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A socio-ecological approach to understanding barriers to mental health care access for Syrian refugee women in Germany - Perspectives of refugee mental health care professionals

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TABLE OF CONTENTS

ABSTRACT

Syrian refugee women are an at-risk population due to the specific pre-, during and post-migration stressors they face. Consequently, knowledge pertaining to this population's barriers to mental health care access is an important tool in providing care. In this study, a socio-ecological approach was used to investigate barriers to mental health care access related to this refugee population with an emphasis on specific ethno-cultural and gender factors.

McLeroy et al. (1988)'s socio-ecological model for health behaviour informs both the literature review and the thematic analysis of 14 interviews with mental health care professionals involved in refugee mental health care provision in Germany. The socio-ecological model was used to illustrate the interconnectedness and complexity of barriers across multiple systems and acknowledges the many influences on mental health services utilization behaviour. The model analyses ways in which micro to macro factors create constraints on mental health services utilization amongst Syrian refugee women in Germany and gives recommendations on design and delivery of mental health care.

Application of the socio-ecological model in thematic analysis revealed multi-systems conditions associated with barriers to mental health care access. Barriers specific to Syrian refugee women include stigma associated to gender-based violence and related fear of indiscretion of mental health care professionals and interpreters, lacking childcare provisions in mental health services , the specific cultural gender role of Syrian women as the primary caregiver, upholder of family values and the related prioritization of the needs of family members above own mental health needs, which also influences, besides stigmatisation, culturally sensitive labelling of the mental health care services and service provision. Barriers not specifically related to gender, but to ethno-cultural factors in Syrian refugee women, are lacking health literacy and unfamiliarity with the Western approach to mental health, a high stigmatisation of mental health and the particular referral pathways to mental health care. Another factor acting as a barrier for Syrian refugees specifically is the lacking interpreter provision in the state mental health relating to subsidiary protection status which most Syrian refugees are granted in Germany.

Keywords: Socio-ecological theory, semi-structured interviews, qualitative inquiry, thematic analysis, mental health care access, Syrian refugee women.

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ABBREVIATIONS

NGO – Non-governmental Agency

UNHCR – United Nations High Commissioner for Refugees

BAMF – Bundesamt für Migration und Flüchtlinge (German Federal Office for Migration and
Refugees)

AsylbLG – Asylbewerberleistungsgesetz (Benefits for Asylum Seekers Act)

PTSD – Post-traumatic Stress Disorder

IPV – Intimate Partner Violence

GBV – Gender-based Violence

SEM – Socio-ecological Model

BAfF - Bundesweite Arbeitsgemeinschaft der Psychosozialen Zentren für Flüchtlinge und
Folteropfer (National working group for psychosocial centres for refugees and victims of torture)

LIST OF TABLES AND FIGURES

CHAPTER 1: INTRODUCTION

Since 2011, the civil war in Syria has forced more than half of the Syrians to leave their home (Neftci, 2017; Sijbrandij et al., 2017). This crisis is defined as the world's largest humanitarian tragedy since the World War II (Neftci, 2017; UNHCR, 2017). Syrians are now the largest refugee population in the world; in 2017, approximately five million Syrian refugees were registered according to the United Nations Higher Commission for Refugees (UNHCR) (2017). Between 2013 and 2017, most of asylum applicants worldwide and also in the EU came from Syria (Eurostat, 2018).

In response to the increased humanitarian needs in previous years worldwide and the resulting refugee crisis, many EU countries have received applications from refugees. Between 2006 and 2014, the number of first time asylum applicants in the 28 EU member states increased steadily from around 200,000 applicants in 2006 to approximately 562,000 applicants in 2014, with a sharp rise to 1,257,000 applicants in 2015 and 1,206,100 applicants in 2016, after which time the numbers returned close to the level in 2014 (Eurostat, 2018, see *Figure 1: Asylum applications (non-EU) in the EU-28 Member States, 2006–2017*).
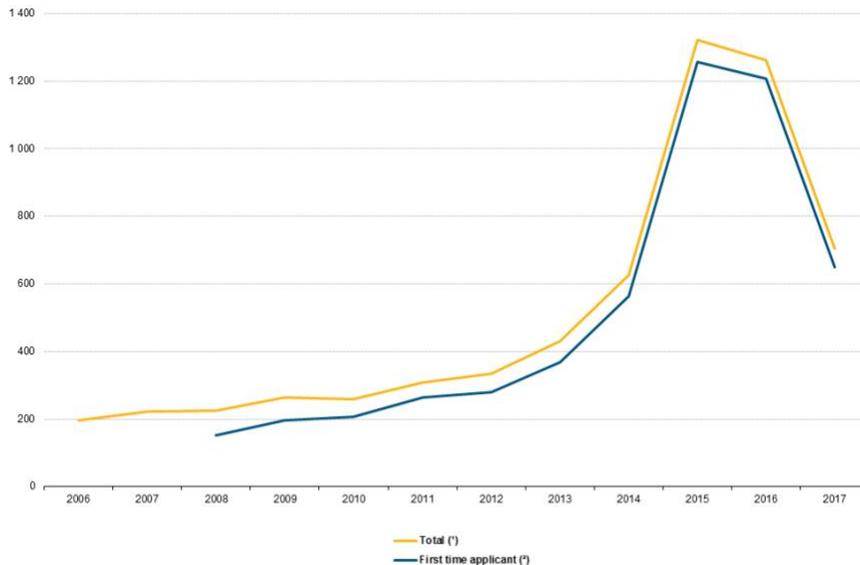
Figure 1: Asylum applications (non-EU) in the EU-28 Member States, 2006–2017

Germany is the main hosting country of asylum seekers in the EU-28 countries, having accommodated 60% of all EU asylum applications in 2016 (722,370 applications) and 31% in 2017 (198,317 applications) (Eurostat, 2018; BAMF, 2018), with the majority of refugees in Germany coming from Syria since 2014 (BAMF, 2018). It was reported that about 12% of the total Syrian refugee population currently live in Germany, approximately 800,000 in total (BAMF, 2018). Close to half of this refugee population is reported to be female (BAMF, 2018).

Due to the nature of the Syrian armed conflict, Syrians have suffered multiple rights violations and abuses from different actors, including torture, kidnap, rape, sexual slavery, brutal executions, disappearances and they have often undertaken a risky and stressful flight (Neftci, 2017; Silove et al., 2017). They have lost family members, their homes and livelihoods (Hassan et al., 2016). During their displacement, they have experienced increasing levels of poverty, soaring unemployment, limited access to food, water, sanitation, housing, health care and education, which have had a devastating impact (UNHCR, 2014; UNHCR and REACH, 2014).

Particularly women are victims of human rights violations before and during the displacement with gender-based violence (GBV) now being "the most salient feature of the current conflict" (Parker, 2015). But intimate partner violence (IPV) also is on the rise in such harsh conditions, with 70% of Syrian refugees disclosing such abuse (Parker, 2015). Additionally, women are often forced to exchange sexual acts in favour of basic necessities like food, clothing and shelter both pre- and during displacement (Parker, 2015). Post displacement stressors of refugees centre around structural problems such as lacking financial resources, unemployment, unsatisfactory accommodation in host countries, the uncertainty of the asylum procedure, discrimination and stigmatization, which further increase the vulnerability of refugees, particularly that of women (Laban et al. 2004). Additionally, many refugee women unable to make a decent livelihood engage in prostitution or survival sex to feed themselves and their families (The Forced Migration Network, 2017). Refugees in general have a higher level of mental illness than the native population (Palmer & Ward, 2007) and refugee women are in a particularly vulnerable position in terms of psychological stressors which may lead to severe mental illness (Flatten et al., 2001; Palmer & Ward, 2007).

Poor mental health and functional impairment has been found to be related to an inability to develop relationships with local people, seek employment, seek education or training and learn the language of the host country (Phillimore, 2011; Schick et al., 2016; Silbermann et al., 2016). All of

these activities are relevant to integration and untreated symptoms of PTSD and depression may prevent integration into host societies (Schick et al., 2016). Disintegrated refugees face the risk of isolation, unemployment, poverty, criminality, pose a major strain on the welfare system and segregate society. Integrating refugees is also of economic interest to host countries - it is estimated that the current refugee cohort can generate an EU GDP contribution of approximately 60 to 70 billion EUR annually by 2025 (McKinsey Global Institute, 2016). Refugees also change demographics in receiving countries that benefit aging societies (McKinsey Global Institute, 2016). Apart from facilitating integration, treatment of mental illness in refugees is also required to fulfil EU legislation for particularly vulnerable individuals (BAfF, 2016), which Syrians identify as.

Whilst the mental health of Syrian refugees has been an increasing point of focus of studies in recent years, the particular aspect of gender, much as in other refugee populations, has been relatively neglected by researchers (Shishegar et al., 2017; Floyd & Sakellariou, 2017; Gerard & Pickering, 2013; Mengesha, 2017; Shishehgar et al., 2017; Sönmez et al., 2017, The Forced Migration Network, 2017; Wohler & Dantas, 2017) and policymakers and are not met in current mental health care provision in Germany (Caritas, 2016). This results in underutilization of mental healthcare, despite refugee women being amongst the most vulnerable individuals during war conflicts and are affected in the worst ways by these experiences, in terms of physical, mental and social consequences (Sönmez et al., 2017).

Therefore, culturally appropriate mental health care and psychosocial support has been identified as one of the most pronounced concerns resulting from the current Syrian crisis in a joint assessment led by the United Nations and the Government of Syria (Quosh, 2013). With Syrians being the biggest refugee population in Germany and women representing close to 50% of this refugee cohort since 2016 (BAMF, 2018), studying barriers to mental health care pertaining to Syrian refugee women sheds light on important determinants of health services utilization behaviour of this particular population (Sword, 1999). This knowledge is relevant for refugee mental health care professionals and policymakers to inform the design and delivery of mental health care services adequate for this population. This can ultimately enhance qualities of psychological and social wellbeing of this marginalised population and therefore is also relevant for integration which ultimately benefits economies of the receiving countries. The qualitative research component of this thesis focuses, therefore, specifically on Syrian refugee women's ethno-cultural and gender-related

barriers to mental health care access in Germany, as perceived by mental health care professionals working with Syrian refugee women in Germany.

Purpose of the Study

The objective of this study is to explore barriers to access to mental health care which Syrian refugee women in Germany encounter, as perceived by mental health care professionals, with particular emphasis on ethno-cultural and gender influences. The study of barriers is particularly relevant as they act as important determinants of mental health care utilization behaviour and are therefore crucial to the adequate design and delivery of mental health care services for specific populations such as Syrian refugee women. The particular research question guiding this study is: *"What are the barriers to access to mental health care services for Syrian refugee women in Germany?".* To answer this question, a qualitative study was conducted based on the thematic analysis of semi-structured interviews with mental health care professionals working with Syrian refugee women in Germany. This thematic analysis is guided by McLeroy et al. (1988)'s socio-ecological model for health behaviour and performed according to Braun & Clarke's 6 stages method of qualitative thematic analysis (2006).

Therefore, by the end of this thesis, the author aims to utilize current literature to explore the barriers pertaining to Syrian refugees in general and specifically refugee women, where available. This literature review locates the barriers on the five levels of McLeroy et al. (1988)'s socio-ecological model as outlined in the section *Theoretical Framework.* Furthermore, the author also aims to give an overview of the specific methodology used for data collection and analysis of this study and answer the research question with the data obtained from the thematic analysis of 14 in-depth interviews with mental health care professionals working with Syrian refugee women in Germany. These findings will be organized according to McLeroy et al. (1988)'s socio-ecological model. Finally, a discussion of the findings will be provided alongside policy recommendations.

Structure of this Thesis

The overall structure of the study takes the form of five chapters, including this introductory chapter. The second chapter sets forth the theoretical framework and reviews the relevant literature. This chapter also details the prevalence of mental illness in Syrian refugee populations, with an emphasis on women, in more detail. The third chapter details the methodology employed for data

collection and analysis, which consists of the thematic analysis of 14 interviews with mental health care professionals in Germany, that work directly with Syrian refugee women.

Following this, the fourth chapter presents and analyses the results of the thematic analysis. This analysis is guided by the theoretical framework detailed in the second chapter. The final chapter gives a brief summary and critique of the findings, tying up the various empirical strands identified in the literature review and includes a discussion of the implications of the findings to future research and policymaking.

CHAPTER 2: LITERATURE REVIEW

Theoretical Framework

To identify and understand the barriers to mental health care access for Syrian refugee women in Germany, the socio-ecological model (SEM) was used as an organizing framework to situate the barriers on the various SEM layers spanning from individual to policy level. In this study, McLeroy et al. (1988)'s adaptation of the SEM was used, which is geared specifically towards explaining how different individual and environmental factors determine health behaviour in individuals (see *Figure 2: The Socio-Ecological Framework adapted from McLeroy et al. (1988))*.

Socio-ecological Model (SEM)

The socio-ecological model (SEM) assumes that individual decisions and behaviours are determined by reciprocal interactions within and between the social and physical environment of individuals and are interdependent in nature. This reciprocal causality means that, at the individual level, meaning and behaviour is developed in micro-systems in connection with others and with larger macro-systems, through shared ideals, symbols, language and experiences (Henderson & Baffour, 2015). At the same time, individuals also contribute to their social ecology in terms of constructing norms, beliefs and culture across multiple macro-systems (Henderson & Baffour, 2015). Consequently, micro systems feed into macro systems and vice-versa. As such, the SEM states that individual-level behaviour is shaped by multiple environmental factors and vice-versa, as illustrated in *Figure 2*.
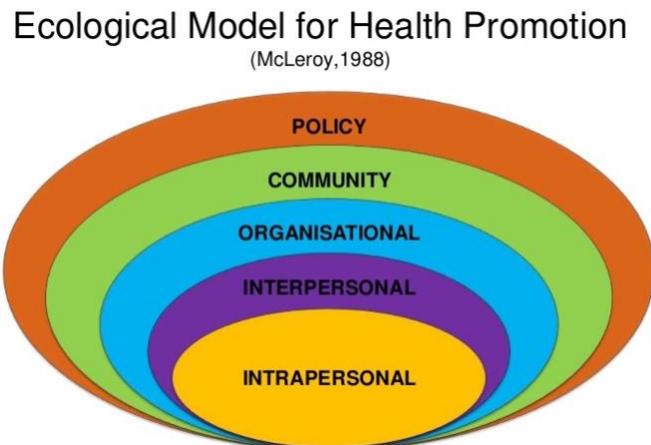
Figure 2: The Socio-Ecological Framework adapted from McLeroy et al. (1988)

The SEM recognises the importance of social environmental and biological factors that may foster or inhibit individual attitudes and behaviours (Hong et al., 2015). In the context of barriers to mental health care access, it serves as a framework to identify, organize, systematize, and analyse determinants in Syrian refugee women in Germany.

