by Kassam et al. (2023) as a facilitator of happiness and community integration.

While the importance of considering and using non-clinical strategies emerged clearly as a theme in this IR, recognizing their potential impact does not obviate the need for primary care providers to implement clinical and pharmacological interventions when necessary and appropriate.

Theme 4: Trauma and Provision of Trauma-Informed Care

The theme of past trauma, effects of prolonged displacement, and trauma-informed practices emerged from many of the articles included in this review (Al-Hamad et al., 2023; Almoshmosh et al., 2020; Kassam et al., 2023; Nakeyar & Frewen, 2016). Through their semi-

structured interviews with 25 Syrian women, Al-Hamad et al. (2023) found compounded trauma and hardship to be a recurring theme and one that impacted women's health, especially women who also reported a lack of family support. These compounded traumas included loss of identity, perpetual struggles with emotions, and prolonged grieving and loss, even after the period of resettlement in Canada was considered at an end (Al-Hamad et al., 2023). Many participants in Kassam et al. (2023) and O'Mahony et al. 's (2023) studies also reported feelings of sadness and depression related to witnessing upsetting events in their home country, being displaced from their home country, and being separated from family.

In their efforts to provide a cross-cultural guide for healthcare practitioners, Almoshmosh et al. (2020) highlighted studies showing a positive correlation between trauma and psychiatric disorders, such as anxiety, depression, and post-traumatic stress disorder (PTSD). As a starting point, they introduced the Adaptation and Development after Persecution and Trauma (ADAPT) model as a resource for developing foundational knowledge about the hardships commonly experienced by refugees to Canada and the coping methods that refugees reported using. The intention of this tool is to guide trauma-sensitive care (Almoshmosh et al., 2020) and it is built on the belief that stable societies rely upon five key psychosocial pillars: 1) safety/security, (2) bonds/networks, (3) justice, (4) roles and identities, and (5) existential meaning (Silove, 2013). The ADAPT model emphasizes the contextual meaning of trauma, hope for positive adaptations, the fluid nature of maladaptive responses to trauma, the need for repeat re-appraisals of the dynamics between individuals and their new social context, the acknowledgement of recovery as an active process, the importance of hope for growth and change even in the most dire circumstances, and the need to advocate for the severely mentally ill alongside those with traumatic stress reactions (Silove, 2013).

For some individuals who have been traumatized by the resettlement process, avoidance and isolation were reported as common responses (Almoshmosh et al., 2020). Healthcare practitioners were advised to educate their clients about potential responses to trauma, as many may not be aware that certain behavioural changes or symptoms can be manifestations of past or present traumas (Almoshmosh et al., 2020). Education about somatic responses to trauma was also emphasized as a potential mitigator of the stigma or confusion regarding the involvement of mental health professionals in one's healthcare provider team (Almoshmosh et al., 2020). Almoshmosh et al. (2020) cautioned that most screening and assessment tools are limited in their application across different cultural and migration contexts; however, they identified the Harvard Trauma Questionnaire (HTQ) (see Harvard Program in Refugee Trauma, n.d.) as a self-report tool with proven internal consistency for resettled Syrians. The HTQ was also recommended by Nakeyar and Frewen (2016) as a valid tool to start the assessment process, followed by a more comprehensive interview if the HTQ were to show "high symptom endorsement" (p. 240). If Syrian Adults screen high on the HTQ, Nakeyar and Frewen (2016) recommended using the Clinically Administered PTSD Scale for DSM (CAPS). The authors note that no studies in their systematic review utilized the most recent version of the CAPS using DSM-5 symptoms (CAPS-5) and therefore further clarification would be required to know if the CAPS-5 is also valid for this population (Nakeyar & Frewen, 2016). The CAP can be administered in 45 to 60 minutes by clinicians or allied staff (e.g. nurses, social workers) with the appropriate training and "working knowledge" of PTSD (International Society for Traumatic Stress Studies, n.d.). As previously mentioned, the studies included in Nakeyar and Frewen's (2016) systematic review did not have a majority of Syrian participants; however, the alignment of these authors' findings with Almoshmosh et al. (2020) offer some reassurance in the validity of the HTQ.

Two articles in this IR referred to Narrative Exposure Therapy (NET) for individuals who had experienced multiple traumatic exposures (Almoshmosh et al., 2020; Nakeyar & Frewen, 2016). NET is a form of exposure and cognitive-behaviour therapy (CBT) developed to address multiple traumas over a lifetime and is specifically for use in populations having refugee and torture experiences (Nakeyar & Frewen, 2016). While acknowledging that only two studies in their systematic review examined NET, the authors concluded that this treatment was correlated with lower PTSD and depression symptoms after the completion of three to 12 sessions (Nakeyar & Frewen, 2016). Trauma-focused therapies, such as NET and culturally adaptive CBT, showed a large effect size related to efficacy against PTSD and depression symptoms (Lambert & Alhassoon, 2015, as cited in Almoshmosh et al., 2020).

Correlates of mental health, cultural and linguistic considerations (including stigma and culturally relevant screening tools), non-clinical approaches to mental wellbeing and trauma-informed care were the four themes that arose from an analysis of the 12 articles included in this IR. These themes provide a broad range of considerations for NPs working with Syrian Adults, ranging in applicability from clinical to community settings and considering a wide range of factors influencing mental health.

CHAPTER V: DISCUSSION

This IR contributes to an existing body of knowledge pertaining to the mental wellbeing of adults from Syria who have resettled in Canada, and the findings suggest that, by building their own foundational knowledge, NPs can provide comprehensive, culturally appropriate and trauma-informed care for these patients. Key strategies identified in the literature include the use of validated tools tailored to Arabic speaking and/or refugee populations when conducting mental health screening in primary care, fostering trust and a sense of safety through thoughtful engagement, and leveraging interpreters and cultural brokers when appropriate. Assessing social determinants of health, such as housing stability, quality of employment, language fluency and social support, will help NPs understand the influences on their patients' mental health. Additionally, collaborative care models that involve mental health specialists, community organizations, and peer support groups may enhance access to care and overall mental wellbeing. Finally, ongoing professional development in cross-cultural mental health can help NPs build the skills that will help them navigate each patient's needs while advocating for system changes to improve broader mental health equity.

Although this may be self-evident, it is critical to emphasize that readers must be cautious not to apply the findings of this IR indiscriminately to all Syrian Adults and must remain vigilant of the need to treat these patients as individuals with unique belief systems, experiences, perceptions, needs and desires.

Strengths and Limitations of Literature Included in Review

The strengths of the Kuo et al. (2020) and Kuo and Rappaport (2024) studies included their involvement of both Syrians and experts in Syrian culture when developing the screening questions that were used, the inclusion of both men and women in the study, and their relatively

large sample sizes (i.e. 235 participants). Since the participants of the Kuo et al. (2020) study only included adults who had settled in Ontario within the previous 12 months and focused solely on acquiring baseline data, further research would be required to confidently apply these findings to Syrian Adults beyond the initial settlement period and to those Syrian Adults who settled in other parts of Canada. Additionally, caution must be taken not to overstate the correlations between post-migration factors found by Ahmad et al. (2021) and Kuo and Rappaport (2024) given that *pre*-migration stressors or trauma were not considered in either study.

In the qualitative studies by Abi Zeid Daou et al. (2024), Mahajan et al. (2022) and Newaz and Riediger (2020) where smaller participant numbers were reported (i.e. eight, 12, and nine, respectively) and only women were engaged in the studies, it is difficulty to confidently generalize the findings to men or, in some cases, women who are not mothers. However, the thick descriptions reported in their findings offered insight into coping strategies (Abi Zeid Daou et al., 2024), the influence of social networks on mental health and acceptability of participating in mental health services (Mahajan et al., 2022) and perspectives of the already available mental health services (Newaz & Riediger, 2020).

Implications for Practice

Several practical implications can be gleaned from this IR, beginning with the importance of cultural considerations. Culturally appropriate services are an important topic that also arise in other reviews, including that of Cherubini (2024). Cherubini (2024) explored the role of stigma, embarrassment, and shame as they relate to mental illness and found that stigma can not only prevent mental health seeking behaviours but can also prevent Syrian Adults from discussing emotional wellbeing in general. Stigma has been defined by the APA (n.d.) as a

negative social attitude applied to an individual, suggesting a deficiency of some type. A stigma often carries social disapproval and, for the person stigmatized, may lead to unfair exclusion and discrimination (APA, n.d.). This definition offers insight into the reason why it is so important for NPs to be aware of the impact of stigma as they aim to support the mental wellbeing of Syrian Adults. The source of this stigma may be multifactorial, but some authors suggest it may be rooted in the former Syrian regime's opposition to mental health services (Abo-Hilal & Hoogstad, 2013, as cited in Cherubini, 2024). As mentioned earlier, knowing the barriers that stigma may create, it is important for NPs to integrate mental health screening and discussions within the provision of general primary care services and be intentional about discussing mental health neutrally in the same way they would any physical ailment (Newaz & Riediger, 2020). This matter-of-fact and neutral approach can be instrumental in removing potential shame from the subject.

Knowledge of mental health correlates may inform NPs' early mental health risk assessments. During initial visits, NPs may assess education level, satisfaction with employment, English language proficiency, financial struggles, housing stability, and quality of friendships, and then use this information to stratify mental health risk among Syrian Adults to whom they provide care. This information may inform the frequency with which future assessments or follow-ups are arranged but should not be used to pre-emptively label or diagnose, given the prevalence of stigma. Additionally, signs of depression or early depressive symptoms are important to identify early given their strong predictive value for future mental wellbeing, including decreased self-efficacy, feelings of helplessness, and perceived control over life situations (Kuo & Rappaport, 2024).