Based on ecological systems theory (EST), the SEM was first introduced by Urie Bronfenbrenner, who posited that human development is shaped by a number of systems or contexts (Bronfenbrenner, 1979, 1986). McLaren & Hawe (2005, p. 9) define the SEM as "a conceptual framework designed to draw attention to individual and environmental determinants of behaviour. The visual metaphor is a series of concentric or nested circles which represents a level of influence on behaviour". The SEM conceptualises human development by placing the individual into the centres of circles surrounding it (Kilanowski, 2017), highlighting the interrelationship of multiple interdependent determinants of development and interactions at the personal, relational and collective levels within this dynamic socio-ecological environment (Henderson & Baffour, 2015) (see *Figure 2: The Socio-Ecological Framework adapted from McLeroy et al. (1988)*).

McLeroy's Adaptation of the SEM: Health Behaviour

Since the 1980s, various authors from different fields have applied the model to different contexts to explain different types of behaviour. Barriers to health services utilization have been conceptualized in McLeroy et al.'s (1988) adaption of the SEM. This adaptation acts as a framework to explore the determinants of health behaviour in the dynamic interplay between individuals and their environment (Sword, 1999). McLeroy et al.'s adapted SEM contains five hierarchical levels: intrapersonal, interpersonal, organizational, community, and policy environment (see *Figure 2: The Socio-Ecological Framework adapted from McLeroy et al. (1988)*).

Levels of the SEM

I.   Intrapersonal Level

In a health services utilization context, the intrapersonal level consists of the individual-level factors that determine and inform health services utilization behaviour (McLeroy et al., 1988). These include demographic factors (for example, socio-economic standing, gender, age), personal history, and personal beliefs and knowledge about healthcare utilization (McLeroy et al., 1988).

Specific factors on the intrapersonal level identified in the literature on refugee populations include pre- and during migration stressors, such as history of organized deliberate violence and

oppression and GBV (Shannon et al., 2014; Hassan et al., 2016), post migration stressors such as acculturation stressors (Asgary & Segar, 2011; Kaplan et al., 2016; Shishehgar et al., 2017) and a lack of knowledge about available mental health care services (Asgary & Segar, 2011; Donnelly et al., 2011; Posselt et al., 2017; Salami et al., 2018; Shannon et al., 2014; Shishehgar et al., 2017; Sijbrandij et al, 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010; Wohler & Dantas, 2017).

II.   Interpersonal Level

On the interpersonal level, health services utilization behaviour in McLeroy's model is seen as being influenced by groups, such as social networks and social supports. These social networks and supports are provided by family, friends, neighbours, acquaintances and co-workers (McLeroy et al., 1988). Social networks and support systems provide important social resources, including emotional support and information, and are important mediators of life stressors and components of overall wellbeing (McLeroy et al., 1988). As such, social relationships are essential aspects of social identity and inform health behaviour (McLeroy et al., 1988). For example, the decision whether a doctor should be consulted and the timing of such a consultation may be substantially influenced by a significant other (McLeroy et al., 1988).

Furthermore, the relationship between the physician and the service user inherently informs health services utilization behaviour (Sword, 1999). Specific interpersonal barriers in refugee mental health care provision include language barriers with healthcare providers (Asgary & Segar, 2011; Donnelly et al., 2011; Hassan et al., 2016; Jensen et al., 2013; Kaplan et al., 2016; O'Mahony & Donnelly, 2007; Posselt et al., 2017; Salami et al., 2018; Salt et al., 2017; Schouler-Ocak, 2017; Shishehgar et al., 2017; Sijbrandij et al., 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010) Other interpersonal determinants which may affect the relationship between the healthcare provider and the service user include agency characteristics, skills, knowledge and attitudes and philosophy of health service providers and financial resources (Sword, 1999). This was identified to be particularly the case with barriers connected to intercultural communication between migrants and native mental health care professionals (Asgary & Segar, 2011; Dow, 2011; Kaplan et al., 2016; Salt et al., 2017; Schouler-Ocak, 2017). Other barriers identified on the interpersonal level include health literacy (Jensen et al., 2013; Schouler-Ocak, 2017; Thomson et al., 2015), power dynamics (Hassan et al., 2016) and somatization (Hassan et al., 2016; Jensen et al., 2013; Thomson et al., 2015; Wohler & Dantas, 2017).

III. Organizational Level

The organizational level in McLeroy's model focuses away from inter- and intrapersonal factors and looks more towards environmental determinants of behaviour and how organizational characteristics inform health services utilization behaviour (McLeroy et al., 1988). Specifically, this level looks at how formal and informal rules, regulations and ethos of mental health services providers may promote or endanger mental health services utilization on an organisational level (McLeroy et al., 1988). McLeroy et al. (1988) conceptualize that organizational settings, structures and processes can have a substantial influence on health-related behaviour of individuals.

Organizational barriers in the migration literature mention, for example, the way in which organizations provide mental healthcare to refugees (Asgary & Segar, 2011; Posselt et al., 2017; Salami et al., 2018; Shannon et al., 2014; Shishehgar et al., 2017; Sijbrandij et al, 2017; Thomson et al., 2015; Wohler & Dantas, 2017), the availability of services (Asgary & Segar, 2011; Donelly et al., 2011; Sijbrandij et al., 2017; Wohler & Dantas, 2017), systemic discrimination of ethnic minorities (Asgary & Segar, 2011; Dow, 2011; O'Mahony & Donnelly, 2007; Salt et al., 2017; Thomson et al., 2015, Wohler & Dantas, 2017), logistical barriers (Asgary & Segar, 2011; O'Mahony & Donnelly, 2007; Salami et al., 2018; Thomson et al., 2015; Wohler & Dantas, 2017), such as childcare and transport, and lack of cultural sensitive training of mental health professionals (Asgary & Segar, 2011; Dow, 2011; Kaplan et al., 2016).

IV. Community Level

In McLeroy's SEM, community is defined as face-to-face primary groups to which individuals belong or relationships within a defined geographical or political area, which implies that community is characterized by certain power structures within these areas (McLeroy et al., 1988). This level therefore focuses on how factors such as shared identities, cultural values, norms and gender-related norms influence health services utilization. As such, community can be seen as a mediating structure, transmitting certain values and norms to individuals, which inform health services utilization behaviour (McLeroy et al., 1988).

In the context of mental health care provision, the most predominant community level factor shaping access is the stigmatization of mental illness amongst refugee populations (Asgary & Segar, 2011; Dow, 2011; Hassan et al., 2016; Posselt et al., 2017; Shannon et al., 2014; Salami et al., 2018; Salt et al., 2017; Thomson et al., 2015; Wohler & Dantas, 2017). These cultural and societal

beliefs and attitudes around mental health also inform help-seeking behaviour and therefore may adversely affect access to mental health care services (Salami et al., 2018; Shannon et al., 2014).

V.   Policy Level

On the policy level of McLeroy et al. (1988)'s model is the use of regulatory policies, procedures and laws to protect the mental health of the community. Such policies and procedures also regulate mental health care access for refugees and may promote or prohibit access through eligibility criteria and entitlements according to national law and provisions. It has been identified in various pieces of literature, that healthcare entitlements may be one of the most prominent barrier for refugees (Asgary & Segar, 2011; Dow, 2011; Schouler-Ocak, 2017; Wohler & Dantas, 2017).

Other factors which may restrict access to mental health care on the policy level are the structure and complexity of the health care system (Asgary & Segar, 2011; Kaplan et al., 2016; Salt et al., 2017). However, broader national policies, laws and regulations, also feed down into other layers of the SEM, such as local directives, spending priorities, education and work experience of health services professionals (Sword, 1999). Policies and regulations may promote or prohibit mental health care access; where service utilization is possible and encouraged and where health care is appropriate and responsive to needs, a high potential for utilization exists (Sword, 1999). Educational and social policies therefore determine mental health services utilization as they help create climate where mental health care access is encouraged or inhibited through social and cultural norms (Level, 2002).

Summary

In summary, exploring barriers to mental health care access for Syrian refugee women within a socio-ecological systems framework illustrates the complexity of mental health services utilization behaviour and underlying socio-cultural factors and interconnectedness of these factors. Qualitative inquiry into health services utilization with the SEM model can illustrate how macro-level systems influence both meso- and micro-level behaviour and attitudes (Henderson & Baffour, 2015), which are relevant for program and service delivery in health care (Sword, 1999).

Literature Review

Mental Health of Syrian Refugee Women

As with other populations affected by collective violence and displacement, the most prevalent and clinically significant problems amongst Syrian refugees are emotional disorders such as

depression, prolonged grief disorder, post-traumatic stress disorders (PTSD) and other forms of anxiety disorders due to traumatic experiences, including torture (Ahearn, 2000; De Jong et al. 2003; Mollica et al. 2004). Many of these refugees suffer from continuous sleeping difficulties, nightmares, flashbacks and problems with emotional regulation (Leopoldina, 2018). Somatoform disorders, a condition in which physical pain cannot be traced to a physical cause but is rather of psychological nature, also play a significant role (Rohlof et al., 2014).

In an attempt to quantify mental illness amongst refugees from the Middle East, the Federal Chamber of Psychotherapists of Germany conducted a study which showed that at least half of all refugees from this region suffer from some form of definable mental illness (Bundespsychotherapeutenkammer, 2017). Approximately 70% witnessed violence and 50% had been victims of violence, 40 – 50% suffer from PTSD (Post-traumatic stress disorder), 50% from depression (often both) (Bundespsychotherapeutenkammer, 2017). It is well documented that PTSD is a valid and cross-cultural mental disorder which affects functioning on a personal and professional level and results in a higher level of suicidality (Fazel, 2012).

Syrian refugee women are at a particular risk of developing mental illness as a result of adverse experiences the country of origin, in refugee camps, during their journey to Europe or in the host country (particularly in accommodation centres with no separate living spaces for women and girls) (The Forced Migration Network, 2017). The rights of women are systematically infringed and forced displacement often results in women being exposed more often to violent situations and often have less resources to defend themselves (Hassan et al., 2015). GBV includes systematic rape in conflict and post-conflict situations, rape as a method of control of community and family destruction, rape as a punishment for men and for ethnic cleansing, sexual assault, sexual torture, sexual slavery, trafficking, corrective rape of LGBT identifying women, early and forced marriage, female genital mutilation and domestic violence (The Forced Migration Network, 2017).

In Syria, sexual and GBV has increased substantially, as the conflict carries on, partly due to disruption of traditional networks and protection mechanisms (Hassan et al., 2015). However, GBV does not end post-displacement; women often continue to face other forms of sexual violence, such as domestic violence, early marriage, harassment and isolation, exploitation and survival sex (Hassan et al., 2015). As a result of the conflict, domestic violence has also been reported to have become more aggressive and common as a result of rising stress in men (Hassan et al., 2015). Early marriage

may be a significant source of distress for girls and often results in interruption of education, health risks and increased risk of domestic violence (Hassan et al., 2015). GBV can be devastating for the survivor and may carry ripple effects throughout the family and wider community (Hassan et al., 2015). Traumata sustained from so called 'man-made disasters' that are intentional, such as GBV, are much more damaging to the psyche of the victims and lead more often to symptoms associated to PTSD (BAfF, 2016).

Generally speaking, refugees have higher levels of mental illness than the native population in host countries and are amongst the most vulnerable and most socially excluded in host societies, particularly women (Palmer & Ward, 2007). Asylum laws in the EU incorporate the provision of mental health care for refugees, but in practice member states have difficulties to diagnose and treat these conditions. The current mental health care system in Europe does not always take into account the cultural practices of refugees, particularly those of women, many of whom have experienced gender-related violence and were victims of trafficking (Caritas, 2016). This has raised the question on how European member states can provide mental health services that are both accessible and tailored to refugee women.

Mental Health Care for Refugees in Germany

With so-called Beveridge systems, which facilitate healthcare through state owned facilities and no fees or limited fees (such as the United Kingdom or Scandinavia), healthcare is much more accessible for refugees and asylum seekers. Germany, however, employs the Bismark model, which is based on social insurance and therefore requires registration of new arrivals (Collantes, 2010). Entitlements for mental health care for asylum seekers[1] are regulated through the *AsylbLG* (Benefits for Asylum Seekers Act) (Böttche et al., 2016). According to the AsylbLG*,* in the first 15 months of their stay, asylum seekers have restricted entitlements, which include medical emergency services only, such as pregnancy care, vaccinations and treatment for people "with acute diseases or acute pain" or "other necessary preventative measures" (AsylbLG § 4 and §6*)* (Bezorgmehr & Razum, 2015; Böttche et al., 2016; Kickbusch et al., 2017). Any other treatment can be obtained at the discretion of the Social Welfare Office (usually non-medical staff) on a case-to-case basis a process which involves much bureaucracy (Böttche et al., 2016).

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[1] see Appendix 2 for definitions of migration status in Germany

In most cases, mental health care is denied under the provisions of the AsylbLG due to mental illness not being seen as an acute illness and therefore often times deemed as not requiring treatment (BAfF, 2016). This leads to a severe gap between the refugee mental health care that is needed and the provision that is made by the state and NGOs (Böttche et al., 2016), the so-called *Versorgungslücke* (provision gap). Asylum seekers are given unrestricted entitlements after the initial first 15 months or when they are granted asylum (i.e. transitioning to the status of 'recognised asylum seeker') (Bezorgmehr & Razum, 2015). The legal restrictions on healthcare access for asylum seekers and relatively high administrative barriers to healthcare in Germany in general have been criticised since the 1990s (Bezorgmehr & Razum, 2015), particularly so, because the EU Reception Conditions Directive 2013/33/EU prescribes that entitlements for particularly vulnerable groups, such as refugees, may not be restricted by EU members states and adequate psychological treatment is to be facilitated (BAfF, 2016).

The MIPEX health score (a summary indicator for entitlements and access to health services) ranks Germany below average "compared with countries with comparable migrant populations and GDP", making the country "just halfway favourable from an integration perspective" (Kickbusch et al., 2017, p. 907). In terms of economics, the current healthcare provision for asylum seekers does not make much sense, as it would be cheaper to give asylum seekers unrestricted entitlements (Bezorgmehr & Razum, 2015). Particularly so, because responsibility for care is currently shifted from the less expensive primary care sector to costly treatments for acute conditions in the secondary and tertiary sector (Bezorgmehr & Razum, 2015).

Barriers to Mental Health Care Access

In order to properly identify the barriers to mental health care among Syrian refugee women, dynamic multi-level interactions must be considered. Previous theoretical and empirical studies from the fields of psychology, sociology, policy and migration studies have identified a myriad of barriers to mental health care access for refugees and migrants. However, the literature is fragmented and focuses on specific refugee or migrant groups. The conducted literature review on barriers to mental health care access summarizes this knowledge using the SEM as an organizing framework as detailed in the section outlining the *Socio-ecological Model (SEM)*, arranging barriers on the intrapersonal, interpersonal, organizational, community and policy level.

I.   Intrapersonal Barriers

Previous studies intended to pinpoint the influence of individual factors on the access to mental health care. Studies on demographic factors were inconclusive, however, it was reported in some studies focusing on refugee populations that pre- and during migration factors, such as a history of organized deliberate violence (such as humiliation, degradation and torture and oppression) and GBV, influence refugees' mental health services utilization behaviour on the intrapersonal level (Hassan et al., 2016; Shannon et al., 2014). Experiences of GBV in particular were found to be an important barrier to mental health care access due to the associated shame and the fear of repercussions from their perpetrators, family, husbands or the fear, that nobody would believe them (Shannon et al., 2014; Spencer et al., 2015). With the continuing violent conflict in Syria, pre- and during-migration stressors most likely affect mental health care access for Syrian refugee women. The specific ways in which shame connected to GBV and other traumatic experiences affect Syrian refugee women and their access to mental health services is an area that remains to be explored and will be part of this study.

Post-migration stressors resulting from acculturation, such as finding housing, food, employment, the asylum procedure, and location of and unification with family members and supporting family members often act as a barrier since these activities are often prioritized over health care (Asgary & Segar, 2011) or may impact on refugees' ability to engage effectively with mental health services (Kaplan et al., 2016). Additionally, women often carry the extra burden of supporting family members and protecting and upholding family values, culture and beliefs (Shishehgar et al., 2017) in the post-migration process. As such, it is important to explore how specific acculturation stressors in Germany affect Syrian refugee women and act as barriers to mental health care services.

Apart from migration factors, numerous studies identified that the lack of knowledge and information about mental health services acts as a major organizational barrier for refugees (Asgary & Segar, 2011; Donnelly et al., 2011; Posselt et al., 2017; Salami et al., 2018; Shannon et al., 2014; Shishehgar et al., 2017; Sijbrandij et al, 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010; Wohler & Dantas, 2017). It is therefore important to know how culture and gender informs how Syrian refugee women obtain information on mental health care services. It is expected that

stigmatisation may also play an important role in acquiring knowledge about services available to Syrian refugee women.

II.   Interpersonal Barriers

On the interpersonal level, numerous studies cite language and a lack cultural sensitivity as the main barrier to mental health care access for refugees (Asgary & Segar, 2011; Donnelly et al., 2011; Hassan et al., 2016; Jensen et al., 2013; Kaplan et al., 2016; O'Mahony & Donnelly, 2007; Posselt et al., 2017; Salami et al., 2018; Salt et al., 2017; Schouler-Ocak, 2017; Shishehgar et al., 2017; Sijbrandij et al., 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010). Particularly with interpreters and cultural mediators often not being provided for or not asked to attend (Kaplan et al., 2016; Posselt et al., 2017; Salami et al., 2018; Schouler-Ocak, 2017; Shishehgar et al., 2017; Sijbrandij et al, 2017; UNHCR, 2007; WHO, 2010; Wohler & Dantas, 2017), not qualified enough or unavailable (particularly for recently arrived refugees, whose language may not be covered in the pool of interpreters) (Asgary & Segar, 2011; Kaplan et al., 2016). On the other hand, refugees may also perceive interpreters as hindering their treatment (Sijbrandij et al, 2017). It was found that refugee women in particular may not be willing to share their personal experiences with interpreters due to fear of misinterpretation, exposure, long waiting times or perceived impatience (Shishehgar et al., 2017; Wohler & Dantas, 2017).

It can be assumed that the language barrier is relatively high for Syrian refugee women in Germany due to lacking German language skills. With the health care system being public in Germany, it is expected that the provision of interpreters may act as an organisational and policy barrier for Syrian refugee women. It is unclear from previous studies in how far the barrier of interpreter provision is affected by the culture or gender of Syrian refugee women. For example, stigmatisation of mental illness, a much-raised barrier on the community level, may also affect interpreter provision.

Language, however, is oftentimes not the only communication barrier. The relationship between mental health care professional and patients from ethnic minorities it also complicated by a lack of cultural understanding in health care professionals around symptoms, diagnosis, family and societal norms, which is often referred to as health literacy. This is a problem because failure to accurately read relevant cultural cues often leads to misunderstandings, misdiagnosis and incorrect treatment with serious consequences for the service user (Asgary & Segar, 2011; Dow, 2011; Kaplan

et al., 2016; Jensen et al., 2013; Salt et al., 2017; Schouler-Ocak, 2017) due to the cultural variety in clinical presentations of mental illness, culturally based perceptions of the nature of mental health problems and related help seeking behaviour (Kaplan et al., 2016; Jensen et al., 2013; Salt et al., 2017; Thomson et al., 2015; Wohler & Dantas, 2017). For example, refugees often experience difficulty in understanding the connection between the psychological and physical symptoms (Hassan et al., 2016; Jensen et al., 2013; Posselt et al., 2017) with emotional or mental distress commonly manifesting and being described as physical symptoms, such as headaches, body pains, numbness, tingling sensations, stomach ache or breathing problems (Asgary & Segar, 2011; Hassan et al., 2016; Salami et al., 2018), a phenomenon referred to as somatisation. Health literacy may also be complicated by a lack of psychiatric vocabulary, depending on the culture of the refugee. The UNHCR has identified such lack in Syrian refugees (UNHCR, 2013).

From the literature review, the prevalence of culturally inflicted somatisation of mental illness or lacking vocabulary in Syrian refugee women is unclear or whether this acts as a barrier to mental health care access. It is also important to explore how health literacy of refugee populations in mental health care professionals in Germany may counteract this barrier. Additionally, it is important to explore how stigmatisation of mental health and experiences of GBV, as explained on the community level, influence somatisation and health literacy of Syrian refugee women in Germany.

III. Organizational Barriers

On the organizational level, a number of studies have found that limited availability of mental health services and mental health professionals acted as a barrier to mental health care (Asgary & Segar, 2011; Donnelly et al., 2011, Sijbrandij et al., 2017; Wohler & Dantas, 2017). These studies identified that long waiting lists and lack of continuing care complicate mental health care delivery (Asgary & Segar, 2011; Donnelly et al., 2011; Wohler & Dantas, 2017) due to limited and inconsistent funding (Asgary & Segar, 2011).

It was also identified that systemic discrimination results in refugees and minority groups being underserved by the mental health system (Dow, 2011; Thomson et al., 2015; Wohler & Dantas, 2017). Refugees often feel judged unfairly be medical staff due to their race, gender, lack of financial capital, immigration status and how well they speak the language of the receiving country (Asgary & Segar, 2011; Dow, 2011; O'Mahony & Donnelly, 2007; Salt et al., 2017). Particularly

refugee women face multiple forms of inequities and discrimination based on race, class and gender (Thomson et al., 2015).

Logistical barriers, such as lack of transportation (Asgary & Segar, 2011; Kaplan et al., 2016; Salami et al., 2018; Salt et al., 2017; Wohler & Dantas, 2017), and childcare (Bell et al., 2016; Salami et al., 2018; Wohler & Dantas, 2017), have been cited as barriers to mental health care in a few studies, which is particularly relevant for women in their role as primary caregiver and often lacking own transport.

Delivery of mental health care is further complicated by the context, in which it is provided. Due to the stigma associated to psychiatry, psychosocial programs provided in non-psychiatric settings can increase mental health care access for Syrian refugees in particular (Hassan et al., 2016). Additionally, the lack of culturally sensitive training amongst health care staff and the underrepresentation of minorities in health care professionals act as a barrier to mental health care access for refugee populations (Asgary & Segar, 2011; Dow, 2011; Kaplan et al., 2016) (for example, Arabic speaking psychologists and psychotherapists in European countries hosting Syrian refugees (Sijbrandij et al., 2017)).

Organisational barriers in Germany may well affect the provision of mental health services to Syrian refugee women. With the stigmatisation of mental illness amongst Syrian suggested on the community level, location and context may play an important role mental health care provision. Organisational barriers in general, affected by state regulations and policies, such as limited availability of mental health care, most probably affect Syrian refugee women as a population as much as they affect other population, whilst lacking skills to treat ethnic minorities may impede access gravely for Syrian refugee women, if their particular ethno-cultural and gender related needs are not met. This area remains to be explored further and will be addressed in this study.

IV. Community Barriers

On the community level, the most pronounced barriers impeding mental health care access which has been identified in a myriad of previous studies, is the stigmatization of mental health amongst refugees (Asgary & Segar, 2011; Dow, 2011; Hassan et al., 2016; Posselt et al., 2017; Shannon et al., 2014; Salami et al., 2018; Salt et al., 2017; Thomson et al., 2015; Wohler & Dantas, 2017). Stigma is influenced by cultural beliefs, attitudes and actions and takes place when an objective characteristic of the individual leads to a negatively valued social identity (Shannon et al.,

2014) where individuals describe a feeling of shame (Posselt et al, 2017; Salami et al., 2018; Shannon et al., 2014) or failure with the fear of social exclusion or discrimination (Salami et al., 2018). As such, stigmatization is ethno-culturally variable (Shannon et al., 2014) and gender specific (Amering, 2018; Bell et al., 2016). Stigmatization was found to mainly act as a barrier to mental health care access due to the fear of social exclusion, censure from community members and repercussions (Donnelly et al., 2011; Posselt et al., 2017; Shannon et al., 2014), particularly so for refugee women (Donnelly et al., 2011; Wohler & Dantas, 2017).

Mental health care access on the community level was also found to be dependent on the cultural conceptualisation of mental health and related health beliefs. Due to immigrants often perceiving symptoms of mental illness as a crisis of faith, a personal weakness, punishment from God or invasion of evil spirits (Dow et al., 2011; Salami et al., 2018), symptomatology indicative of mental illness was not seen as related to mental health (Salami et al., 2018). Additionally, a number of studies identified that the Western treatment approach may not be seen as appropriate by service users with a refugee background (Asgary & Segar, 2011; Donnelly et al., 2011; Dow, 2011; Posselt et al., 2017; Scheffler & Miller, 1991; Shannon et al., 2014; Wohler & Dantas, 2017). Particularly, the concept of primacy of the individual over the group seems to be at odd with many refugee and migrant populations (Dow, 2011). Particularly so, because classical talking therapy, as developed in Western high-income countries, is primarily ego-based and requires detached introspection (Sen, 2016), which could be unfamiliar to socio-centric individuals. These individuals might respond better to directive and authoritative approaches ('What do you need to do') (Sen, 2016). It is very likely that this may also be the case with Syrian refugee women, but the literature has not specifically focused on this population so far.

Stigmatization was also found to inform coping strategies and help-seeking behaviour with refugees and migrants often suffering in silence (Salami et al., 2018; Shannon et al., 2014). In fact, ethnicity was found to be a prime factor in different patterns of help-seeking behaviour amongst individuals suffering from mental illness in Vancouver (Dow, 2011) and gender may also be a factor with women generally being more likely to rely on self-care strategies, despite the wish to receive care (Bell et al., 2016) and sharing personal and familial problems outside of the family may be seen as a matter of infringing the honour of the family (Donnelly et al., 2011; Thomson et al., 2015). Education was also seen to be relevant to help-seeking behaviour with women with a higher level of

education being more likely to accept and seek treatment (Bell et al., 2016). Additionally, consulting treatment with their partners can be crucial for women in the decision-making process and a lack of understanding or support from their partner or family may act as a significant barrier to mental health care access (Bell et al., 2016). Furthermore, due to women's role as the primary caregiver in the family (O'Mahony & Donnelly, 2007), seeking out mental health care services may be seen as betraying the family or abandoning their traditional role (O'Mahony & Donnelly, 2007).

Stigmatisation often extends to the family, where having a family member with mental illness could result in loss of social status, social exclusion and discrimination (Salami et al., 2018; Sijbrandij et al, 2017). Additionally, Dow (2011) identified amongst Arab populations the fear of not being able to get married due to own mental health problems or those of family members. It is not clear, however, in how far this applies to Syrian refugee women, specifically.

Caused by stigma, negative repercussions connected to mental illness included a fear of being deported back to the country of origin or put in an immigration detention centre alongside other family members (Asgary & Segar, 2011; Dow, 2011; Posselt et al., 2017; Wohler & Dantas, 2017), being put in a hospital and separated from their family (Shannon et al., 2014; Wohler & Dantas, 2017), fear of people in authority related to their previous experiences with corrupt or violent government officials (Posselt et al., 2017), fear of gossip by interpreters (Posselt et al., 2017), fear of spies in the community and resulting consequences for their families back home (Shannon et al., 2014), fear of losing custody of children (Salami et al., 2018; Wohler & Dantas, 2017), imprisonment of spouses in case of domestic violence, losing housing (Shannon et al., 2014) or termination of employment or the chances of ever attaining employment (Salami et al., 2018; Shannon et al., 2014).

Despite the myriad of barriers identified in previous studies, little attention has been paid to the specific ethno-cultural and gender aspects pertaining to stigmatisation, gender-specific repercussions resulting from the use of mental health services and cultural concepts of mental health in Syrian refugee women. This is important as it informs if and how Syrian refugee women seek help for mental health problems and how this population accesses mental health care and will therefore be crucial for service design and delivery of mental health care providers on the organisational and policy level.