While the concept of trauma and trauma-informed care emerged as a theme, many authors discourage *routine* screening of traumatic exposure and, instead, recommend that providers remain alert for signs and symptoms of post-traumatic stress disorder and consider the potential implications of unexplained somatic symptoms, sleep disturbances, or symptoms of depression and anxiety (Canadian Collaboration of Immigrant and Refugee Health [CCIRH], 2013; Hansen & Huston, 2016). The GOC (2018) asserts that providers do not need to elicit an individual's trauma or violence history in order to provide safe and supportive care and, instead, the GOC encourages incorporating universal trauma precautions in all policy and practice. Such precautions are based on the following principles: (1) understanding how trauma and violence impacts lives; (2) creating spaces that feel emotionally and physically safe; (3) fostering choice, connection and collaboration; and (4) focusing on strengths and capacity-building to support clients (GOC, 2018). Although knowledge of cultural and linguistic variations, and specific knowledge and skills related to a client's traditions remain important, providers are encouraged to shift their focus to include cultural safety, where the emphasis is on lifelong self-reflection and an understanding of "power differentials inherent in healthcare service delivery" (Newaz & Riediger, 2020, p. 11).

As previously discussed by Almoshmosh et al. (2020), providers are encouraged to standardize their welcome processes at the onset of patient-provider relationships. This may include a thorough explanation of the care setting and process and a review of clinic principles such as collaboration and privacy (Almoshmosh et al., 2020).

Accurate measurements of mental health distress can be highly challenging when there are both linguistic and cultural variations in these expressions; therefore, baseline knowledge about cultural idioms of distress is encouraged (Almoshmosh et al., 2020). Hassan et al. (2015)

have provided a detailed list of common idioms of distress in both Syrian Arabic and Kurdish (Kirmanji dialect) (see Appendix E). Although Almoshmosh et al. (2020) noted that somatic symptoms such as nausea, dizziness, insomnia, headaches and appetite changes could be correlated with distress, these symptoms do not always suggest mental health challenges but instead could be *caused by or exacerbated by stressors* and may be the presenting concern during a visit with the primary care provider (Almoshmosh et al., 2020).

When NPs do identify the need for further assessment or management related to traumatic exposures, they may, with permission, refer to mental health specialists (i.e. psychiatrists, psychologists, mental health counsellors) who are familiar with NET. This type of therapy has demonstrated benefits for people who have experienced multiple traumatic exposures (Nakeyar & Frewen, 2016).

In their overview of health considerations for Syrian refugees during the resettlement process, Hansen and Huston (2016) encourage the use of UNHCR Syrian-specific mental health resources, which is in line with recommendations by Hassan et al. (2015), and clinical checklists for new immigrants and refugees from the CCIRH (see CCIRH, 2013 for access to checklist). Hansen and Huston (2016) named social determinants of mental health as a "foundational layer" in the quest to support mental wellbeing; however, they acknowledged that providers may already be "oversubscribed" and at risk for compassion fatigue (p. s6). With the risk of fatigue in mind, Hansen and Huston (2016) recommended collaboration with community organizations, resettlement agencies and formal or informal support groups.

With the knowledge gleaned from this IR and supporting publications, NPs can make their own primary care toolkits that include validated screening and assessment tools, approved checklists and a list of local organizations, and agencies and practitioners with whom the NPs

can collaborate to support their clients. A sample toolkit is provided in Appendix F; however, customization is necessary based on locally available resources, organizations, specialists, and client need patterns.

Implications for Policy

Among other competencies, NPs are expected to advocate for education and resource development that address oppression, social, political and structural determinants of health and equitable access to care (BCCNM, 2024). Although it is well-known that the primary care environment is currently overwhelmed, NPs can still start their advocacy at the clinic level in small but meaningful ways by providing input on clinic policies and procedures. For example, NPs can ensure their clinics have user-friendly access to language services (i.e. interpretation) and advocate for periodic in-services to encourage all members of the team to utilize these services with clients who would benefit. NPs can also advocate for lists of local recourses to be placed in high visibility locations and can ensure that these lists include agencies that offer cultural brokerage and resettlement services, mental health services with Arabic-speaking team members, local WorkBC centres, and, if relevant, information about the *Residential Tenancy Act*. NPs who work in clinics that provide services for a significant number of Syrian Adults (or individuals with similar refugee experiences) may advocate for appropriate screening and assessment tools to be integrated into their electronic medical records for easy access and use.

Implications for Education

In 2016, the Canadian Council of Registered Nurse Regulators (CCRNR) published the first version of entry-level competencies (ELCs) for NPs in Canada. The expectation is that NPs educated in Canada will have a standard set of baseline knowledge and skills as they enter practice (CCRNR, 2016). Including select findings from this IR in future iterations of the ELCs

may be of benefit, particularly the value of the cultural formulation interview (CFI) from the DSM-5. This suggestion might be included in the BCCNM version of ELCs under item 1.4d which states that NPs must, "[c]onduct a mental-health assessment, applying knowledge of emotional, psychological, and social measures of well-being" (BCCNM, 2024, p. 9). A reference to the CFI directs NPs to a practical tool to explore the role of culture and origin on perceptions of mental health, thereby making mental-health assessments more comprehensive.

Review Limitations

Potential limitations of this IR relate to the duration of time that participants of each study had been in Canada. Most study participants were in Canada between zero and five years. Although this is a limitation of the IR, it is a challenging one to overcome at this time given that the number of Syrians resettling in Canada only began to rise in 2016 and most studies were conducted in the years following this influx. This limitation implies that future research examining mental health and psychosocial wellbeing five, ten, or more years following resettlement might create a more inclusive understanding of predictors, facilitators, and barriers to wellbeing beyond the initial resettlement period.

Excluding publications with a specific focus on the parenting or perinatal experience of Syrian Adults may have led to overlooking a common experience among resettled Syrians and one which carries its own identity changes and vulnerabilities. The choice to exclude these publications was due to their additional focus on family, children, and adolescents and their frequent exclusion of men as participants; however, including these studies in future reviews might elucidate how parenting experiences can influence the mental wellbeing of Syrian Adults (See Table A2 in Appendix A for additional explanation of exclusion criteria).

It is important to note that there is a paucity of research related specifically to the challenges faced by NPs who provide care to Syrian Adults. As a result, for the purposes of this IR, the challenges identified by medical doctors in primary care has been extrapolated to NPs. Finally, the single authorship of this IR makes it vulnerable to unintentional selection bias and a potentially incomplete thematic analysis during data synthesis.

Review Strengths

This rigour of this review was prioritized by searching within multiple databases and search engines, establishing specific inclusion and exclusion criteria to ensure objectivity in IR decision-making, and using validated tools to appraise the quality of the included studies. An initial meeting with the UNBC librarian was arranged to garner input on search terms and strategies, helping to minimize retrieval bias and to broaden the number of relevant generated search results as much as possible. Specific inclusion and exclusion criteria ensured reproducibility of the search results and the selection of publications for this IR. The appraisal of each article with a validated tool ensured the author viewed each with a critical lens, remaining cognizant of their limitations as they were referenced in the IR.

CHAPTER VI: CONCLUSION

This review has highlighted the knowledge and strategies that NPs can consider integrating into their practice as they provide care to Syrian Adults in primary care settings. While NPs are generally aware of the role they play in mental health screening, assessment, diagnosis, and management, it can be difficult to appreciate how this practice can be made culturally appropriate and meet the needs of clients who may have experienced a unique set of circumstances leading to their arrival in Canada. Although there was no single correct approach identified in the literature, knowledge about the correlates of mental health, the role of stigma, validated screening and assessment tools, trauma-informed care, and the social determinants and facilitators of mental health can provide a strong practice foundation for NPs. Despite the noted limitations of this IR, it offers a starting point for NPs who may feel overwhelmed by the responsibility of providing care for a community of people whose experiences are likely far removed from their own. Further research into the long-term effects of resettlement, culturally appropriate screening tools, and stigma-free approaches to integrating mental wellbeing into primary care would be valuable to further understand this research question.

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Appendix A

Search Strategies

Table A1

Search Terms and Results

Database (Date of Search)	Search Terms	Articles Resulted
APA PsycInfo (Nov 1, 2024)	*No field specified:* (refugee* or asylum* or "displaced people*" or "displaced person*" OR displaced) AND (Syria or Syrian*) AND ("mental health" or "mental disorder*" OR "mental wellness" OR "mental wellbeing" OR psychological OR psychosocial) AND (canada or canadian or "british columbia*" or alberta* or saskatchewan or manitoba* or ontario or quebec or "new brunswick" or "nova scotia" or "prince edward island" or newfoundland or labrador or "northwest territories" or yukon or nunavut)	57
MEDLINE with Full Text (EBSCO) (Nov 1, 2024)	*No field specified:* ((refugee* or asylum* or "displaced people*" or "displaced person*" OR displaced)) AND ((Syria or Syrian*) AND ("mental health" or "mental disorder*" OR "mental wellness" OR "mental wellbeing" OR psychological OR psychosocial)) AND ((canada or canadian or "british columbia*" or alberta* or saskatchewan or manitoba* or ontario or quebec or "new brunswick" or "nova scotia" or "prince edward island" or newfoundland or labrador or "northwest territories" or yukon or nunavut))	57
Google Scholar (Nov 1, 2024)	*Advanced search interface:* → with **all** the words: (~wellbeing OR ~wellness OR ~"mental-health") AND ~Canada → with the **exact** phrase: "syrian OR syria OR syrians" →Date range: 2016-2024 →Manual search limited to first 10 pages (i.e. first 100 results) →Applied inclusion/exclusion criteria and ignored duplicate results	17, 300 (7 potentially relevant)
Google Search Engine (Nov 5, 2024)	*General search:* → search terms: syria british columbia mental health →Manual search limited to first 10 pages (i.e. first 100 results) →Applied inclusion/exclusion criteria and ignored duplicate results	1702 (2 potentially relevant)
Web of Science (Nov 1, 2024)	*Advanced search interface:* ALL=(syria OR syrian or "Syrian refugee" or "displaced") AND ALL=("mental health" OR "mental wellbeing" OR "mental disorder" OR "psychological" OR "psych*") AND ALL=(strateg* OR coping OR cope OR screen OR screening OR "screening tool*" OR "integrated" OR trauma-informed OR "trauma informed" or collaborative OR "patient-cent*" OR "patient cent*" OR intervention* OR care OR pathways OR self-manag* OR "self manag*" OR community OR culturally OR cultural OR culture OR medication OR pharmacology OR interven* OR therap* or impact* or counsel*) AND ALL=(canada or canadian or "british columbia*" or alberta* or saskatchewan or manitoba* or ontario or quebec or "new brunswick" or "nova scotia" or "prince edward island" or newfoundland or labrador or "northwest territories" or yukon or nunavut) →*Date limited to*: 2016-2024 →*Refined to*: English, Canada	291 (18 potentially relevant)
Total retrieved sources		141

Note. the preceding search strings combined terms using Boolean operators OR and AND to expand or narrow the search, respectively. Additionally, an asterisk (*) was used to truncate words or terms to "capture all forms of that word" (Lawless & Foster, 2020, p. 31). Within Google Scholar, a tilde (~) alongside a term was used to include synonyms of the associated term.