V. Policy Barriers

According to Schouler-Ocak (2017), one of the most fundamental barrier at the policy level for refugees in Germany is the lack of adequate legal entitlements, which was also observed in studies from other countries (Asgary & Segar, 2011; Dow, 2011; Salami et al., 2018; Thomson et al., 2015; Wohler & Dantas, 2017). Additionally, general complexity and idiosyncrasies of the health system were also criticized as a policy barrier towards accessing mental health services (Asgary & Segar, 2011; Kaplan et al., 2016; Salt et al., 2017; UNHCR, 2007; WHO, 2010). Apart from lacking entitlements, inclusion criteria to access mental health care services due to limited availability of treatment places may also deter refugees from accessing mental health services (Posselt et al., 2017).

BAfF, the German umbrella organisation of treatment centres for victims of human rights abuses and political persecution also has published a document detailing the specific barriers to mental health care access for refugees in Germany, such as the difficulties obtaining treatment in the first 15 months of asylum seekers' stay in Germany according to *AslybLG* (Benefits for Asylum Seekers Act), the pronounced language barrier in Germany and the related problem of interpreter provision in the public healthcare system (BAfF, 2016).

With Germany having a public healthcare system, the study will look into the role the German state plays in providing mental health care to Syrian refugees. It is expected that gender will not determine access to provisions made by the state, however, the study will highlight barriers for refugees in general and if barriers for Syrians as a group differ from the general refugee population. The study will also explore whether there are any ethno-cultural or gender barriers pertaining to Syrian refugee women in terms of adequate provisioning of mental health care through state mental health policy, which may be relevant to address intrapersonal, interpersonal and community barriers pertaining to this refugee population.

Summary

Most of studies examined in this literature review focus on refugee populations without making a difference between genders, despite refugee women being amongst the most vulnerable groups during war conflicts and are affected in the worst ways by these experiences, in terms of physical, mental and social consequences (Sönmez et al., 2017). In general, refugee women remain a largely understudied population (Floyd & Sakellariou, 2017; Gerard & Pickering, 2013; Mengesha, 2017; Shishehgar et al., 2017; Sönmez et al., 2017).

Syrians are the biggest refugee population in Germany and women represent over 50% of the general refugee cohort since 2016 (Women's Refugee Council, 2016), which highlights the importance of studying this population more in-depth. Understanding how the specific ethno-cultural and gender aspects inform mental health care access for this population remains an area of study that can provide valuable input to future policymaking to increase mental health services utilization resulting in improved mental health of this population and therefore facilitate integration. Particularly the experiences around GBV and the associated stigma, which both are assumed to be relatively high amongst this population, may have an important impact on mental health care access for Syrian refugee women. However, the particular gender and ethno-cultural factors pertaining to this population may also influence other barriers, such as the specific ways Syrian refugee women access the mental health care system and obtain information about existing services, the specific acculturation stressors for Syrian refugee women in Germany, the language barrier and working with interpreters, health literacy both of the mental health care professional and the refugee women themselves, systemic discrimination of refugee women, logistical barriers (which may be influenced by the cultural gender role in Syria), cultural health beliefs and the cultural conceptualisation of mental health of this population. Organisational and policy barriers, such as interpreter provision, availability of mental health care services, lack of training to treat ethnic minorities adequately and lacking legal entitlements, may, however, not be influenced severely by gender or culture specific factors of this population, but this study will aim to explore whether these regulations and policies address the specific needs of this population.

As laid out above, the qualitative research component of this thesis focuses, therefore, specifically on ethno-cultural and gender-related barriers to mental health care access in Germany, as perceived by mental health care professionals working with Syrian refugee women in Germany. This study, therefore, seeks to address the central question: "What are the barriers to access to mental health services for Syrian refugee women in Germany?".

CHAPTER 3: METHODOLOGY

Study Design and Purpose

The objective of this study is to explore barriers to access to mental health care that Syrian refugee women encounter in Germany, with particular emphasis on ethno-cultural and gender influences. For this purpose, a qualitative approach was chosen to answer the research question. The research design was deductive in manner, whereby the socio-ecological model (SEM) (as outlined in the section *Socio-ecological Model (SEM)*) served as a framework to identify barriers to mental health care access from existing literature. Drawing from this, semi-structured qualitative interviews were conducted with a mixed sample of social workers and psychologists. These were analysed based on thematic analysis to identify barriers that inform mental health care access for this specific group in order to confirm, expand and refine the theory and to explore new angles or perspectives on the research topic relating particularly to Syrian refugee women (Matthew & Ross, 2010). The need for inductive data to conform and explore this topic does not foreclose the use of a proposed model, such as the SEM, as a guiding framework; "most qualitative studies lie somewhere between a loosely structured, emergent, inductively grounded method and a deductive confirmatory technique" (Sword, 1999, p. 1175).

A qualitative approach was seen as appropriate in the context of this study as it allows the author to explore knowledge about factors and processes influencing the use of mental health services by Syrian refugee women. Qualitative inquiry can highlight the socio-political context in which behaviour emerges and is conform with the ideology of empowerment that is embedded in health promotion and which acknowledges influences of the environment onto individual's health behaviour (Sword, 1999).

Sample

In an effort to understand and identify the multi-level barriers to access to mental health care for Syrian refugee women across various layers of the socio-ecological model, spanning from individual to policy and government barriers, the author interviewed a sample of psychologists and social workers to obtain a broad range on data on all levels and throughout the process of accessing mental health care, i.e. providing and facilitating access to mental health care. Purposive sampling

based on the inclusion and exclusion criteria as laid out in section *Sampling Characteristics: Inclusion Criteria for Participants* was used to enable the researcher to explore the research question in depth.

The unit of analysis of this study is Syrian refugee and asylum seeker women in Germany. Both refugee and asylum seeker women were included in this group, as they do not differ in mental health care entitlements in Germany within the first 15 months of their arrival in Germany (Bertelsmann Stiftung, 2016), as outlined in the Section *Mental Health Care for Refugees in Germany.* It was therefore assumed that their experiences with mental health care access in Germany do not differ greatly, either. Furthermore, with non-governmental organizations providing most of the (accessible) refugee mental health care services in Germany, most of mental health care is provided indifferent of status. Therefore, the barriers to mental health care access across the two groups are assumed to be relatively similar.

Sampling Method

Purposive sampling of participants was used to enable the researcher to explore the research question in depth (Matthews & Ross, 2010). Participants were sampled deliberately and purposively from centers specializing in providing mental health care to refugees, whether church, state or grant funded, across three federal states in Germany based on convenience and purpose, i.e. the numbers of refugees in each federal state (according to the *'Königsteiner Schlüssel'*, see below in the section *Sampling Method*) and the amount of psychological services, to observe commonalities in their experiences in mental health care provision for Syrian refugee women. Onward/Snowball sampling was used intermittently where the interviewee identified other suitable study participants based on the same characteristics as them, whom the researcher can contact (Matthews & Ross, 2010).

Due to ethical, time and financial constraints, interviews with asylum seekers and refugees were not conducted. However, the author does acknowledge and recognize the importance of capturing the perspectives of both refugee women and health care providers. Instead, semi-structured interviews were conducted with social workers and psychologists to explore their experiences in refugee mental health care provision and liaison, directly with Syrian refugee women.

Sampling Characteristics: Inclusion Criteria for Participants

Purposive sampling was used based on meeting the following inclusion and exclusion criteria that were directly related to the area of interest and the research questions, which enabled the researcher to study the topic in depth (Matthews & Ross, 2010). Inclusion criteria for social workers

were a minimum qualification of a Bachelor degree in *Sozialpädagogik* (Social Work) or *Soziologie* (Sociology). For psychologists, the minimum qualification was a *Psychologie Diplom* (Master degree in Psychology).

All participants of this study were required to have had a minimum of 1 year work experience with refugees, amongst them Syrian refugee women, and were required to work in specialised centres for refugee/migrant mental health care (psychologists/social workers) or liaising with such services (social workers) at the time this study was conducted. Social workers were included into the sample due to their broad knowledge about barriers that refugees are facing before and when accessing mental health care. Psychologists were included to the sample to collect qualitative data more specifically about barriers encountered during the provision of mental health care.

Sampling Locations

Participants were sampled in Germany for its relatively limited access to healthcare for both asylum seekers and refugees in the first 15 months of their stay in Germany (Bertelsmann Stiftung, 2016), despite being one of the main receiving countries of this particular group of refugees in the EU during the last years (Eurostat, 2018). In Germany, healthcare entitlements for asylum seekers are regulated through the AslybLG on a federal level, however, since the health system is decentralized, health care entitlements vary slightly between federal states. Therefore, sampling was restricted to three federal states, partly based on the quota of refugees and asylum seekers being sent to these federal states (Germany uses a quota system, the so called Königsteiner Schlüssel, to distribute refugees and asylum seekers among German federal states, based on tax receipts and population numbers of each state), and partly due to convenience of access to study participants:

North-Rhine-Westphalia (NRW) was chosen due to its geographical proximity to the author's University city (Maastricht), therefore providing convenient access to participants. Furthermore, NRW receives the highest percentage (according to GWK (2018) 21%) of asylum seekers of all German federal states. Second, Baden-Württemberg was chosen which ranks third amongst the federal states in terms of accommodating refugees and asylum seekers (between 12 – 13% of all asylum seekers (GWK, 2018)). It was also chosen for being the author's native region and ease of access to participants in this area. Third, the capital city of Berlin was chosen due to accommodating a hub of specialized services for refugee mental health care.

Sampling Procedure

A recruitment email was sent to sampled participants through email. The initial message was sent to 107 participants. Responses were received from 29 individuals, 15 of which were sampled for interviews.

Study Participants

Total number of participants who were interviewed for the study is 15; 5 social workers/sociologists and 10 psychologists. One interview was ultimately omitted, because the participant did not meet all the inclusion criteria. Ultimately, the final sample size yielded 14 mental health professionals. Years of work experience were variable with a minimum of 1 year as inclusion criteria. They had different levels of involvement with mental health services provision and liaison with mental health services. Saturation was reached after 15 interviews.

Selected Participant Demographics

Table 1: Demographics of participants

Participant	Gender m/f	Profession Social Worker (SW) Psychologist (PSY)	Type of Organisation	Region urban/rural
1	f	SW	Church-funded	urban
2	f	PSY	NGO	rural
3	f	SW	State-funded	urban
4	f	PSY	NGO	urban
5	f	PSY	NGO	urban
6	f	PSY	Church-funded	rural
7	f	PSY	State-funded	urban
8	f	PSY	NGO	urban
9	f	PSY	Church-funded	rural
10	f	PSY	NGO	urban
11	m	PSY	NGO	urban
12	m	SW	State-funded	urban
13	f	PSY	NGO	urban
14	f	SW	Church-funded	rural

The information pertaining to the federal state in which each participant practices their profession was removed because it was felt that this information compromised the anonymity of individuals.

Data Collection Method

Semi-structured in-depth non-standardized interviews were conducted with the aim to explore in depth the experiences, understanding and opinions of mental health care professionals involved in the mental health care provision for Syrian refugee women in Germany. An interview guide as detailed in *Appendix 1: Interview Guide* was used to conduct the interviews, following a common set of open-ended questions in each interview. However, due to the semi-structured nature of these interviews, interviews differed in structure and standardization within and between interviews, where questions were asked in different ways or orders as appropriate for each interview and participant (Matthews & Ross, 2010). The duration of these interviews was between 25 – 58 minutes.

Interview questions involved exploring whether participants viewed Syrian refugee women as having difficulties accessing mental health care services in Germany to explore barriers on several levels of McLeroy's (1988) Socio-Ecological Model as detailed in the section *Socio-ecological Model (SEM),* which assumes that behaviour is integrated in a dynamic and complex network of intrapersonal factors, interpersonal processes, institutional factors and public policy (Sword, 1999). Rich data on the participants' view was obtained and this increased the author's awareness of the contextual factors that intersect and organize Syrian refugee women's experiences at any given time, with a particular emphasis given to gender and ethno-cultural aspects. The participants were also asked what would be helpful to meet Syrian refugee women's mental health needs.

The interviews were conducted by the author herself, a qualified psychotherapist, until saturation, i.e. until there was no further data emerging from each additional case (Matthews & Ross, 2010). Written and audio consent was explained and obtained prior to conducting the interview via Skype and interviews were digitally recorded. No monetary incentives were provided to participants; however, participants were offered a copy of the thesis in return for their participation in the study. In total, 13 interviews were conducted via Skype and digitally recorded. One interview was not digitally recorded due to technical issues. Instead, notes taken during the interview, were transcribed. One interview was conducted in person with a digital recorder.

Interview Language

Interviews were conducted, transcribed and coded in German language, as the study participants were all located in Germany. This was done in one language to prevent data loss, both quantitative and qualitative, due to translation. Findings were then translated into English and endnotes of the original text were provided, where necessary.

Data Analysis

Thematic Analysis according to Braun & Clarke (2006)

Qualitative thematic analysis according to Braun & Clarke (2006) was used in this study to address the nature of the first research question. This method was used to identify contributing factors and their interdependent nature based on the perspectives of mental health care professionals across the various layers of the socio-ecological model (SEM). Thematic analysis can be described as a "foundational method for qualitative analysis" (Braun & Clarke, 2006, p. 4) with the advantage of providing theoretical freedom whilst providing a flexible and useful research tool which can present "a rich and detailed, yet complex account of data" (Braun & Clarke, 2006, p. 5). It is a method that identifies, analyses and reports patterns and themes within data (Braun & Clarke, 2006). Thematic analysis segments, categorizes and relinks aspects of the data to interpret participants' words, stories, accounts and explanations in a meaningful way (Matthews & Ross, 2010). Given the constructionist paradigm of this study, thematic analysis used in this context does not only focus on individuals' motivation, but rather on socio-cultural contexts and structural conditions that enable individuals and their experiences (Braun & Clarke, 2006). In this study, these factors were mapped according to McLeroy et al. (1988)'s adapted SEM. Through constant data mining, the researcher began to cluster codes into meta-codes and identify themes. A process whereby the researcher organizes data from the semantic level using basic codes, to the latent level for theme development (Henderson & Baffour, 2015). At the latent level, themes reflect assumptions, interdependent concepts and cultural and ideological norms.

As discussed before, a deductive approach was used in that existing data obtained through a literature review, which was organized according to the SEM, was used to provide a basic coding structure. Additionally, new themes were added to the coding as they emerged and this analysis of new themes was in a second step guided by the socio-ecological model. The analysis revealed an

adjusted model for barriers according to the data provided by the participants. Texts and codes were organized to reflect structural conditions and socio-cultural contexts (Braun & Clarke, 2006), which allowed the author to develop visual networks and conceptual links between factors and actors in mental health care access facilitation for Syrian refugees in Germany across the SEM.

The Process of Thematic Analysis

According to Braun and Clarke (2006), "the process of carrying out a thematic analysis consists of six separate stages, there is a great deal of unbridled going backwards and forwards between the different stages of the analysis" (Howitt, 2013, p. 182). The first step is the familiarization with the depth and breadth of the content, reading through the interview transcript and getting an overview of the collected raw verbal data, looking for patterns of meaning and issues of potential interest in the data (Braun & Clarke (2006).

The next step involves line-by-line coding, ascribing codes that describe the main essence of the sentence. In this study, the codes were both inductive (data driven) and theory driven, meaning they originated both from the author's own theoretical understanding of the data derived from the existing literature and organized by the chosen theoretical framework, the socio-ecological model, and therefore informed by a pre-existing coding frame and preconceptions, and from the study participants' views. Although the analysis was deductive, the focus of the study is on the respondents' perspectives and experiences, building on inductive principles. After coding the entire dataset, all the codes are collected.

In the third stage, codes are gathered into more and more abstract codes, organizing codes that are similar in meaning content, until they represent a broader pattern or potential theme. A theme is defined as the smallest unit that can express in a meaningful way the codes that are included in it (Braun & Clarke, 2006). A theme can represent an underlying concept which the codes included in it express, or it can give meaning to similar codes gathered in a theme.

The next step involves reviewing and refining the themes to determine if the themes depict a convincing story behind the data. Themes might collapse, break down into separate themes or are eliminated due to not being supported by enough data or due to being too diverse (Braun & Clarke, 2006). This process should yield meaningful coherence between themes and clear and identifiable distinction between them and a thematic map of themes distributed across the layers of the socio-ecological model. Following this, the themes are defined and named.

The sixth (last) step involves writing a report of the themes (Howitt, 2013). This report should aim to "tell the complicated story of your data in a way which convinces the reader of the merit and validity of your analysis" and provide "a concise, coherent, logical, non-repetitive, and interesting account of the story the data tell – within and across themes" (Braun & Clarke, 2006, p.23).

This analysis process generates a detailed and nuanced account of themes within the data (Braun & Clarke, 2006) and across the layers of the SEM, which served as an organizing framework in this study. The analysis took a latent approach, that is the thematic analysis went "beyond the semantic content of the data" identifying the underlying ideas, ideologies, assumptions and conceptualizations that govern what people say. This approach involves interpretative work, as the analysis is not just a description, but is already theorized (Braun & Clarke, 2006). This method of analysis is driven by the research question and the broader theoretical assumptions.

Coding Software

The interviews were manually coded with Microsoft Excel.

Limitations

The most pronounced limitation of the study is that it lacks the voice of the unit of analysis, Syrian refugee and asylum seeker women, themselves. Therefore, the extent to which the findings reflect the accurate experience of Syrian refugee women themselves may not be validated and congruent with those of Syrian refugee women, as suggested in previous literature (Aved et al., 1993). However, due to vast direct professional experience of the study participants with the studied refugee population, Syrian refugee women, the study is able to examine in-depth the experiences of participants with the unit of analysis and to provide recommendations for professionals, mental health care providers and the state.

Furthermore, this qualitative study uses a relatively small non-probability sample size with specific characteristics to allow the researcher to study the research topic in depth (Matthews & Ross, 2010). Therefore this sample cannot be seen as statistically generalizable to the population due to the way the sample is collected through purposive and convenience sampling, i.e. it does not give every member of the population the same chance of being included in the sample (Matthews & Ross, 2010) and may therefore omit alternative or additional perspectives on Syrian refugees' mental

health as experienced by other stakeholders in refugee mental health care, apart from the sampled social workers and psychologists. However, whilst this study may not be generalizable to other refugee population, the purposive sampling method based on specific criteria which aimed to ensure professionals have a strong interest in the topic, gives a detailed and in-depth account of participants' very personal and specific opinions and experiences with Syrian refugee women in mental health care in Germany.

Additionally, due to the nature of mental health care provision for refugees in Germany with the state providing psychiatric and psychotherapeutic care for asylum seekers and refugees only in emergency cases based on the discretion of the Social Welfare Office and based on the AsylbLG, specialized refugee mental health services are mainly provided by church, grant and federal state funded non-governmental organizations. The voices of mental health care professionals employed in state mental health care facilities for refugees are therefore underrepresented in this study.

The fact that the author interviewed mostly individuals from non-governmental organizations providing mental health care to refugees due to lacking entitlements in the state health care system may have influenced the opinions elicited by participants during the interviews. The continuous need for more funding in such organizations and the reason they have been established may have informed some of the opinions given in the interviews, as may also have the author's positioning and identification as left-leaning health care professional during the interviews. Likewise, choosing a profession such as mental health care and opting to work in refugee mental health services may also suggest a certain positioning of the participants interviewed for this study.

Finally, as suggested in Maxwell (2008), the relationship between researcher and participant is often mutually influenced by a myriad of factors and influences the data obtained in the interview. The author's social identity as a white, female, 33-year old, working class, Western, feminist, impacted the study without doubt in a multiplicity of ways beyond her control (Byrne, 2012). Furthermore, her left-leaning political view and previous work as a person-centred psychotherapist empowering marginalized and deprived women, meant that she approached the topic disappointed with entitlements to psychological care for refugees and asylum seekers in Germany's state health care system. She kept these considerations, however, in front of mind throughout the research process, in line with Spivak's (2003) demands for heightened self-reflexivity concerning researchers' positionality.

Ethical Considerations and Data Protection

In semi-structured interviews conducted as part of this study, participants elicited very personal experiences and opinions. To protect the confidentiality of this sensitive data, the following steps were taken: All data was stored securely in an external password protected hard disk, that was stored safely in a locked cabinet. Furthermore, particular care was taken to protect the identity of interview participants to prevent identification of participants from any data used in this dissertation, so that participants could not be identified, particularly by their employing organizations (Matthews & Ross, 2010). Where verbatim quotes from interview data were used to illustrate findings, these were selected in a way that prevented identification of the participant from this quote.

Furthermore, consent was obtained from interviewees before the interview in terms of consent for publication of the data or preservation of the data as a public resource and consent for recording of the interviewees (as audio files and for the purpose of transcription and data analysis). Additionally, information was provided to participants before the interview that any recorded contribution to the study shall be used in accordance with the wishes of the interviewee. Participants were also informed that interviewees' names will not be listed in the data transcription or in the thesis/report. An interview guide was provided to the interviewee before the interview to determine suitability and to inform about the content and nature of data that would be obtained during the interview and participants were aware they would withdraw from the study at any time. Finally, interviewees were provided with contact details of the study supervisor in case of any complaints or issues with interviews.

CHAPTER 4: FINDINGS AND ANALYSIS

The thematic analysis of the interviews aims to explore barriers to mental health care access for Syrian refugee women in Germany. As set forth in the methodology section of this thesis, the interviews were conducted with social workers and psychologists in NGOs, church funded organisations and state-funded mental health care services. A detailed table of participant demographics is provided in *Chapter 3: Selected Participant Demographics.*

The thematic analysis was informed by McLeroy et al. (1988)'s socio-ecological model (SEM). Therefore, the 5 layers of the SEM served as the main themes, grouping data into intrapersonal, interpersonal, organisational, community and policy barriers. These main themes are further divided into a total of 19 sub-themes, as outlined in *Table 2: Essential structure of perceived barriers to mental health care access for Syrian refugee women in Germany.*

Table 2: Essential structure of perceived barriers to mental health care access for Syrian refugee women in Germany

Theme 1: Intrapersonal barriers
Shame related to experiences of gender-based violence
A history of organised deliberate violence and oppression
Acculturation stressors
Knowledge of available services
Demographics
Education
Unfamiliarity with Western approach to mental health
Health Literacy and somatisation

Theme 2: Interpersonal barriers
Language
Interpreters

Theme 3: Organisational barriers
Referral Pathways
Logistical barriers
Lack of cultural and trauma sensitivity
Availability of mental health care services

Theme 4: Community barriers
Stigmatisation of mental health
Cultural gender role

Theme 5: Policy barriers
State mental health care provision
Interpreter provision in state mental health care
Missing screening of vulnerable individuals

Theme 1: Intrapersonal Barriers

Demographics

Most of the participants gave a short description of the demographics of Syrian refugee women accessing mental health care services in their organisation, however, agreed that factors such as age, marital status, ethnicity or income were not a specific determinant for access to mental health services. However, some participants said that most Syrian refugee women that attended services were between 25 – 40 years of age and that women did not access mental health services directly after their arrival in Germany; but rather that the acculturation activities take precedence and most women access services after a minimum period of 6 months. Some participants also suggested that refugee women from bigger cities (for example Aleppo) were more likely to access services than women from smaller cities or rural areas, which was conceptualised to be related to an increased level of education and reduced stigmatisation of mental illness in urban areas.

Education

According to participants, the most prominent demographic factor related to access of mental health services for Syrian refugee women seemed to be education. It was suggested by some participants that this was beneficial in self-identifying a need for mental health care and an increased familiarity with the Western concept of mental health.

Unfamiliarity with Western Approach to Mental Health Care

Almost all participants said that unfamiliarity with the Western concept of mental health acted as a major barrier to mental health care access to Syrian refugees. Syrians often seemed to expect a more directive approach from mental health care professionals and were often unfamiliar with the concept of psychotherapy resulting in individuals being passive, expecting solutions and some seemed to experience difficulty to engage into the therapeutic process and self-reflect. One participant elicited that Syrians as a group often

„expect solutions. And my professional approach or my understanding of psychotherapy is: I offer solutions and then you [the patient] needs to see what fits best. We give patients a lot of autonomy to decide themselves and not everybody likes that. Particularly for this group [Syrians], it does not seem to fit."[i]

Participant 9

It was suggested that Syrian refugees see the mental health care professional as the expert, who can diagnose and treat mental illness with medication. A recurrent sub-theme was the expectation of being given a *'magic pill'* to cure mental illness, which suggests a slightly different concept of mental illness and treatment of such compared to Western countries. None of the participants, however, suggested that there are gender differences connected to this theme. Psychoeducation was highlighted as a major facilitator and important part of the therapy process for this group.

Knowledge of Available Services

Not knowing where and how to obtain help and support for mental illness was suggested as a barrier to mental health care access by the majority of the participants. This was suggested to be partly due to the complexity of the health care system in Germany and the additional barrier of not speaking the German language to obtain information with most of the information about services not being translated into different foreign languages due to lacking resources, which a number of participants identified. Difficulties in linking existing services on offer with refugee women voicing a need for mental health was a recurrent theme in the data, which highlights the importance of formal and informal referral pathways as suggested in barriers on the organisational level.

Acculturation Stressors

Most of the participants suggested that acculturation stressors such as living in unsafe and unsuitable mass accommodation, sometimes for years, and the uncertainty of the asylum procedures acted as a barrier to mental health care access for refugees in general. The asylum application, in particular, was seen as a major stressor, destabilising individuals. This was suggested to be highly influential on the mental health of refugees in general.

Furthermore, participants stated that stressful living conditions post migration destabilise individuals repeatedly, requiring continuous crisis interventions by mental health care professionals

without ever providing the safe base to touch on deeper traumas sustained pre- and during the forced displacement. Such stressful living conditions also mean that acculturation and integration activities are often prioritized over the need for mental health care due to the deep desire to settle in a new country and finally find peace.

Acculturation stressors have been found to be more pronounced for refugee women due to their cultural role of the caregiver, where not being able to cook and to provide a safe family home is a major stressor. It was also voiced by a number of participants that family unification acts as a major stressor to refugee women, due to the high importance of family in the Syrian culture.

History of Organised Deliberate Violence and Oppression

A number of participants also suggested that an individual's history of organised deliberate violence and oppression pre-migration influences access to mental health care in refugee populations that were displaced by an armed conflict as is the case in Syria. It was stated that institutions are linked to terror, fear, violence and torture and therefore individuals are highly suspicious of state provided services and have difficulty establishing trust with mental health care professionals.

Health Literacy and Somatisation

Another factor that was identified by most participants to influence access to mental health care on the intrapersonal level is health literacy. Many participants stated that they experienced Syrian refugees as having difficulty identifying mental health problems, resulting in them identifying primarily physical symptoms such as headaches, stomach aches, insomnia, nightmares, etc. For example, one participant explained that Syrian refugees have problems

> „identifying symptoms. A lot [of refugees] arrive with complaints about pain and go from doctor to doctor. And until there is an understanding that this pain may be connected to the psyche, that this goes together, that takes some time."[ii]

<div align="right">Participant 1</div>

Participants said that Syrian refugees often times did not link physical symptoms to mental illness and more generally that the mind and body are connected. This often results in medication being prescribed without ever resulting in any improvement in condition. Syrian refugee women, in general, were found to predominantly identify and focus on physical symptoms, rather than talking

about emotions, which may be influenced by a lack of mental health vocabulary in Syrian refugees, as suggested by a few participants. They said that Syrian refugees often expressed their mental health problems with metaphors, depicting their emotions. It was suggested that this may be influenced by the cultural stigmatisation of mental health, the language barrier and lacking provision of interpreters on the interpersonal level, the cultural concept of mental illness and lacking mental health vocabulary. This highlights the importance of culturally sensitive training and health literacy of mental health care professionals to correctly diagnose mental illness in refugee populations.

Shame Related to Experiences of Gender-Based Violence (GBV)

Some participants suggested that shame acted as a barrier to mental health services for Syrian refugee women, particularly shame related to experiences of GBV or domestic violence. However, these participants also suggested that, much like Western women, Syrian refugee women found it hard to open up and talk about very intimate topics to a stranger and that this phenomenon was not specifically related to culture or religion of these refugee women. A few other participants said that they could not detect any shame acting as a barrier to mental health care access.

Theme 2: Interpersonal Barriers

Language

The majority of participants suggested that language is one of the most pronounced barriers for Syrian refugees, particularly so for women with children, that often times do not have the opportunity to attend language courses. In Germany, language is a particular barrier as mental health care professionals often do not speak other languages or do not feel confident enough to provide therapeutic services in a foreign language and refugees often times may only speak English, if they speak any foreign language at all. The language barrier is therefore directly connected to whether interpreters are arranged for by mental health care providers and much influenced in state provided services by interpreter entitlements depending on the migration status, as detailed in barriers to mental health care access on the policy level.