Table A2

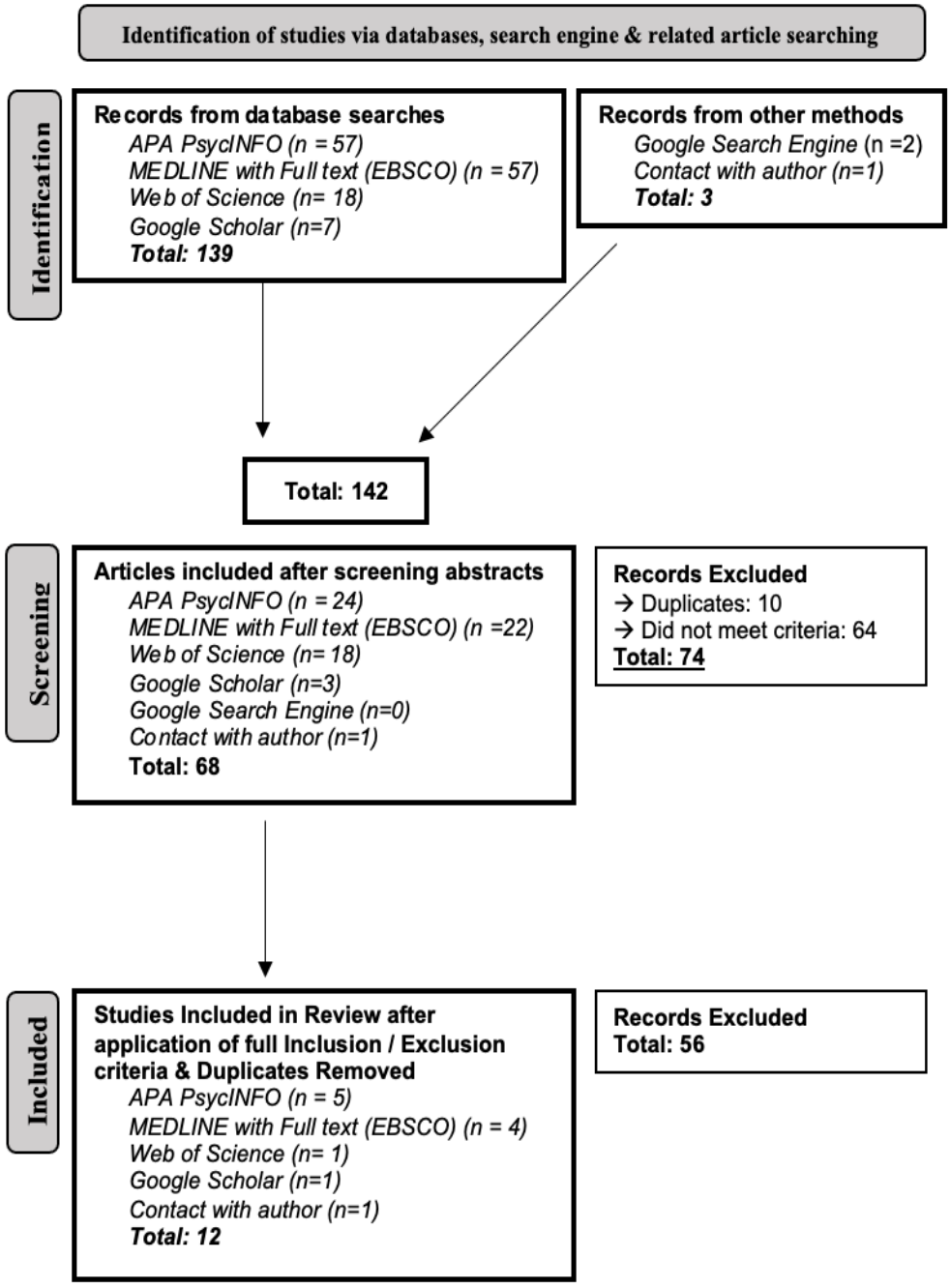
Inclusion and Exclusion Criteria

	Inclusion	**Exclusion**
Population	Focus on *Syrian adults who have had refugee experiences* (i.e. needed to leave homeland for safety) and settled *in Canada* Studies that included Syrian adults *among* other Middle Eastern participants (e.g. Kurdish, Iraqi) if inclusion of Syrian adults was made clear	Primary focus on *children, youth, adolescent*s or specific focus on *parenting* in adult populations Research that focused specifically on the peripartum period (labour, delivery, postpartum etc.) Publications on refugees in general (origin country not specified) Publications focused on Syrian adults living outside of Canada (e.g. Jordan, Turkey, Germany, Sweden, U.S.A)
Phenomena of Interest	Focused on mental health outcomes, correlates of mental wellbeing, coping, screening, interventions of transcultural approaches	Sole focus on physical health Focused on general settlement variables and/or outcomes, without their correlation to mental wellbeing Articles limited to description - i.e.) describing and reporting rates of mental health disorders
Scope	Focus on interventions, tools, approaches and supports. Focus limited to what is reasonable within the scope of practice of a nurse practitioner	Focus on role of theatre and expressive arts Abstracts of past conferences/congresses Focus on specialised mental health interventions usually restricted to the scope of psychologists, psychiatrists and other mental health professionals (e.g. registered counsellors)
Timeframe	Publications between 2016-2024	Publications before 2016
Language	English publications	Published in a language other than English
Publication Type	Quantitative and qualitative primary studies; systematic or integrative reviews; expert opinion/guidelines	News articles, organizational opinion pieces, review articles, student theses

Note. Limiting the timeframe from 2016 to 2024 ensured the inclusion of research that reflected the influx of Syrian refugees during Operation Syrian Refugees (GOC, 2017) commenced in November 2015. Only English-language publications were included as there was no access to translators for the purpose of this review.

Figure A1

Flow Diagram of Literature Search and Selection



Appendix B

Critical Appraisal Matrix (CAM) of Included Integrative Review Articles

	In- Text Citation	Clear Aims / Objectives OR Clear Subject Matter	Strong Method OR Experts Presented on Topic Before	Strong Design OR Interest of Patients is Central Focus	Good Sampling Methods & Recruitment OR Relevant Literature Used OR Based on Evidence	Relation between researchers & participants considered	Are the Ethics Sound?	Rigour of Data Analysis OR Meaningful Analysis of Literature	Can Generalize OR Transfer Findings	Clear Findings OR Recommendations Made for Future Practice OR Opinions Clearly Stated	Direct(D) or Indirect (ID) Relevance to IR Question	Minimal Bias OR Congruent with Existing Literature	Overall Rating
	Quantitative												
1	Kuo et al. (2020)	Y	Y	Y	Y	N	Y	Y	?	Y	D	?	S
2	Kuo & Rappaport (2024)	Y	Y	Y	Y	N	Y	Y	Y	Y	D	Y	S
3	Bridekirk et al. (2021)	Y	Y	Y	Y	N	Y	Y	?	Y	D	Y	S
	Qualitative												
4	Abi Zeid Daou et al. (2024)	Y	Y	Y	?	Y	?	Y	?	Y	ID	?	M
5	Ahmad et al. (2021)	Y	Y	Y	Y	N	Y	Y	Y	Y	ID	Y	S
6	Al-Hamad et al. (2023)	Y	Y	Y	Y	Y	Y	Y	Y	Y	D & ID	?	M
7	Kassam et al. (2023)	Y	Y	Y	Y	Y	Y	?	?	?	ID	?	M
8	Mahajan et al. (2022)	Y	Y	Y	Y	N	Y	?	Y	Y	D & ID	?	M
9	Newaz & Riediger (2020)	Y	Y	Y	?	N	Y	Y	?	Y	D	Y	S
10	O'Mahony et al. (2023)	Y	Y	Y	Y	Y	Y	Y	?	Y	ID	?	M
	Systematic Review												
11	Nakeyar & Frewen (2016)	Y	Y	Y	Y	N/A	N/A	Y	?	Y	D/?	Y	M
	Guideline / Expert Opinion												
12	Almoshmosh et al. (2020)	Y	Y	Y	Y	N/A	?	Y	N/A	Y	D	Y	S

Note. CAM developed via a modified combination of Joanna Briggs Institute (McArthur et al., 2022), Critical Appraisal Skills Programme (CASP, 2024a, 2024b) and Johns Hopkins Evidence-Based Practice Critical Appraisal Tools (Dang et al., 2022); *Y= Yes*; *N= No*; *?= Not Certain/ Significant Limitations; S= strong; M= moderate; W= weak.*