Interpreters

Most of the participants said that interpreters are crucial for the provision of mental health care to Syrian refugee women, both in individual and group therapy settings. Some participants said

that interpreters for some less prominent languages spoken in Syria are harder to come by and if interpreters are arranged for, the fear is high that these interpreters are part of the community and would speak to other community members about the mental illness of individuals, as identified in the barrier relating to discretion on the mental health care staff and interpreters on the community level. Another interpersonal barrier in mental health care provision is when the interpreter is from an opponent group of the individual that is being treated.

The lack of training of interpreters was also highlighted as an important barrier relating to interpreter provision by most of the participants, particularly by those participants working in state mental health care services. Some participants' organisations facilitated in-house training and supervision of interpreters, increasing the quality of the interpreting services substantially and decreasing the risk of re-traumatisation of interpreters.

Theme 3: Organisational Barriers

Referral Pathways

The majority of participants said that referral pathways act as a major barrier to mental health care access for Syrian refugees. A recurrent theme amongst participants was that Syrians did not usually come to mental health care providers themselves. Rather, they relied on third parties, such as volunteers or social workers in accommodation centres, doctors, asylum lawyers, refugee social services or asylum counselors, friends, the community and other Syrian refugees in the accommodation centres to facilitate access. It was suggested that Syrians relied on personal connections and relationships and trust was an important element in accessing mental health care.

This barrier was specifically identified by participants to be related to the Syrian culture. This highlights the importance of mental health care providers to undertake outreach work to accommodation centres and other third parties to reach Syrian refugees and to link them up with these services. A recurrent pattern amongst participants' views was that mental health care access depended a lot on "luck" to have referral agents that have the time to listen to individuals concerns, are skilled in detecting a mental health care need (as detailed in health literacy of refugee populations below) and know about available mental health services where they can refer individuals. This also highlights the need for more standardised screening as detailed in barriers on the policy level to

ensure individuals with mental illness are treated. For example, one participant said that being
identified as needing mental health care

> "seems like a coincidence to me. That you are lucky enough, to have a volunteer or social
> worker, that knows about available services, that refers you on. Some do not have that
> luck."[iii]

Participant 11

One participant felt that social workers in accommodation centres

> "1. often do not have the necessary knowledge to identify a mental health need in refugees,
> 2. do not have the time to sit down and listen."[iv]

Participant 7

This was echoed by another social worker who said:

> "I feel bad about this, but I don't have the time to actually determine if a mental health care
> need exists. I don't ever get to that point, where I could clarify that."[v]

Participant 14

Lack of Cultural and Trauma sensitivity

Several participants said that, due to the complex symptomatology sustained from multiple
traumas pre- and during displacement and instability after the displacement (as identified on the
intrapersonal level in the sub-theme acculturation stressors), lack of cultural and trauma sensitive
skills of mental health care professionals often act as a major barrier. This lack of skills often results
in symptomatology being interpreted inaccurately (i.e. affecting health literacy of mental health care
professionals). Professionals often feel unprepared to work with refugee populations due to lacking
skills, as identified under availability of mental health care services below.

A few participants also suggested, that a lack of skills in social workers and other referral agents to work with different refugee populations affects referral pathways, which results in refugees not receiving the mental health care they need. For example, one social worker said that

"there is no basic knowledge amongst social workers and there is no basic training provided regarding forced displacement and related trauma. They [social workers] do not know how to interpret symptoms. They cannot explain to people, what their symptoms mean, either. For me this is a very important factor contributing to individuals not receiving the care they need. Because it is not identified. There is a striking lack of knowledge amongst social workers in relation to trauma education."[vi]

Participant 7

Additionally, some participants said that the offer of mental health care services lacks culturally sensitivity. They reported that particularly the labelling of mental health services acted as a barrier to mental health access for Syrian refugee women. One participant, for example, said that her organisation

„started to offer women groups regarding gynaecology, followed up by groups to talk about *Dealing with stress* or *Dealing with kids in stressful situations* and *Taking care of yourself*. We did not describe these groups as psychological counselling groups […], because otherwise the acceptance amongst refugee women would not be as high."[vii]

They also specifically chose topics related to women's health, such as

"pregnancy, giving birth and period pains, because men are not interested in these topics and for women, it's very important."[viii]

Participant 3

These results may be explained by the stigma attached to mental health and providing psychosocial groups that do not specifically focus on mental health, but rather on childcare,

women's health, getting familiar with welfare systems or healthcare systems in general, etc., may be a good facilitator to access to mental health care for Syrian refugee women, since these topics also fit with the particular cultural gender role of Syrian refugee women. The participants also stated that state provided mental health care often lacks this sensitivity and is often not suitable for Syrian refugee women, which acts as a major access barrier.

According to participants, lacking cultural sensitivity also affects mental health screening where standardised tests are not suitable for refugee populations, affecting the validity of such tests and diagnoses.

Availability of Mental Health Care Services

The majority of participants alluded that the availability of mental health care services acts as a pronounced barrier for refugees. A recurrent sub-theme amongst those working in specialised refugee mental health care centres was, that the demand for services is much higher than what they can provide resulting in long waiting list, some longer than one year. This finding emerged particularly amongst participants whose organisations provide interpreters for all therapeutic services. It was suggested that more therapeutic services are needed, but also that psychosocial services are needed to close the gap between demand and offer. One participant, for example, stated that

> „it is necessary that the offer of therapeutic services is increased. Services are needed in all
> areas; psychiatric care, both psychotherapeutic care and also psychosocial care."[ix]

> Participant 5

Some participants reported that not having enough resources to provide services to meet the demand also results in eligibility criteria being set higher. Two participants said, that Syrian refugees are often seen as relatively less vulnerable compared to refugees from other countries, because they are often granted subsidiary protection[2] in Germany, which is seen as a stabilising factor. This results in less services available to Syrian refugees in particular.

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[2] See Appendix 2: Definitions of Migration Status in Germany

Additionally, participants from organisations in rural areas said that mental health care provisions are insufficient particularly in rural areas. Refugees in refugee accommodation centres in rural areas have relatively few options to access mental health care and providers are often overloaded. One participant alluded that waiting lists are totally closed for any mental health services in that particular county, even for state psychiatric clinics. Therapists in own practices are often the only avenue in this case, but often do not feel equipped to treat this population, to do any additional paperwork to have the costs of the treatment covered or to work with interpreters, resulting in systemic discrimination of this population. Additionally, it was reported that state provided mental health services in rural areas often lack cultural sensitivity.

Logistical Barriers

A few participants said that the availability of mental health care services for refugee women is further affected by mental health care services not offering childcare. For example, one participant said that

"a problem with a lot of mental health care services on offer is that they do not consider childcare. I think that is where it often fails."[x]

Participant 11

An additional logistical barrier for refugees, that some participant identified, is the distance to the closest mental health service. Expectedly this barrier was reported to be more pronounced in rural areas, where availability of mental health care services is scarcer than in urban areas. It was reported that this often times added additional stress to already vulnerable individuals. One participant from a rural area felt that

"for people, that are [mentally] sick, those distances and the time needed to master them, are not doable."[xi]

Participant 13

Theme 4: Community Barriers

Cultural Gender Role

Numerous participants said that the cultural gender role plays a major role in mental health care access for Syrian refugee women. Syrian women, as primary caretakers of the family, organise daily life, cook, take care of appointments, prioritize language courses, other integration activities and family members. This leaves relatively little time to attend to their own mental health and caring for themselves and often means that Syrian women seek help much later than Syrian men.

A number of participants also indicated that, due to the cultural gender role of the Syrian woman, mental health care professionals or interpreters of the opposite sex acted as a barrier to mental health care for Syrian refugee women. Much alike Western women, this is particularly a concern if women have experienced GBV. Psychiatrists in state mental health care in Germany are predominantly male, which was reported to act as a deterrent to Syrian refugee women to mental health care in the public healthcare system.

Additionally, some participants elicited that some Syrian spouses had concerns about their wives attending mental health care and it was indicated that women relied on the counsel of their husband to decide if it was ok to attend mental health care services. Furthermore, spouses in some cases wanted to attend the sessions together with their wives to monitor the content of the sessions, because they were unaware of the therapy process or the purpose, which links back to the barrier related to unfamiliarity with Western mental health care identified on the intrapersonal level.

Stigmatisation

Societal stigmatisation of mental health and experiences of GBV was identified as a barrier to mental health care access for Syrian refugee women by numerous participants in this study. Syrian refugee women were seen as being afraid of being talked about in the community or being seen in a mental health care facility. Two participants said that the terms psychologist and psychiatrist were connected directly to "being crazy". Stigmatisation was seen as a deterrent to mental health care, which often leads to chronification of mental illness. Stigmatisation of an individual with mental illness was also reported to extend to family members. This sub-theme was somewhat connected to unfamiliarity with the Western mental health approach, as one participant explained:

"[Stigmatisation] is first and foremost a major barrier to even see a mental health care professional. And it is connected to the fear of the treatment. How does the treatment look like, what will happen to me? Patients are often relieved when they see I don't wear a white coat. Above all it's the fear of what others will think, if someone knows about this. And then it's also important [what the] family [thinks]."[xii]

<div align="right">Participant 10</div>

The level of education and whether Syrians came from rural or urban regions in Syria was thought to influence the level of stigmatisation that was experienced by Syrian refugees in general. Gender was not identified as a factor in stigmatisation relating to mental illness, however, participants stated that stigmatisation relating to GBV was relatively high amongst Syrian refugee women. Particularly repercussions related to rape were a major deterrent to seek help for these extremely traumatising events. One participant illustrated this extreme stigmatisation of experiences of GBV as

"any sexual act that has taken place outside the marriage, whether with or without consent, is seen as a dishonour. That means women do not only fear repudiation, they are actually repudiated, this is not only an irrational fear. They actually arrive with documents from the family of their husband asking them to sign a paper confirming that they have not been raped, otherwise the husband can no longer be married to them. Many women come to say that their husbands have divorced them because they cannot rule out that their wives have not been raped. […] and it does not matter at all whether the woman consented to the sexual act, whether it was a violent act. One time a victim of a violent sexual encounter, you are unacceptable [to the family]."[xiii]

<div align="right">Participant 13</div>

This participant added that this enormous fear was very specific to Syrian refugee women and that it was not seen amongst other female refugee populations. It was felt that Syrian women were seen as responsible for maintaining the family honour and any sexual act outside the marriage was seen as staining this honour, which links back to the cultural gender role of Syrian refugee women. That means any experience of GBV cannot be known by the community or family members, which also

acts as a deterrent to mental health care access not directly related to GBV, as community members may think that women attend services because they were a victim of GBV.

A number of participants also alluded that, connected to the societal stigmatisation of mental health and experiences of GBV, the fear of indiscretion of mental health care professionals and interpreters acts as a barrier to mental health care access for Syrian refugee women. Particularly if the mental health care professional or interpreter is Syrian or from the Syrian community, Syrian refugee women often refused to partake in mental health care because of the fear of indiscretion. One participant added that Syrian refugees often were not familiar with the concept of discretion.

Theme 5: Policy Barriers

State Mental Health Care Provision

Nearly all participants identified state mental health care provision as a major barrier to mental health care for Syrian refugees in general. It was felt amongst a number of participants that the biggest problem with state mental health care provision is that entitlements to access depend on the migration status of the refugee. This is a barrier because psychotherapy is seldom provided under the *AsylbLG* (Benefits for Asylum Seekers Act) in the first 15 months of asylum seekers' stay in Germany; health care entitlements within this timeframe do include only treatment for acute pain or illness. Talking about this issue, one participant said that

> "in theory, it [state mental health care] is accessible for refugee women. But we have to distinguish, which migration status they [refugees] have. Before being recognised as an asylum seeker, there are no entitlements given. Because there are no provisions in the AsylbLG. One has to go through a tedious application process. Then a doctor from the Social Welfare Office has to check through the application, to see if psychotherapy is really necessary. The barriers are very high. To obtain mental health care in the state system is very difficult, I would say it's nearly impossible."[xiv]

Participant 9

In relation to this theme, one participant said, under the AsylbLG medication is often prioritized over psychotherapy because of the cost. After the initial 15 months or when refugees'

migration status changes, entitlements change, which carries its own problems. Although the entitlements to health care improve considerably when asylum seekers are recognised as such[3], interpreter provision is much more complicated with this migration status. One participant explained that

> "I have very few approved applications for psychotherapy under the AsylbLG and when asylum seekers' asylum applications are processed [and their migration status changes], they do not fall under this act anymore. Then the Public German Health Insurance regulates entitlements. We have clients, that have been granted authorization to undertake psychotherapy by the Social Welfare Office [responsible for treatment under the Benefits for Asylum Seekers Act], they start therapy and after 4 – 5 sessions they change their migration status […], because their asylum application has been processed. Then the Public German Health Insurance has to pay for their treatment. But then the Health Insurance Office says that they can pay the psychotherapy but not the interpreter. And then we can't go on with the therapy."[xv]

> Participant 5

One participant said that this lack of entitlements in the state mental health system leads to many refugees having to access mental health care elsewhere, such as NGOs or church-funded organisations. In some cases, these organisations were also reported to finance interpreters to attend state mental health care with refugees. The big problem with this dual system of state and non-state mental health care for refugees is that

> "a lot of people do not work on it at the state level and a lot of energy is lost, because one organisation does not know of the activities of the other one, there is no synergy effect. This is truly missing."[xvi]

> Participant 4

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[3] See Appendix 2: Definitions of Migration Status in Germany

Interpreter Provision in State Mental Health Care

Particularly the lacking provision of interpreters in state mental health care was identified as a major and very debilitating barrier for Syrian refugees amongst numerous participants. As previously noted, state mental health services, such as clinics and registered psychotherapists in private practices, do barely provide interpreters. Interpreters have to be applied for in tedious application procedures, leading to delays in obtaining psychotherapy for refugees. It was reported that these applications are often denied by the Social Welfare Office or the Public German Health Insurance Office. One participant said that this leads to

> "*revolving door psychiatry,* where people are admitted into psychiatric wards for a few days, maybe sometimes for a few weeks, are discharged, and not much is done apart from providing psychotropic medication in this time period and maybe a bit of non-verbal communication, because there is no interpreter. And some of them come back to the clinic a few weeks later. And this carries on like that."[xvii]

Participant 1

Particularly for Syrian refugees that have been granted subsidiary protection and fall under the provision of the Public German Health Insurance, interpreters are rarely paid for, which means an Arabic speaking psychotherapist is the only alternative for this refugee population, which is relatively impossible to find, according to a few participants. That means in practice, that refugees that have not been granted subsidiary protection and fall therefore under the provision of the Social Welfare Office are more likely to have interpreter costs approved than Syrians, although Syrians with a subsidiary protection status have entitlements to undergo psychotherapy. This participant also noted, that the lack of interpreter provision was in breach of the EU guidelines for particularly vulnerable refugee populations[4]. Most Syrians are granted subsidiary protection in Germany at the time this thesis was written and therefore are considered particularly vulnerable under this EU guideline, yet had particular difficulty accessing mental health care services with interpreter provision.