Appendix C

Data Extraction Matrices

Table C1

Quantitative Articles

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?						
Abbreviated Citation & Study Details	**Predictors**	**Screening or Prevention Measures**	**Management**	**Broader Considerations/ Implications**	**Cultural & Language**	**Strengths, Limitations & Relevance to IR**
Kuo et al. (2020). https://doi.org/10.47634/cjcp.v54i4.68881 **Relevant Purpose/ Objective(s):** determine how demographics, contextual factors & psychosocial factors predict or explain mental health outcomes. **Hypothesis:** demographic, post-migration context, psychosocial factors predict (significantly) the mental health scores. **Conceptual and/or Methodological Framework(s):** Social Determinants of Health Framework. **Study Method & Design:** Quantitative; cross-sectional analyses within a longitudinal study. Questionnaires. Pearson's correlations & regression analyses **Participants:** Syrian adults living in Windsor, Ontario on average 12 months. **Sample size & sampling method:** n=235; direct phone contact, snowball, social media (WhatsApp) supported by local settlement agency.	*Protective*: male, young, more educated, married, proficient English, sufficient finances, employment, perceived >control over circumstances, lower reported stress, housing & healthcare satisfaction, greater friendship quality. *Demo risk*: older, women *Contextual predictor for better mental health*: satisfied with health services *Psychosocial predictors for better mental health:* perceived control & stress; greater sense of agency/less overwhelmed.	→ Efforts to bridge service gaps, remove barriers, better facilitate navigation through health system →interpretation services →transportation to/from health services/clinics →be vigilant when assess women and older patients in particular →consider social isolation →identify if pt feels control, stress as could be cues/warning signs; need to screen!	→ support through adaptive stress management, coping capacities, encourage the building of resilience **Relevant future research:** effect of other SDH & contextual factors language, discrimination, acculturation, social support, religious identity/ resources	→ collaboration with local networks, social services, government agencies, ethnic/cultural communities, religious/faith-based groups → social advocacy → legal, logistical, subsistence needs	→ access/build on religious faith, identity	*Strengths*: -large sample size -both men and women -questions developed and vetted by Syrians and experts in Syrian culture -generalize with caution *Limitations:* -sample limited to Windsor, Ontario -not randomly selected -unclear if findings can apply after initial settlement period -$40 honorarium - may not be negative but could have drawn those needing money -Likert scales/ quantitative might miss thick description/ nuance -correlation ≠ causation *Relevance:* -identifies predictors that NPs can screen for and remain vigilant/ cognizant about

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?					
Abbreviated Citation & Study Details	**Predictors**	**Screening or Prevention Measures**	**Broader Considerations/ Implications**	**Cultural & Language**	**Strengths, Limitations & Relevance to IR**
Kuo & Rappaport (2024). https://doi.org/10.1177/13634615241227696 **Relevant Purpose/Objective(s):** expand on current research; explore depressions temporal effects on stress, perceived control, social support, and anxiety longitudinally. Answer the questions: (1) *to what extent do baseline depressive symptoms correlate with baseline perceived stress or control?* (2) *to what extent do baseline depressive symptoms predict perceived stress/control 1-year later.* **Hypothesis:** not clear. **Conceptual and/or Methodological framework(s):** transactional model of stress & coping; self-efficacy theory of depression. **Study Method and Design:** Quantitative; prospective longitudinal; questionnaires; cross- lagged panel models, multivariate regression analyses; structural equation models. **Participants:** Syrian adults living in Windsor, Ontario. **Sample size & sampling method:** n=235; direct phone contact, snowball, social media (WhatsApp) supported by local settlement agency.	→ depressive symptoms @ baseline correlates with: 1) lower self-efficacy, higher helplessness @ baseline 2) lower self-efficacy @ f/u 3) lower perceived control at baseline & f/u 4) lower perceived social support at f/u 5) higher anxiety at f/u → high baseline self-control may predict low depressive symptoms 1 year later	→PHQ-9 - robust psychometric measures; internal consistency → perceived stress scale → perceived control scale → multidimensional scale of perceived social support → GAD2 / GAD7 ** caution to take trauma-informed approach when doing psychometric screening/assessment and ensure f/u support → value of longitudinal assessments → confirmation of utility of early, depression-targeted screening, assessment and treatment for Syrian refugees specifically → importance of early assessment to index propensity to adapt in general →early detection may disrupt adverse psychological sequelae of depression and other traumatic/stressful experiences	→consider the effects of depression on resettlement 1 year later → depression not only an outcome but a predictor; as shown in study	→ early culturally responsive mental health services can help offset negative chain of events that can threaten well-being	*Strengths:* -large sample size -both men and women -questionnaires used showed validity among Syrian adults in previous studies *Limitations:* -sample limited to same Windsor, Ontario group -not selected randomly -since depressive symptoms stayed stable over time, could be difficult to determine which factors make it this way -depressive symptoms not changing over time could indicate that the PHQ only captures unchanging elements of depression -directionality of factors not certain -$40 honorarium - may not be negative but could have drawn those needing money *Relevance:* -identifies screeners that have shown validity for Syrian adults -identifies depressive symptoms as potential predictors for future psychosocial factors & general settlement -generalize cautiously

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?				
Abbreviated Citation & Study Details	**Correlates of Mental Wellbeing**	**Broader Considerations/ Implications**	**Cultural & Language**	**Strengths, Limitations & Relevance to IR**
Bridekirk et al. (2021). https://doi.org/10.1007/s10903-020-01108-0 **Relevant Purpose/Objective(s):** *To explore these 3 questions:* 1) Does education level among Syrian refugees predict the quality of current employment, 2 to 3 years after resettlement? (2) *Is there a relationship between job quality and the psychological variables of stress and perceived control? (3) Do education level, employment quality, and psychological variables impact Syrian refugees' general mental health?* **Conceptual framework(s):** -Holistic Integration Model **Study Method and Design:** Data drawn from the first 2y of the SyRIA. lth study. Measures: -survey of demographics -Perceived Stress Scale -RAND 36 for mental health (14 measures from this tool used) *Q 1/ 2:* ANOVA & chi-square *Q 3: linear regression* **Participants:** Adult Syrians - arrived between January 2015 and June 2017. **Sample size & sampling method:** Year 1: 1932 Year 2: 1805 (due to attrition) Snowball, fliers, word of mouth, direct requests at community spaces	*Question 2* findings: -employed ppl *w/ mod & high education* levels reported higher levels of stress on the PSS-10 than those with low education levels - high education levels also reported lower perceived control & lower general mental health on the year 2 RAND 36 mental health subscale, compared to those with low education levels, although all RAND scores were above the standardized mean of 50 for the general US population *Question 3 findings:* -all employment questions (*wage enough, job appropriateness, job satisfaction*) significantly correlated with all mental health and psychological measures (perceived control, stress and general mental health). (Year 2 general mental health on the RAND-36)	-"relative deprivation" explanation of educational differences in well-being among resettled refugees; - disparity between current employment conditions & expectations may have been greater for more highly educated refugees → lower feelings of control, greater stress and ultimately poorer mental health - Adequacy of income = significant predictor of general mental health, reinforcing the findings of other studies that poverty may be the most important driver of distress for resettled refugees -poverty an important SDOH, highlighting the need to ensure adequate financial support for long-term well-being	→ early culturally responsive mental health services can help offset negative chain of events that can threaten well-being	*Strengths:* -large sample size and diverse sampling methods -included men and women -measured a number of variables to answer more than one question *Limitations:* - 627 (34.73%) reported working in year 2, with about 40% of the moderate and highly educated participants reporting employment, which was significantly higher than among those in the low education category *Relevance* -directly discusses correlates of mental health - socially determined like education, employment, job satisfaction:

Table C2

Qualitative Articles

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Abi Zeid Daou, K. R., Abi Zeid Daou, L. R., & Cousineau-Pérusse, M. (2024). https://doi.org/10.1080/02703149.2021.2008520 **Relevant Purpose/Objective(s):** To examine: a) participants perceptions of additional emotional work in family; b) how participants manage emotions & cope with elevated emotional work; c) understanding obstacles of newly settled refugees **Hypothesis:** n/a **Conceptual and/or Methodological framework(s):** Braun & Clarke's thematic analysis framework; inductive analysis. **Study Method & Design:** Qualitative; semi-structured interviews **Participants:** Syrian Mothers who had settled in Quebec, Canada in last 24 months. **Sample size & sampling method:** n=8; recruited from previous study (6) and snowball sampling (2)	*Hiding Negative Affect* → hiding for sake of others, bottling up, pressure to be positive, positive attitude sometimes surpass a person's energy *Overcompensating* →attempting to take on role of lost family members, forget self →having to raise family without past supports *Language Stressors* → stress around not being able to make oneself clear or having to translate for family members *Religion as Coping* → coping source; faith in God; gratitude for God	→ assess individually - without family present to avoid a feeling of needing to hide negative affect → important as self concealment correlates with depressive symptoms, anxiety and psychological distress (emotional regulation = taxing!); screen for additional emotional work - direct effects on well-being. → screening is important; how have supports changed? → assess language ability and that of family members; role of translator in family: → screen for this; ask as part of social history; do you have a religious faith or community you find support in and find connectedness Losing one's home should be a psychotherapeutic category/consideration on it's own. Systemic therapy approaches - consider how society, institutions, family impact individuals;	*Strengths* → strong, trusting rapport between researcher and participants -thick descriptions able to come out in a safe, trusting environment *Limitations* → small sample size → only Mothers → no further demo info reported due to requests for anonymity; therefore, not entirely clear to whom this can be generalized *Relevance:* → offers advice about how screening and mental health interviews might need to be conducted (private?) → suggests that screening for 'supports' is important, as well as language ability. Do you have a religious/ faith community you turn to for support / belonging?

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Ahmad, F., Othman, N., Hynie, M., Bayoumi, A. M., Oda, A., & McKenzie, K. (2021). https://doi.org/10.1080/09638237.2020.1765998 **Relevant Purpose/Objective(s):**. evaluate the prevalence of depression-level symptoms at baseline and 1 year post-resettlement; analyze its predictors. **Hypothesis:** n/a **Study Method & Design:** Structured face-to-face survey interviews. Longitudinal. Depression symptoms were measured using Patient Health Questionnaire 9 (PHQ 9); measured perceived social support, perceived control scale; multivariate analysis for predictors of depression (chi squares) (qualitative assessments with quantitative analysis) **Participants:** Syrian refugees who arrived in Canada between 2015 and 2017; part of the SyRIA.lth 4 year longitudinal study. **Sample size & sampling method:** n=1924; recruited through snowball sampling, public announcements at resettlement / community agencies, food banks, community events and places of significance in neighborhoods with high concentration of Syrian refugees.	→ factors significantly correlated with mod or severe level depression symptoms at both baseline and year 2 were: • Female sex • Being divorced/widowed/separated • GAR (vs private) • Living in Ontario • Muslim (vs other religions) • Unemployment • Financial difficulty • Lower education • Fewer friends • Lower language ability → most powerful predictor for depression at year 2 was baseline depression (moderate → moderate at year 2 10x more likely) → need for interpreter at year 2 increased mod-severe depression in year 2 → factors associated with mod-severe depression at year 2 • Low satisfaction with housing • Lack of satisfaction with health services • Lower perceived control • Lower perceived social support • Living longer in Canada**	→ prompt identification of depression as this is the greatest predictor of future depression → proper management through supportive and clinical measures → building rapport and ensuring patients are satisfied with health services - can ask them directly → community based interventions to strengthen collective identity	*Strengths:* → comprehensive, longitudinal, large sample *Limitations:* → *not random, caution generalizing* → *survey format opens the risk of reporting bias but interviews trained and used both Arabic and English* → *lacking pre-migration trauma as a co-factor* *Relevance:* → identifies the factors that NPs might focus on in their early assessment → identify the patients they might be more vigilant about /plan to check in with more often and re-assess

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Al-Hamad, A., Forchuk, C., Oudshoorn, A., & Mckinley, G.P. (2023). https://doi.org/10.1007/s12134-022-00991-w **Relevant Purpose/Objective(s):**. - explore and describe the pre- and post-migration experiences of Syrian refugee women in Ontario, Canada, and the impact on their physical and mental health. -critically examine how the intersections of gender, trauma, and violence, political, and economic conditions of Syrian refugee women shape their everyday lives and health. -investigates the strategies and practices by which Syrian refugee women are currently addressing their healthcare needs and the models of care they suggest to meeting their physical/ MH needs **Hypothesis/ Assumption:** Syrian refugee women's health is informed by the intersection of multiple levels of power structures and structures of discrimination in the host country. **Conceptual and/or Methodological framework(s):** critical ethnography with an intersectional analysis lens **Study Method & Design:** ethnography; semi-structured 1:1 interviews via online synchronous interviewing (OSI) approach - on secure academia version of Zoom (open ended) **Participants:** Women, adult Syrian refugees in Canada for minimum of 1 year, currently residing in Ontario **Sample size & sampling method:** N=25; recruited through flyers at the main entrance of organizations that provide health, settlement, and integration services for Syrian refugees (including Mosques, cross-cultural centers, refugee alliance centres, churches, community organizations, and city hall)	→ **themes of**: loss of home, culture and family and their effects on mental health →Consistent theme → financial constraints and burden → most women constantly expressed that they are still experiencing prolonged grieving and loss, even now in Canada → worries about children's safety and future and how these impact health/wellbeing → stress, anxiety, insomnia (during pre-migration – can assess if this is still a worry?) → feelings of discrimination, desperation, exclusion and being different in the host countries → "I don't like to be labeled as Syrian refugees not because of being refugees but due to the context and how people perceive it" → displacement made them stronger people and contributed to some personal growth like learning new things and becoming a different and responsible person. Strong women with a voice since being in Canada. → adaptation strategies to overcome current challenges in Canada: → ESL school → helping people or other refugees gave meaning to their own traumatic experiences and transform it into a positive change. → many barriers to culturally informed, affordable healthcare like language/literacy barriers, limited knowledge of Ontario healthcare system, limited social supports, cultural beliefs, unique family dynamics	→ need for more trauma-informed and culturally appropriate healthcare services (ex. Being asked about sexual encounters during miscarriages) → need for culturally sensitive care especially during miscarriage with severe psych pain felt after miscarriage → significance of utilizing intersectionality theory with its key assumptions, particularly the notion of multiple interactions of various aspects of vulnerability → various coping strategies that women currently use to adapt to new culture and healthcare system **Nurse as educator:** → incorporating various teaching pedagogies and simulation scenarios that are based on refugees' lives and behaviours will create better opportunities for change and justice. → embed principles of marginalization, oppression, social justice, empowerment, and culturally sensitive practices into nursing curriculum and programs creates a nursing care trend that minimizes harm and provides positive change for all people → develop and ensign interventions and healthcare services for Syrian refugee women calls for CLEAR understanding of history of trauma, migration-related struggles and hardship —> helps to minimize the harm and prevent further trauma → tailored services → understanding the trauma can help NPs explore health-seeking behaviours	*Strengths:* → decent sample size for qualitative → thick descriptions to get a deeper understanding → understanding of helpful coping strategies → gives strong background information of the experiences/feelings felt in the journey *Limitations:* → not direct relevance to strategies for NPs. more implications for 'awareness' *Relevance:* → some implications about how NP might preceptor future NPs - incorporating principles of marginalization etc to 'set the groundwork' for future NP practice

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Kassam, S., O'Mahony, J., & Clark, N. (2023). Title: **Factors supporting settlement among Syrian refugee women: A longitudinal participatory action research study** (no DOI available) (Retrieved by emailing O'Mahony as this article covers theme 5 and 6 mentioned in the O'Mahony article) **Relevant Purpose/ Objective(s):** examine the perspectives of Syrian refugee mothers living in BC with respect to social support they received in early, middle and later phases of resettlement. To answer the question: *what factors do Syrian mothers perceive to have been supportive in their integration into BC society?* **Hypothesis:** N/A. **Conceptual and/or Methodological framework(s):** intersectionality-framed (Crewnshaw) community-based participatory action research (PAR) **Study Method & Design:** qualitative, longitudinal; in-depth interviews or focus group, socio-dem surveys; personal diaries; Syrian mothers were also co-peer researchers; Braun and Clark thematic analysis & NVivo12. **Participants:** Syrian refugee mothers in Canada <5yrs, childbearing age (18-50), current stable mental health. **Sample size & sampling method:** n=40; via peer research assistants, social service professionals and agencies working with Syrian families	→ leaning on strengths helped with settlement experiences → exercise: when down, walking alone helps with feeling down; but can feel unattainable. → Volunteering: symbiotic relationship with others - caring for others can facilitate happiness → connecting with friends of same gender, culture (feels close to country, religion, culture) → connection to religion could provide peace in the settlement process → positive thinking: having to be strong for the family. Focusing on the good things, gratitude. –Expressing-suppressing emotions: sadness/depression of leaving homes, but also taking on a role of strength in families. Mother's emotions affect family's emotions → preference to reveal sadness to friends instead of family to maintain the happiness of family	→ NPs can give Syrian women a chance to share their negative emotions in a safe environment, without fear that her emotional → HARNESS strengths - identify and encourage → foster community integration and promote independence → emphasizing the need for women who are mothering and refugees to be engaged within volunteering opportunities. - social dependence on male family members limited social integration and access to services → Can assess for: comfort within their religious and cultural practices / connections → Can assess for: relationships with people outside of family members (assess friendships!) – especially as a way to express emotional	<u>*Strengths:*</u> → taps into the experiences of Syrian adults in Canada. Gives a sense of the everyday realities (social justice oriented research inquiries) → use of peer-research assistants (Syrian women) to conduct research increased authenticity, trust, rapport <u>*Limitations:*</u> → only women in childbearing years who are Mothers; cannot be generalized to Syrian adult men in a reliable way → no direct connections made to measurable mental health outcomes but helps understand context <u>*Relevance:*</u> →covers thick descriptions of Syrian adult women's experiences in Canada - barriers / facilitators to integration which is associated with mental health → might provide more background / intro information and some implications for practice (in the broader sense - social determinants / community resourceS)

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Mahajan, S., Meyer, S. B., & Neiterman, E. (2022). https://doi.org/10.1080/17441692.2021.1872679 **Relevant Purpose/ Objective(s):** understand role of social networks in recognition of mental/emotional problems & explore extent to which women identify social networks as facilitating or impeding use of mental/emotional health resources. **Hypothesis:** N/A. **Conceptual and/or Methodological framework(s):** Braun & Clarke's thematic analysis framework; deductive analysis with inductive & deductive coding **Study Method & Design:** Qualitative; semi-structured phone interviews. **Participants:** adult Syrian women living in Canada between 1.5-6 years. **Sample size & sampling method:** n=12; advertising at YMCA & subsequent snowball sampling; partnership with local new Canadian agency	→ social networks used to support uptake mental/ emotional health services → main social networks family members and sponsors → sometimes alternative to formal care - long time friendships, sponsors → some sponsors help refugees connect with psychiatrist (motivator) → supporting determinants of mental health (SNs) - alleviate some of these determinants → SNs had an effect on INTRApersonal relationships - teaching women to take care of themselves, not being too hard on themselves, "addiction to doing too much", neglecting own mental and physical needs SN can include your psychiatrist/ dr → can influence assumptions about mental/ physical health services → Focusing on gratitude & quest to adjust *****social networks, such as family, friends and sponsors, can help women to recognise that there may be a need for acute mental health services by encouraging them to seek help for periodic mental stress that is related to the adjustment of life in Canada. Additionally, social networks were found to encourage women to seek care for physical pain, thus helping them to uncover mental and emotional health issues, in some cases. This finding demonstrates that social networks can play a significant role in the decisions which women make about seeking mental and emotional care	→ families play a BIG role in providing information (ASSESS the current knowledge) → social networks are alternatives - again, assess what people know already → if there is a stigma in a SN, may need to assess privately→ more/less willing to seek out care based on family/ friends assumptions → SN leads to indirect effects on uptake of mental health services → need trusting patient-provider relationship → NPS must recognize key differences in experiences of women who are refugees and be able to regard values and comforts highly in order to TAILOR their practice accordingly **Relevant future research/direction**: what can foster/ facilitate networks	*Strengths:* → semi-structured interviews may have allowed for more fluidity in gathering information and allowed for thick, nuanced descriptions *Limitations:* → very small sample size → only women *Relevance:* → brings in a broader determinant (social networks). → tells us that NPs should/could examine 'current understanding' and current perception of mental health, services, psychiatry etc. to be able to clarify misunderstandings or assumptions → important information for NPs: might consider information sharing with entire family rather than individual, knowing that social networks affect both the perceptions and the willingness to seek formal care.