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[4] See Appendix 2: Definitions of Migration Status in Germany

A few participants also said that the lack of interpreter provision means that Syrian refugees cannot be treated adequately in state psychiatric facilities, because the offer of services is not suitable for them in relation to their language or culture. Likewise, registered psychotherapists in private clinics cannot treat refugees without interpreters, even if a mental health need has been identified and the therapist is willing to take on the extra work of working with a refugee.

A number of participants said that, to close this provision gap related to entitlements, the Germany government started a project where therapists without an approbation by the state could exercise their profession to treat refugees. However, the application process for these therapy places was long and once the initial 15 months of the refugees' stay have passed or the asylum application has been processed, refugees were not entitled to this provision anymore. Furthermore, interpreters were also not provided for under this initiative.

Missing Screening of Vulnerable Individuals

A few participants said that the early and standardised identification of vulnerable individuals is needed to increase access to mental health care for refugees. As one participant suggested,

> "there lies the big problem, after all. It is not only a problem in Germany, but also EU-wide. There is this EU guideline[5], that particularly vulnerable patients have to be identified to receive the care they need. This includes people that have experienced violence, that experienced war and have mental health problems resulting from that. This is not being done in Germany. This identification. And it is missing in the end, results in a gap between people that come here, do not know what they should do, do not know what mental health services are available to them, because they cannot be identified and referred on accordingly."[xviii]

> Participant 4

A recurrent theme amongst these participants was that a physical health screening is undertaken with all refugees when they arrive to Germany. Mental health screening, on the other hand, is totally neglected. Particularly in light of the missing health literacy amongst Syrian refugees, which was

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[5] EU Guideline 2003/9/EG dated 27. January 2003

identified on the intrapersonal level, this screening would detect a mental health need early and adequate mental health care provisions could be made. However, one participant argued that

> "the question remains that, if such a [mental health] need is detected, the therapeutic and medical capacities should be available to undertake the treatment".[xix]

Participant 5

With the provision gap in state mental healthcare as identified above, the screening of vulnerable individuals might put the state mental health care system in Germany in a precarious situation.

CHAPTER 5: DISCUSSION

The purpose of this study was to identify barriers to mental health care access for Syrian refugee women in Germany, integrating McLeroy et al. (1988)'s socio-ecological model (SEM). The use of qualitative inquiry became a method to confirm previous findings relating to barriers to mental health care access for refugee populations and to extend this framework to answer the research question and to take into account the specific ethno-cultural and gender factors influencing access to mental health care for Syrian refugee women in Germany. Both the literature review and thematic analysis used the socio-ecological model to demonstrate the complex nature of mental health care access, the interconnectedness of multiple systems and how barriers influence each other. A myriad of barriers identified in this study, for example entitlements in state mental health care or availability of mental health care services, concern refugee populations irrelevant of ethnicity or gender. The specific barriers influenced by the Syrian culture and the female gender are detailed more specifically below.

As identified by Shannon et al. (2014) and Spencer et al. (2015), the present study also suggested that the fear or repercussions resulting from experiences of gender-based violence (GBV) are relatively high amongst Syrian refugee women, which may also be connected to the fear of indiscretion or unfamiliarity with discretion of mental health professionals and interpreters identified on the community level. This fear of repercussions was identified to be specifically related to Syrian refugee women and was suggested to act as pronounced barrier to mental health services on the community level.

Another important community factor to consider in the provision of mental health care is the barrier of the cultural gender role, which was also suggested in Shishegar et al. (2017)'s study. Syrian refugee women were often seen to carry the role of the primary caregiver and prioritization of the needs of family members over a woman's own health is inherent to this role. This, in combination with acculturation stressors identified on the intrapersonal level, puts a major burden on refugee women during the acculturation phase, specifically. Due to the specific cultural gender role of Syrian women, mental health care professionals or interpreters of the opposite sex often times also act as a barrier, which is an issue with most of psychiatrist in Germany being of the male gender. Connected to the cultural gender role of Syrian refugee women, the specific influence of the

spouse on controlling or limiting mental health care access was also observed in some cases amongst participants.

The cultural gender role also influences acculturation stressors, as identified by participants on the intrapersonal level. Whilst acculturation stressors, such as mass refugee accommodation providing little safety and privacy and the asylum procedure were seen as pronounced barriers for the general refugee population, corroborating the ideas of Asgary & Segar (2011), Kaplan et al. (2016) and Shishegar et al. (2017). The particular aspect of the woman acting as the upholder of family values and carrying for other family members puts an extra burden on refugee women in the acculturation process. This was also seen to act as a barrier to engage into to the psychotherapeutic process, as identified in Kaplan et al. (2016)'s study.

The cultural gender role may also influence such organisational factors as childcare provision and transport, which is also a much-cited barrier in the refugee literature (Asgary & Segar, 2011; Kaplan et al., 2016; Salami et al., 2018; Salt et al., 2017; Wohler & Dantas, 2017). The logistical barrier of childcare provision is often not considered in mental health care delivery according to participants in this study, making it often impossible for Syrian refugee women to attend psychosocial or mental health care services. Transport barriers particularly plays a role in more rural areas where mental health care services are scarce and transport distances can be 'unsurmountable' for individuals, that have a high prevalence of mental illness and may have sustained multiple traumatisation.

The barrier of culturally sensitive labelling of mental health services on the organisational level, which was cited in Hassan et al. (2016) to be fairly high for Syrian refugees due to the stigmatisation of psychiatry, was confirmed in the present study. This sub-theme was also linked to the cultural gender role of Syrian refugee women and services that were described as fitting this role were accepted and accessed much more amongst Syrian refugee women. These descriptions included psychosocial groups on the topic caring for children, women's health, becoming familiar with the welfare or healthcare system in Germany, etc. As suggested by Hassan et al. (2016)'s study, topics associated directly to mental illness or psychiatry were rejected by Syrian refugee women due to stigmatisation of mental health.

The ethno-cultural factors influencing mental health care access for Syrian refugees in general also importantly inform access for Syrian refugee women. One interesting finding of this

study on the organisational level was that Syrian refugees relied on third parties, personal connections and relationships, such as volunteers or social workers in accommodation centres, doctors, asylum lawyers, refugee social services or asylum counsellors, friends, the (Syrian/refugee) community, to access mental health services. This was reported to be influenced by the culturally informed help-seeking patterns amongst Syrians and the way the Syrian society is structured and this factor was seen as specific to the culture of Syrian refugees. Therefore, skills of referral agents and the time they have on hand to listen to the concerns of refugees may act as a pronounced barrier to mental health care access that is specific to this population. Participants often felt that access to mental health care somewhat depended on luck. This sub-theme on the organisational level is interwoven with the lacking health literacy identified on the intrapersonal level. It also highlights the need of a standardised screening of refugees' mental health, which was highlighted by participants on the policy level.

Another theme related to these specific referral pathways amongst Syrian refugees is health literacy of ethnic minorities in mental health care professionals and other referral agents, which is often directly related to lack of culturally or trauma sensitive training on the organisational level. The lack of training is consistent with findings from previous studies identifying this barrier (Asgary & Segar, 2011; Dow, 2011; Jensen et al., 2013; Kaplan et al., 2016; Salt et al., 2017; Schouler-Ocak, 2017), however, puts an emphasis on training not only mental health care professionals, but also other referral agents due to the specific ways Syrian refugees access mental health services.

On the community level, the stigmatisation of mental health plays a pronounced role in mental health care access for Syrian refugee women. Much in line with previous studies (Asgary & Segar, 2011; Dow, 2011; Hassan et al., 2016; Posselt et al, 2017; Shannon et al., 2014; Salami et al., 2018; Salt et al., 2017; Thomson et al., 2015; Wohler & Dantas, 2017), participants of this study said that being seen as 'crazy' remains a major barrier for this population. This community barrier is interwoven with a myriad of other intrapersonal, interpersonal and organisational level barriers and influences mental health care access for Syrian refugee women considerably. Apart from being specific to the Syrian culture, stigmatisation is also gender specific in the case of experiences of GBV. Participants of the study suggested that this acts as a major barrier to mental health services for Syrian refugee women due to the anticipated grave repercussions from their family and the

community. Connected to this sub-theme is also the fear of indiscretion of mental health care professionals and interpreters, as identified by a number of participants.

Interwoven with the community level barrier of stigmatisation, the majority of participants also reported that health literacy acted as a pronounced barrier to mental health care services on the intrapersonal level. Syrian refugee women were often seen to somatise mental health problems, resulting in incorrect onward referral and inaccurate diagnoses and treatment. In how far this can be counteracted by adequate provisions of interpreters and culturally sensitive training of mental health professionals remains unclear. Stigmatisation may also influence the intrapersonal level of unfamiliarity with the Western approach to mental health care, seeing the therapist as the expert and expecting a more directive approach likely resulting in a 'magic pill'. This is in line with findings from Sen's study (2016).

In line with findings from a myriad of studies (for example, Asgary & Segar, 2011; Donnelly et al., 2011; Hassan et al., 2016; Jensen et al., 2013; Kaplan et al., 2016; O'Mahony & Donnelly, 2007; Posselt et al., 2017; Salami et al., 2018; Salt et al., 2017; Schouler-Ocak, 2017; Shishehgar et al., 2017; Sijbrandij et al., 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010), language was confirmed by participants of this study to be a major barrier to mental health care access for Syrian refugee women. The language barrier in Germany is complicated by the policy level barriers of entitlements of interpreters depending on migration status (and the particular difficulties with subsidiary protection status, which many Syrians are granted in Germany, as detailed on the policy level), general problems of interpreter provisioning in the state mental health care system and systemic discrimination of refugee populations where mental health care professionals are not willing or do not feel skilled enough to work with interpreters. This is consistent with findings from previous studies (Kaplan et al., 2016; Posselt et al., 2017; Salami et al., 2018; Schouler-Ocak, 2017; Shishehgar et al., 2017; Sijbrandij et al., 2017; UNHCR, 2007; WHO, 2010; Wohler & Dantas, 2017), however, is affected additionally by health care system complexity and entitlements in the German public health care system and the fear of indiscretion, which is interwoven with stigmatisation of mental health and GBV on the community level and unfamiliarity with the Western mental health care approach on the intrapersonal level. Additionally, due to Syrian refugee women's cultural gender role of the primary caregiver as identified on the community level and lacking childcare provisions as

identified on the organisational level, Syrian refugee women often do not have the time to attend language courses.

More broader barriers to refugee mental health care provision, that are not specifically related to gender or ethno-cultural factors inherent to Syrian refugee women, are, for example, a lack of knowledge amongst refugees of available mental health care services, that was suggested in various previous studies (Asgary & Segar, 2011; Donnelly et al., 2011; Posselt et al., 2017; Salami et al., 2018; Shannon et al., 2014; Shishehgar et al., 2017; Sijbrandij et al, 2017; Thomson et al., 2015; UNHCR, 2007; WHO, 2010; Wohler & Dantas, 2017). This was corroborated amongst the majority of participants in the present study. However, it was suggested to be partly due to the complexity of the health care system in Germany and the difficulty obtaining information in native language, which puts an emphasis on the policy and organisational component of this barrier in Germany.

An interesting organisational finding of this study was the importance that was placed on the training of interpreters. Organisations that provided their own training of interpreters highlighted the increased quality of mental health care delivery, whereas participants in state mental health care reported that lacking training of interpreters and not having their own pool of interpreters added another communication barrier with refugees in mental health care.

Another much cited organisational barrier in the literature (Asgary & Segar, 2011; Donnelly et al., 2011; Sijbrandij et al., 2017; Wohler & Dantas, 2017) is the lack of available mental health care services, which was also mentioned by the majority of participants in the present study. This barrier is complicated by eligibility criteria being set higher and Syrian refugees often being deemed as more stable than refugees from other countries because of the subsidiary protection status they oftentimes receive in Germany. Rural areas are particularly affected by this barrier and systemic discrimination of refugees further complicates the availability of services with mental health care professionals often feeling unskilled to treat ethnic minorities or fear the additional paperwork or the work with interpreters connected to working with refugees. Systemic discrimination of ethnic minorities in health care was also identified in previous studies (Dow, 2011; Thomson et al., 2015; Wohler & Dantas, 2017), however, problems in interpreter provision, as identified on the policy level, contribute further to this systemic discrimination in Germany.

On the policy level, entitlements in the state mental health care system act as a major deterrent to Syrian refugees in Germany, which had previously been identified in the literature

(Asgary & Segar, 2011; Dow, 2011; Salami et al., 2018; Thomson et al., 2015; Wohler & Dantas, 2017; BAfF, 2016). The particular issue of these entitlements depending on the migration status is seen as a major barrier amongst participants. Particularly the lack of provisions in the first 15 months of a refugee's stay in Germany make state mental health care services close to impossible to access for refugees. This is further complicated by lacking interpreter provision in the state mental health care system. Participants identified that Syrian refugees do in theory not have any mental health care entitlements until they are granted subsidiary protection in Germany, which gives them the same entitlements to healthcare as natives, however, does not cover the provision of interpreters. The only other avenue for Syrian refugees is therefore non-state mental health care organisations, which often deem Syrian refugees as relatively stable because of the subsidiary protection status and eligibility criteria of these organisations therefore often rule Syrian refugees out. This puts Syrian refugees as population in a relatively dire situation, leading oftentimes to chronification of symptoms and ending in a revolving door psychiatry, as described by one participant.

Finally, missing identification of vulnerable individuals according to EU guidelines was mentioned by a few participants. Because of the particular referral pathways pertaining to the Syrian culture, as identified on the organisational level, receiving access to mental health care services often times depend on the skills and time of referral agents. It was suggested by participants, that a standardised mental health screening, which could be conducted alongside the already existing physical health care screening, could therefore detect a mental health need early and adequately. However, such a screening would also mean that currently lacking entitlements amongst refugees towards mental health access in the state mental health care system have to be addressed.