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Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
Newaz, S. & Riediger, N. (2020). https://doi.org/10.18297/rgh/vol3/iss1/7 **Relevant Purpose/Objective(s):** to examine user and service provider perspectives on improving mental healthcare services for refugee women in Winnipeg, Manitoba **Hypothesis**: N/A **Study Method and Design:** qualitative; semi-structured interviews; thematic analysis using Braun and Clarke suggestions and aided by NVivo 12 software. **Participants:** Syrian refugee women, service providers, decision maker **Sample size & sampling method:** N=9 Syrian refugee women; N= 5 service providers; N=1 decision maker (total 15); mix of convenience and snowball sampling approach.	→ lacking knowledge of the western perspective of mental health → interest in learning about mental health and services (presentations, therapy, counselling and special programs just for women) → educating what therapy means → important to educate refugee women about overcoming stigma and being open about mental health issues → service providers need to have understanding of the culture; don't put everyone in the same category; dont assume things are part of the culture. eg) → misconception that Muslims don't use birth control - misconception! → service providers need to reach out to the community to learn; you have to know the culture before you can provide culturally sensitive service → trauma might prevent refugees from reaching out/ going to clinic (outreach?) →Socialization and networking are very important for the mental wellbeing of the refugee women. For many refugee women, loneliness and isolation are a source of stress → Peer support a good resources → culturally competent care = paramount → need for privacy, most won't talk about abuse in front of a man → may not be comfortable talking about sex → having knowledge about religious, islamophobia, racial discrimination and stereotypes will contribute to improve care. → interpretation and cultural brokers can close gaps in communication (helps both parties) → confidentiality is challenged when no professional interpreter → need strong interdisciplinary communication to avoid duplication of services → strong desire to participate in society and give back to the Canadian Government	→ "have to make them understand that mental health is illness like diabetes or any other diseases" → Assess patient's understanding of mental health → on intake / Meet and Greet, ask patient which parts of their culture are important to them or affect their mental wellbeing → find a way to provide services in community hubs - like city recreation facilities, gyms, halls, community centres - where education sessions can occur or meet ups → assess for social circle, social support, isolation, loneliness → assess if newer refugees are in contact with peers who have been here longer (they can share which mental health services are available) → use professional interpreters → volunteering can give a sense of community - ownership of the community (helping in the settlement centre)→ language programs should be more flexible → Service providers should use guidelines developed by UNHCR and Canadian Physicians in providing culturally competent care → provide enough time to establish relationship of trust → be aware of this group's way of reporting symptoms → service providers must be away of th whid range of tractors that put people at risk for mental disorders and consider the interaction between the individuals, community, societal factors and relationship while providing services → services: flexible, affordable, accessible and culturally/linguistically appropriate → providers NEED to understand clients' cultural idioms of distress → shift from cultural competency to cultural safety which focus on self-reflection among health practitioners → suggests using UNHCR report (Hassan et al) → improving social determinants (refer to social worker or work collaboratively with team in health centre) → WORK (connect to local resources) → Discrimination at doctor's office will also need to be addressed.	*Strengths:*→ captures different perspectives - Syrian refugees and service providers → gives tangible suggestions for improving access and quality of healthcare *Limitations:* → small sample size, only women, only sampled from one city in Canada → "service provider" not clearly defined so not entirely clear whose perspectives are captured in this study *Relevance:* → provides direct strategies for supporting the well being of this particular group → offers specific resources to utilize in Canada if caring for Syrians refugees

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?			
Abbreviated Citation and Study Details	**Relevant Findings / Themes**	**Relevant Practical Implications and Findings**	**Strengths & Limitations & Relevance to IR**
O'Mahony, J., Kassam, S., Clark, N., & Asbjoen, T. (2023) https://doi.org/10.1371/journal.pone.0281765 **Relevant Purpose/ Objective(s):** examine the perspectives of Syrian refugee mothers living in BC with respect to social support they received in early, middle and later phases of resettlement. To answer the question: *what factors do Syrian mothers perceive to have been supportive in their integration into BC society?* → Published 4 of 6 themes (see Kassam et al. for further extraction) **Hypothesis:** N/A. **Conceptual and/or Methodological framework(s):** intersectionality-framed community-based participatory action research (PAR). **Study Method & Design:** qualitative, longitudinal; in-depth interviews or focus group, socio-dem surveys; personal diaries; Syrian mothers were also co-peer researchers; Braun and Clark thematic analysis & NVivo12. **Participants:** Syrian refugee mothers in Canada <5yrs, childbearing age (18-50), current stable mental health. **Sample size & sampling method:** n=40; via peer research assistants, social service professionals and agencies working with Syrian families.	→ emotional & physical health connected, healthcare access needs to address both → importance of culturally sensitive support networks and accessible services emphasized → lack of interpreter services a barrier access and receiving healthcare; language skills a barrier / facilitator → social isolation, especially from family and past supports, a recurring issue mentioned (worsened during Covid 19 pandemic) → especially unsettling after birth; responsibilities normally shared with a woman's mother or other family member (who are not with them now)	→ NPs can ensure that they are assessing physical and mental health longitudinally → Ensure that interpreters are available and appropriate to the dialect - *having a family member interpret can be a barrier to proper mental health assessment or a cultural risk* given the stigma regarding mental illness or family's lack of knowledge about perinatal / reproductive mental health. → NPs should be aware of local groups, English learning groups, community agencies that support refugees → Be prepared to connect patients with workBC or other places that might help with finding a job → Good to assess housing situations - implications: might need to be aware of places to look for apartments, rentals, homes etc. Connect with social worker. → especially after birth, assess a woman's social supports and ?plan for home visits if appropriate and desired	*trengths:* → taps into the experiences of Syrian adults in Canada. Gives a sense of the everyday realities. →use of peer-research assistants (Syrian women) to conduct research increased authenticity, trust,rapport (social justice oriented research inquiries) *Limitations:* → only women in childbearing years who are Mothers; cannot be transferred to Syrian adult men in a reliable way → no direct connections made to measurable mental health outcomes but helps understand context *Relevance:* →covers thick descriptions of Syrian adult women's experiences in Canada - barriers / facilitators to integration which is associated with mental health → might provide more background / intro information and some implications for practice (in the broader sense - social determinants / community resourceS)

Table C3

Guidelines / Expert Opinions

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?					
Abbreviated Citation and Study Detail	**General Information**	**Baseline Understanding**	**Approaches to Avoid**	**Useful tools**	**Strengths, Limitations and Relevance to IR**
Almoshmosh et al. (2020). https://doi.org/10.1108/jmhtep-03-2019-0013 **Relevant Purpose/ Objective(s):** Prepare healthcare providers in high-income countries to deal with mental health and psychosocial issues among resettled Syrian refugees. **Target audience:** mental health professionals; relevant to primary care providers and other healthcare workers. **Conceptual framework(s):** social and cultural frameworks related to mental health **Study Method & Design:** Collaborative work of authors on a comprehensive review of social context, cultural frameworks and related issues in the mental health and psychosocial well-being of resettled Syrian refugees. **Participants:** N/A	*pre settlement stressors:* isolation, loss of cultural identity, maintaining language/ identity, discrimination, nostalgia *post settlement stressors:* social isolation, unemployment, acculturation stress, lack of vocational/ education opportunities, discrimination, language barriers. Mental health problems among conflict-affected Syrians: 1) *Loss & grief*: family, homes, materials - erodes sense of agency, control - on going and exposure on the news 2) *Emotional & mood disorders*: low mood, complicated grief, stress 3) *Victims of Torture*: mood, anxiety, somatic, suicidal, shame & guilt MAY prevent care-seeking 4) *Substance & Alcohol use*: less success quitting smoking 5) *Challenges to providing adequate mental health services for refugees from Syria*	→ be cognizant that ongoing instability in Syria is a *persistent source of stress* (has not ended) → economic challenges affect *access to healthcare cause psychological stressor*→ screen → assess social isolation, employment → long term relationships protective (including cultural community) → assess & encourage → presence of symptoms does NOT always indicate mental illness; can be "sub clinical" i.e.) demoralization, hopelessness related to existential concerns about safety, trust etc. → focus on non-clinical interventions ie. improve living conditions → *barriers to services* even when 'available' - $$ issues, language, stigma, acculturation – *can pts cover direct/indirect costs: transport or meds?* → person-centred, partnership, collab → empower (ACTIVE involvement can help people who felt robbed of power /control) → safe spaces = explain settings & privacy, interpreters/ cultural brokers, customs, allow time → somatic (headaches, nausea, dizziness, appetite changes & insomnia) → ?assess psych wellbeing (don't dismiss the possibility of organic causes) → survivors of sexual/gender based violence identify supportive members of SN → community based	→ AVOID diagnostic labeling as conventional diagnostic classifications may not be sufficient and symptoms may not fit specific categories → engage integrated multidisciplinary teams →AVOID creating situations of helplessness and dependency; do not convey the message that your client does not have the means for helping/healing themselves →AVOID psychological jargon / psych labeling →integrate MH into medical clinics / visits to avoid stigma → do NOT just focus on symptoms – social functioning,	→ engage in smoking cessation conversations (discuss health benefits) →*Validated tools:* Hopkins Symptom Checklist, Harvard Trauma Questionnaire and WHO-5 well-being index– adequate psychometric properties among Arabic speakers → screen: integrate questions exploring local modes of expression → CFI in DSM 5 offers approach (ex) ask patients views of the illness and their expectations for care as well as psychosocial stressors and supports and relevant aspects of ethno- cultural identity → provide education on what it means to be mentally unwell (isolation, fear, aggression)	*Strengths:* -experts in transcultural psychiatry, working with refugees; many are Arabic speakers; one is confirmed to be of Syrian heritage *Limitations:* -some of the recommended management techniques (NET, CBT, EMDR) require further training but not necessarily out of the scope of a PCP *Relevance:* -provides foundational knowledge about stressors, cultural understandings of MH, tangible tools to screen

Sample size & sampling method: N/A	→Labeling emotional suffering as psychological or psychiatric can be embarrassment/stigma, "crazy" – shame →Measuring MH distress ~difficult d/t language /cultural expression variation	groups like parenting can improve couple & family functioning → support re-establishment of (+) & resilient PRE-establishment coping ways →avoid smoking, ++ watch news, withdrawal, neg rumination (community involvement, planning for future, decision making) → reduce learned helplessness → women CRITICAL & central role in promoting MH in family & community; assist men to find work to prevent social marginalization, isolation; Bandura's theory	(+) contributors, coping, resiliency	→talk about non stigmatized manifestations 1st: concentration, sleep, appetite → consider family members who join appointments as valuable opportunity to educate. → be aware of resources like interpreters /cultural brokers → improve access → consider referrals to specialists who can apply NET, CBT and EMDR (esp. For PTSD / depress.). → severe MH: consider med- culturally informed education may improve adherence = explore meaning of meds, negotiate tx; stigma; meds might legitimize 'sick role'	and specific examples of strategies to support mental well-being of Syrian adults

Table C4

Systematic Review

Research Question: What strategies and considerations must NPs in Canada be aware of to support the mental wellbeing of Syrian adults with refugee experiences?				
Abbreviated Citation & Study Details	**Culturally Validated Screening Tools**	**General Advice**	**Treat/ Manage**	**Strengths, Limitations & Relevance to IR**
Nakeyar, C. & Frewen, P.A. (2016). http://dx.doi.org/10.1037/cap0000067 **Relevant Purpose/ Objective(s):** determine evidence-base for informed recommendations on culturally sensitive psychological services to be provided to Iraqi, Kurdish & Syrian asylum seekers in the context of PTSD; establish a list of these measures, treatments and biomarkers use in literature **Target audience:** those providing psychological services to Iraqi, Kurdish and Syrian asylum seekers in Canada- especially those who experience PTSD **Conceptual and/or Methodological framework(s)**: N/A **Study Method & Design:** Systematic Review **Number of studies:** 17 manuscripts reviewed **Inclusion Criteria:** 1. Research conveyed data on PTSD per criteria in DSM-IV or DSM-5 (with formal psych assessment measures, psychological treatments or biomarkers 2. Research reported on Syrian, Iraqi or Kurdish refugees residing in a developed country at time of research conducted (Australia, N. America, W. Europe, Scandinavian countries) 3. English articles 4. Primary research, systematic reviews, meta-analysis, literature reviews 5. Written after 2011 (relevant to current Syrian conflict)	*Self-Report* → Harvard Trauma Questionnaire (HTQ) (begin with this then if high symptom endorsement, can conduct follow up interview like CAPS); Hopkins Symptom Checklist 25 (HSCL 25); Post-migration Living Difficulties Questionnaire *Trauma exposure* → Vivo checklist of War, Detention, & Torture *PTSD diagnosis and severity (diagnostic interview)* → Clinically Administered PTSD Scale for DSM (CAP) (training required) → need clarification in future studies because none included in this review used CAPS 5 ** assessors may require psychologically educated translators be present to afford the valid conduct of diagnostic interviewed *Related psychological symptoms/disorders* → Mini International neuropsychiatric interview → Hamilton Depression Rating Scale (HAM-D) ** Use HTQ 1st to exclude non cases for PTSD → then use CAPS to confirm non-excluded cases ** HSCL-25 to exclude non cases for anxiety/depressive → then use HAM-D to assess for diagnosis of comorbid depression	*** HSCL-D (items on depression), HTQ and structural clinical interviews for DSM-IV altogether are better at identifying non-cases than cases so the best approach might be to use self-report measures first to exclude non=cases then structured interviews to confirm diagnosis (like HAM-D or CAP) ** PMLD to identify severity of stressor exposure following migration THEN use CAPS to confirm → provide support for those with subthreshold symptoms as well - not just diagnosed PTSD / depression	→ *Narrative exposure therapy (NET)* effective for PTSD in Iraqi, Kurdish and Syrian refugee populations in 2 studies → meant as ST treatment for traumatic stress disorders specific to refugees and asylum seekers with exposure to multiple traumatic events ** greater symptom reduction	*strengths:* -focus is on asylum seekers in Canada -reviewed 17 studies *Limitations:* -majority of 17 studies included participants from Iraqi, Mandaean refugees; a few were 'mixed background' and only one explicitly states that Syrians were among the participants thought he mixed group may have -limited focus to PTSD specifically -feasibility and cost-effectiveness of conduct of these clinical interviews may be in questions *Relevance:* → despite limitations, geographical proximity of the groups studied makes findings relevant to Syrians -identifies screening tools that can be used and treatment → if not feasible for NP to apply or train in their use, guidance could be shared with interdisciplinary team members like counsellors or psychiatrists →self-report measures provided which are more cost effective, convenience and show good clinic utility in this population - especially HTQ (in Arabic)

Appendix D

Culturally or Linguistically Validated Tools

Table D1

The World Health Organization- Five Well-Being Index (WHO-5)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.
Example. If you have felt cheerful and in good spirits more than half of the time during the last two weeks, select number three.

		All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	I have felt cheerful and in good spirits	5	4	3	2	1	0
2	I have felt calm and relaxed	5	4	3	2	1	0
3	I have felt active and vigorous	5	4	3	2	1	0
4	I woke up feeling fresh and rested	5	4	3	2	1	0
5	My daily life has been filled with things that interest me	5	4	3	2	1	0

Scoring Comment: The raw score is calculated by totalling the scores on each of the five questions. The raw score *ranges from zero to 25*, *zero representing worst possible mental well-being* and *25 representing best possible mental well-being*. To get a percentage score ranging from zero to 100, the raw score is multiplied by four. A percentage score of zero represents worst possible mental well-being; a score of 100 represents best possible mental well-being.
Comment: A percentage score below 50 (or a raw score below 13) has been suggested as a cut-off for poor mental well-being and as an indication for further assessment for the possible presence of a mental health condition (e.g., depressive disorder).

Note. WHO allows for the use of this Index provided it is cited appropriately. Their suggested citation is: World Health Organization. The World Health Organization-Five Well-Being Index (WHO-5). Geneva: World Health Organization; 2024. Licence: CC-BY-NC-SA 3.0
See also World Health Organization (2024) in reference list.

Table D2

Cultural Formulation Interview (CFI)

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about ***your*** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.
CULTURAL DEFINITION OF THE PROBLEM	
CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would *you* describe your problem?
Ask how individual frames the problem for members of the social network.	2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
Focus on the aspects of the problem that matter most to the individual.	3. What troubles you most about your problem?
CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT	
CAUSES (Explanatory Model, Social Network, Older Adults)	
This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. *Note that individuals may identify multiple causes, depending on the facet of the problem they are considering.*	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? *PROMPT FURTHER IF REQUIRED:* Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.
Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS (Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)	
Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality).	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?
ROLE OF CULTURAL IDENTITY (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)	
	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By ***background*** or ***identity,*** I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse. *Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).*	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING	
SELF-COPING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)	
Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). *Probe as needed (e.g., "What other sources of help have you used?").* *Clarify the individual's experience and regard for previous help.*	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? *PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:* What types of help or treatment were most useful? Not useful?
BARRIERS (Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)	
Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment. *Probe details as needed (e.g., "What got in the way?").*	13. Has anything prevented you from getting the help you need? *PROBE AS NEEDED:* For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?
CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING	
PREFERENCES (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)	
Clarify individual's current perceived needs and expectations of help, broadly defined. *Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?").*	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?
Focus on the views of the social network regarding help seeking.	15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?
CLINICIAN-PATIENT RELATIONSHIP (Clinician-Patient Relationship, Older Adults)	
Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. *Probe details as needed (e.g., "In what way?").* *Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.*	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

Note. The American Psychiatric Association (2013) permits the reproduction of the CFI by researchers and clinicians for use with their patients.

Table D3

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

Major depressive disorder (MDD) is suggested if:
• Of the 9 items, 5 or more are checked as at least 'more than half the days'
• Either item 1 or 2 is checked as at least 'more than half the days'
Other depressive syndrome is suggested if:
• Of the 9 items, between 2 to 4 are checked as at least 'more than half the days'
• Either item 1 or 2 is checked as at least 'more than half the days'

PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally the numbers of all the checked responses under each heading (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below

Functional Health Assessment: The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, life at home, or relationships with other people. Patient response of 'very difficult' or 'extremely difficult 'suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.
Note: *Depression should not be diagnosed or excluded solely on the basis of a PHQ-9 score*. A PHQ-9 score ≥ 10 has a sensitivity of 88% and a specificity of 88% for major depression.1 Since the questionnaire relies on patient self-report, the practitioner should verify all responses. A definitive diagnosis is made taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Note. This PHQ-9 and its notes were obtained from British Columbia Ministry of Health (2022).

Table D4

Hamilton Depression Rating Scale (HAM-D)

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name _____ **Today's Date** _____

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

☐ **1. DEPRESSED MOOD**
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

☐ **2. FEELINGS OF GUILT**
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

☐ **3. SUICIDE**
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

☐ **4. INSOMNIA - Initial**
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

☐ **5. INSOMNIA - Middle**
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **6. INSOMNIA - Delayed**
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

☐ **7. WORK AND INTERESTS**
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

☐ **8. RETARDATION**
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

☐ **9. AGITATION**
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

☐ **10. ANXIETY - PSYCHIC**
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

☐ **11. ANXIETY - SOMATIC**
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **12. SOMATIC SYMPTOMS - GASTROINTESTINAL**
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

☐ **13. SOMATIC SYMPTOMS - GENERAL**
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

☐ **14. GENITAL SYMPTOMS**
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

☐ **15. HYPOCHONDRIASIS**
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

☐ **16. WEIGHT LOSS**
0 = No weight loss
1 = Slight
2 = Obvious or severe

☐ **17. INSIGHT**
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: _____
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

☐ **18. DIURNAL VARIATION**
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM ( )

☐ **19. DEPERSONALIZATION AND DEREALIZATION**
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

☐ **20. PARANOID SYMPTOMS**
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

☐ **21. OBSESSIONAL SYMPTOMS**
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

Note. Score is based on the first 17 items. For more information, see APA (2025b).

Appendix E

Common Expressions and Idioms of Distress

Table E1

Common Expressions and Idioms of Distress in Syrian Arabic

TABLE 1: COMMON EXPRESSIONS AND IDIOMS OF DISTRESS IN SYRIAN ARABIC

Arabic term or phrase	Transcription	Literal translations	Emotions, thoughts and physical symptoms that may be conveyed through these expressions
متضايق كتير هالفترة حاسس حالي متضايق ضايج نفسي مخنوقة	- Meddayyek ketir hal fatra - Haassess haalii meddayyek - Dayej - Nafsi makhnouka	- I am very annoyed these days - I feel annoyed - To be cramped - My psyche is suffocating	- Rumination tiredness, physical aches, constriction in the chest, repeated sighing - Unpleasant feelings in the chest, hopelessness, boredom
حاسس روحي عم تطلع	- Hassess rouhi 'am tetla'	- I feel my soul is going out	- Dysphoric mood, sadness - Inability to cope, being fed up - Worry, being pessimistic
قلبي- مقبوض انعمى على قلبي	- Qalb maqboud - In'ama 'ala kalbi	- Squeezed heart - Blindness got to my heart[1]	- Dysphoria - Sadness - Worry, being pessimistic
تعبان نفسياً- حاسس حالي تعبان- حالتي تعبانة- نفس تعبانه	- Taeban nafseyan - Hassess halii ta3ban - Halti taebaneh - Nafs ta'bana	- Fatigued self/soul	- Undifferentiated anxiety and depression symptoms, tiredness, fatigue
-ما قادر اتحمل الضغط علي كتير- مو قادر ركز من الضغوطات -	- Ma ader athammel - El daght 'alayy ketiir - Mou kaader rakkezz men el doghoutaat	- Can't bear it anymore - The pressure on me is too much - Can't concentrate because of the pressure	- Feelings of being under extreme stress or extreme pressure - Helplessness
فرطت-	- Faratit	- I am in pieces	- General state of stress, sadness, extreme tiredness, inability to open up and to control oneself, or to hold oneself together
و الله مو شايف قدامي-	- Wallah mou shayef oddaamii	- By God, I can't see in front of me	- General state of stress, feelings of loss of options, loss of ability to project into the future, - Confusion, hopelessness
-حاسس الدنيا مسكرة بوشي - ما في شي عم يزبط معي	- Hases eddenia msakkra bwishi - Ma fi shi 'am yizbat ma'i	- I feel the world is closing in front of my face - Nothing is working as planned with me	- Hopelessness, helplessness, state of despair
- شو بدي إحكي...الشكوى لغير الله مذله - الحمد لله	- Sho baddi 'ehki… el shakwa le gher allah mazalleh -Al hamdullillah	- What am I supposed to say… it is humiliating to complain to someone other than God. - Praise be to God.	- Reference to shame in asking for help - State of despair, surrender
ما بعرف شو بدي إعمل بحالي	- Maa ba'ref shou beddi a'mel be halii	- I don't know what I am going to do with myself	- General state of distress - Feeling upset, edgy, helplessness -Hopelessness, lack of options
متوتر	- Mitwatter	- I feel tense	- Nervousness, tension
خيفان حاسس بالخوف مرعوب	- Khayfan - Hases bil khof Mar'oub	- I am afraid - I feel fear - Frightened, horrified	- Fear, anxiety - Worry - Extreme fear
مُعَصّب	M3asseb	- I feel angry	- Anger, aggressiveness - Nervousness

Sources: This table is based on suggestions by Arabic speaking mental health professionals, including: Alaa Bairoutieh, Tayseer Hassoon, Ghayda Hassan, Maysaa Hassan, Hussam Jefee-Bahloul, and Mohamed el Shazli.

Note. From Hassan et al. (2015, p.25).

Table E2

Expressions in Kurdish (Kirmanji Dialect)

TABLE 2: EXPRESSIONS IN KURDISH (KIRMANJI DIALECT)		
Kurdish terms or expressions	**Literal translations**	**Emotions, thoughts and physical symptoms that may be conveyed through these expressions**
Bena mn tanga *Nafasa mn tanga*	- My breath is short	- Low mood
Chi béjim/ chi bikim vala ye	- What am I supposed to say/to do without result	- Helplessness - Hopelessness - Loss of options
Dunia lber mn tari buya *Dunya li ber chavé min resh búye*	- The world became dark in front of me - The world is closing in front of my face	- Despair - Hopelessness - Helplessness - Depression
Ez dihisim gu ezé bifetisim *Béna min dichiki*	- I feel I am going to suffocate	- Restlessness - Loss of options, - Feeling constricted
Dil shikestime, *Dilé min déshe*	- My heart is broken - My heart is aching	- Tightness in the chest - Chest pain - Stress - Anxiety - Sadness
Az taabima *Nefsí/ westyame* *Pir westyame*	- I'm tired - Fatigued self - Fatigued soul	- Helplessness - Hopelessness - Fatigue
Az nkarm bshughlm	- I can't fulfil my duties or responsibilities	- Inability or loss of drive or motivation to perform activities
Az galak dfkrm	- I think a lot	- Excessive thinking /excessive worry - Could be associated with anxiety or depression
Lashe mn grana	- My body is heavy	- Fatigue
Kharna mn tunaya	- I have no appetite	- Loss of appetite that could be associated with grieving, anxiety, worry or depression
Az ghaidm *Az qahrima* *Az ejzm*	- I am sad - I feel sorrow - I feel incapable or impotent	- Low mood - Sadness - Incapacity - Feelings of injustice or of being defeated by unjust life circumstances
Jisme mn sist dbit	- My body becomes rigid	- Spasm of body parts which may occur in non-epileptic seizures and in epileptic seizures
Tahamula mn kem buya *Tahamula mn tunaya* *Nema tahmúl dikim* *Ez feritime*	- I feel that my ability to bear things is reduced	- Excessive stress - Easily losing control over one's emotions - Difficulty coping, handling stress or pressures
Ez nizanim chi bi seré xwe bikim	- I don't know what I am going to do with myself	- General distress - A state of confusion, loss of options and disappointment
Source: This table is made with expert input of Kurdish speaking mental health professionals: Rawisht Rasheed, Aram Hasan and Naz Baban.		

Note. From Hassan et al. (2015, p.26)

Appendix F

Supporting Mental Wellbeing of Syrian Adults - Primary Care Toolkit (Sample/Template)

Practitioners who accept Interim Federal Health Program (IFHP) Funding	**Provider Search:** https://ifhp.medaviebc.ca/en/providers-search
Care or Support in Arabic	**Psychology Today:** https://www.psychologytoday.com/ca/therapists/british-columbia?category=arabic **To register for primary care provider (NP/MD) with interpreter:** https://www.healthlinkbc.ca/find-care/health-connect-registry#paragraph-4420
Mental Health providers who offer CBT and/or specialize in Trauma/PTSD	**Psychology Today:** https://www.psychologytoday.com/ca/therapists/british-columbia?category=arabic&spec=19&spec=293
Resettlement / Newcomer/ Family Agencies & Services	**Kelowna Community Resources (KCR) Settlement & Integration Services**: https://kcr.ca/immigrant-services/settlement-integration-services/ **KCR Translation & Interpretation Services**: https://kcr.ca/immigrant-services/translations/ **Central Okanagan Family Hub**: https://cofh.ca/about-us/
Housing & Rental Information	**Residential Tenancy Branch – Accessing Services in Arabic**: https://bcgovnews-etg7c8etapa6btfr.z03.azurefd.net/translations/releases/2023HOUS0060-000874/RTB_LanguageServices_Arabic.pdf
Employment Resources	**WorkBC Kelowna:** https://www.workbc.ca/workbc-centres/workbc-centre-kelowna
English Language Courses/ Programs	**English Corner (Held in Public Libraries):** https://englishcorner.ca/kelowna/ **Okanagan College English Language Studies**: https://www.okanagan.bc.ca/english-language/english-language-studies **OCCA Communities Association**: https://occabc.ca/services/esl/
Patient Resources	**Patient Mental Health Information / Handouts:** https://multiculturalmentalhealth.ca/consumer-information/mental-health-information-resources-in-arabic/ **CMHA Depression (Arabic):** https://www.heretohelp.bc.ca/sites/default/files/Plain%20Language%20Depression_Arabic.pdf **CMHA Depression (English)** https://www.heretohelp.bc.ca/infosheet/what-is-depression