Conclusions

This thesis explored the barriers to mental health care access for Syrian refugee women in Germany by using McLeroy et al. (1988)'s socio-ecological framework in thematic analysis of interviews given by refugee mental health care professionals in Germany. The results are anticipated to provide practical use for refugee mental health care professionals, referral agents to mental health care services and policymakers. The findings suggest an interdependent nature between micro- and macro-level factors that contribute to mental health care access for Syrian refugee women, implying

that efforts to reduce these barriers require multi-systematic collaboration. This means that changes on one level of the SEM also result in changes on other levels, so called reciprocal causality (Henderson & Baffour, 2015). For example, lacking health literacy in Syrian refugee women may be addressed by the following multi-systemic interventions: on the organisational level, the provision of culturally sensitive psychosocial groups, which include psychoeducation and provide basic information on mental health, increases health literacy in individuals. Additionally, on the organisational and policy level, the cultural and trauma sensitive training of mental health care professionals and referral agents addresses lacking health literacy in refugees by enabling professionals to detect a mental health need, provide adequate treatment or facilitate onward referral to adequate services. These interventions may also feed back to the community level by decreasing stigmatisation of mental health and familiarising Syrian refugee women with the Western approach to mental health care and reduce barriers related to unfamiliarity with the mental health care system in Germany.

In this study, the gender role of the Syrian refugee women was identified to have a particular effect on access to mental health care services. It was observed by participants in this study that Syrian women identified as the primary caregiver and upholder of family values and that the prioritization of family members' needs above their own mental health needs acted as a deterrent to mental health care. This coupled with the high stigmatisation of mental health and experiences of GBV on the community level was seen as a specific barrier for this population. These intrapersonal and community barriers affect the provision of mental health services in different ways. First, there is an immense fear of indiscretion of mental health care professionals and interpreters, which would result in major percussions from the community and family members, particularly so if mental health care services are accessed for traumas relating to GBV. As discussed by participants, experiences of GBV were related to staining the honour of the family and resulted in severe repercussions from the community and family members, including repudiation. Second, to ease the burden of being the primary caregiver of the family, lacking childcare provision is a major barrier for these women to attend mental health services. Third, the cultural gender role also stresses the importance for gender and culturally adequate mental health services. The insensitive context and labelling of services often results in being a deterrent to mental health care because services are not gender and culturally adequate to the role of the Syrian refugee woman. Fourth, acculturation stressors specifically affect

women because of their gender role. Changes on the policy and organisational level such as facilitation of family unification and safe accommodation may be an important stabilising factor in the psychosocial health of Syrian refugee women.

Not specifically gender related, but inherent to Syrian refugees as a group is the way mental health care services are accessed. It was identified amongst participants in this study that mental health care is accessed through third parties and personal connections. This puts a particular emphasis on skills, knowledge and available time of referral agents such as social workers, volunteers, general practitioners, etc., and highlights the importance of outreach work of organisations. The particular trauma and culture sensitive skills needed to identify a mental health need and treat refugee populations also act as an essential barrier on the organisational level to address lacking health literacy in this population and lacking knowledge of the Western approach to mental health, both of which were identified as barriers in this study. Another barrier specifically related to this refugee population, although not ethno-cultural or gender related, is the lacking interpreter provision relating to subsidiary protection status which most Syrian refugees in Germany are granted.

Barriers not specifically gender or culture related to Syrian refugee women, but which affect mental health care provision for refugee populations in Germany in general are barriers such as transport barriers, above all in rural areas where mental health care services are scarce, language barriers and lacking entitlements towards interpreter provision in the state mental health care system, knowledge of available services, culturally insensitive screening tools and availability of mental health services. Particularly systemic barriers, such as lacking entitlements in state healthcare provision and lacking identification of vulnerable individuals are a major deterrent to mental health care for refugees in Germany. To remove these barriers surrounding service accessibility, design and delivery, change on the organisational and policy level is required.

Policy Recommendations

The present study suggests various implications for policy. The most pressing topics are entitlements under AsylbLG, financing of interpreters, culturally sensitive training of mental health care staff, the increased provision of psychosocial services, reduction of acculturation stressors and standardised screening.

Entitlements towards mental health care under AsylbLG and universal financing of interpreters in state mental health care services. The present study suggests that lacking entitlements to mental health care under AsylbLG in the first 15 months of a refugee's stay in Germany, lacking interpreter provisioning in state mental health care and changing entitlements depending on migration status are all pressing issues that need to be addressed to improve mental health care access for refugees. Especially for individuals with subsidiary protection, which are particularly vulnerable, access to mental health care and interpreter provision need to be addressed to facilitate integration and psychosocial health.

Improved provision of mental health care services in rural areas. The present study suggests that mental health care provision for refugees in rural areas is inadequate and logistical barriers of transport impede access to mental health care noticeably. With most of the specialised treatment centres for refugees being situated in urban areas and refugees in rural accommodation centres having therefore no alternatives to state mental health care, lacking entitlements for refugees in the state healthcare system and lacking interpreter provision acts as an additional barrier.

Culturally sensitive and trauma sensitive training of mental health care professionals and referral agents, such as social workers and volunteers. As identified by participants in this study, culturally sensitive and trauma sensitive training should be addressed for mental health care professionals and referral agents on the organisational and policy level. This would improve health literacy of refugee populations amongst professionals and the detection of a mental health need in individuals, resulting in more adequate onward referral and treatment of vulnerable individuals and more culturally sensitive labelling of mental health care services.

Increased provision of psychosocial services. According to findings of this study, increased provision of psychosocial services reduces barriers on different levels: (1) Relieve the burden on psychotherapeutic services by providing an alternative, relatively less stigmatised outlet for individuals with a mental health need and provide room to discuss issues connected to psychosocial health and more practical issues to do with acculturation, that do not necessarily require a psychotherapist. They also provide relatively non-stigmatised stabilising support particularly in the

acculturation phase and therefore improve psychosocial health. (2) Can act as a relatively non-stigmatised pathway to identify a need for psychotherapeutic and psychiatric services, if psychosocial services are provided with mental health care professionals, social workers or other trained referral agents in attendance. (3) Can provide psychoeducation on the Western mental health care approach, improve health literacy amongst individuals and reduce stigmatisation of mental health. (4) Can be gender appropriate in nature with activities that are culturally and gender sensitive, such as knitting, cooking, caring for children, providing information on how to access public services in Germany, women's health, etc.

Reduction of acculturation stressors through adequate housing and family unification. The present study suggests that inadequate housing over a prolonged time periods and lacking rights to family unification amongst Syrian refugees (due to their subsidiary protection) are pronounced acculturation stressors. The majority of participants stated that reducing these stressors would improve mental health in individuals and engagement into psychotherapeutic services and therefore improve psychosocial health in refugees and reduce barriers to mental health care.

Standardised screening of vulnerable individuals. According to participants in this study, mental health screening following EU legislation[6] to identify vulnerable individuals is a much needed instrument to identify a mental health need in individuals, however, this requires the provision of entitlements in the state mental health care system for identified individuals.

Childcare provision for mental health care services. Participants in this study suggested that childcare provision would decrease logistical barriers to mental health care access by addressing the specific needs of refugee women and the cultural gender role of Syrian refugee women.

Psychoeducation on the therapeutic process and discretion of mental health care professionals and interpreters could decrease the specific barriers relating to the unfamiliarity with

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[6] EU Guideline 2003/9/EG dated 27. January 2003

the Western mental health care approach and discretion, particularly in connection to fear of repercussions around experiences of GBV.

Provision of mental health care professionals and interpreters of female gender for refugee women in general and particularly Syrian refugee women were seen in the present study to reduce barriers relating to the cultural gender role and in particular the stigmatisation of experiences of GBV.

Future Research

As identified in the methodology section, the present study was conducted with thematic analysis of interviews given by mental health care professionals in Germany. This means that specific ethno-cultural and gender-related barriers described in this study are perceived barriers by third parties; the voice of Syrian refugee women themselves are missing in this study. Carrying out further research into barriers as perceived by Syrian refugee women could therefore enhance knowledge and understanding of the specific barriers relating to this refugee population.

Furthermore, identifying barriers is only the first step towards improving mental health care for Syrian refugee women. Research into the specific facilitators to overcome these barriers would naturally be the next step in addressing the particular mental health needs of Syrian refugee women.

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APPENDIX 1: INTERVIEW GUIDE

Interview Guide

Barriers to mental health services access for Syrian refugee women

BACK-GROUND INFORMATION:

1) What kind of organisation do you work for and what is your responsibility within this organisation?

2) How long have you been working with refugees? With Syrian refugee women, in particular?

3) Tell me about the demographics of the Syrian refugee women who receive mental health services from your organisation.

INTERVIEW QUESTIONS – BARRIERS TO MENTAL HEALTH SERVICES:

4) In your experience, what are some of the challenges that Syrian refugee women face in learning about/finding out about mental health services that exist in Germany? Particularly about your organisation and the mental health care services you provide?

5) What role does language play in Syrian refugee women's access to mental health services?

6) In your experience, do Syrian refugee women's migration experiences affect their access to mental health services in Germany (particularly the aspect of gender-based violence)?

7) How does the Syrian culture shape access to mental health services for Syrian Refugee women?

8) Does stigma around mental health affect access to mental health services for Syrian refugees? For Syrian refugee women, in particular?

9) In your opinion, is the Western approach to mental health (e.g. 1:1 talk therapy, medication) effective for Syrian refugee women?

10) Is mental health care, in your experience, accessible and suited for Syrian refugee women in Germany? Which role does the state play in facilitating mental health services for this group? Which role do other providers play (such as NGOs and church funded services)?

11) Does the availability of services/therapists in this geographic area meet the mental health needs of Syrian refugees? In particular, the specific needs of women?

12) In your opinion, is there a need to increase mental health services for these women? If so, what specific types of services are needed? What would help most to increase access to mental health services?

13) Can you think of any other barriers affecting access to mental health services for Syrian refugee women?

LOOKING FORWARD

14) Do you think innovative approaches such as CBT-based apps and online-based counselling services could be an appropriate alternative for this particular group?

15) In your opinion, do mental health services play a role in the socio-economic and cultural integration of this particular refugee group? Please explain and cite specific examples.

16) Do you have any questions? Is there anything else I should know?

THANK YOU FOR YOUR PARTICIPATION.

APPENDIX 2: DEFINITIONS OF MIGRATION STATUS IN GERMANY

In Germany, migration status is regulated through article 16a of the Constitution (Bundesregierung, 2018). Refugees arriving to Germany to seek asylum are called *Asylsuchender* (asylum seeker) (Bundesregierung, 2018). Once refugees apply to the *Bundesamt für Migration und Flüchtlinge* (BAMF - German Federal Office for Migration and Refugees) for asylum, they change their status to *Asylbewerber* (asylum applicant) (Bundesregierung, 2018). If the applicant can prove that he is persecuted in his home country, he is granted asylum and his status changes to *Asylberechtigter* (recognized asylum seeker) (Bundesregierung, 2018). Beyond that, Germany also grants *subsidiärer Schutz* (subsidiary protection) to those refugees, whose life is threatened in their home country (Bundesregierung, 2018). However, when conditions in their home country change, this subsidiary protection is lifted (Bundesregierung, 2018).

i Also "ich fordere Lösungen von Ihnen". Und meine Tätigkeit oder mein Verständnis von
Psychotherapien ist: ich biete Lösungen an und Sie schauen was für Sie da am besten passt. Man
gibt den Leuten viel mehr Autonomie da selbst zu entscheiden und das will nicht jeder gleich. Aber
das scheint für diese Gruppe nicht zu passen.

ii Auch Symptome zuordnen können. Ich sage mal viele kommen auch mit Schmerzen, und rennen
von Arzt zu Arzt. Und bis da auch mal ein Verständnis besteht, dass das auch psychisch bedingt sein
kann, dass es zusammen hängt, das dauert.

iii Weil so kommt es mir vor wie viel Zufall. Das mein Glück hat, dass man einen fitten
ehrenamtlichen hat, einen fitten Sozialarbeiter, oder wie auch immer. Der dann weiter
versorgt. Manche haben halt das Glück einfach nicht.

iv 1. Haben sie das wissen nicht, 2. Haben sie oft, nicht immer, aber oft, die Zeit nicht dafür, aber
die haben in erster Linie das Wissen nicht.

v Und da ist es oft, das tut mir auch irgendwie leid, da komme ich in der Beratung gar nicht so weit,
oder bis zu dem Punkt, dass ich das exakt klären könnte.

vi Es gibt eben auch auf Seiten der Sozialarbeiter kein Basiswissen und es gab auch nie eine Basis
Fortbildung zu Flucht und Trauma. Die wissen es dann eben auch einfach nicht einzuordnen. Die
können das dann auch den Leuten nicht erklären. Das finde ich einen ganz wesentlichen Faktor
dafür, dass Menschen nicht die Versorgung erhalten, die sie bräuchten. Weil es einfach gar nicht
erkannt wird. Es gibt einfach einen eklatanten Wissensmangel auf Seiten der Sozialarbeiter, was
Traumapädagogik angeht.

vii Wir haben jetzt in diesem Jahr damit angefangen nicht nur zum Thema Gynäkologie ein
Gesprächskreis durchzuführen, sondern als Folgeveranstaltung quasi ein Gesprächskreis zum
Thema Umgang mit Stress oder mit Kindern in Stresssituationen, Fürsorge für sich selbst. Wir
haben das nicht psychologische Beratung genannt, sondern versucht das anders formulieren, weil
ansonsten auch die Akzeptanz nicht so groß wäre.

viii Deswegen haben wir das Thema Frauengesundheit gewählt mit dem Schwerpunkt auf
Schwangerschaft, auf Geburt, auf Menstruationsbeschwerden. Solche Sachen, die erstens Männer
nicht interessieren und zweitens für die Frauen ganz wichtig sind.

ix Also es ist auf jeden Fall nötig das Therapieangebot zu vergrößern. Angebote werden benötigt in
allen Bereichen. Also sowohl psychiatrisch, als auch direkt psychotherapeutisch, als auch
sozialpsychiatrisch beratend.

x Was immer wieder Thema ist bei Angeboten ist, ob die Angebote
Kinderbetreuung mitberücksichtigt. Und daran glaube ich scheitert es häufig.

xi Das sind Wege und Zeiten, die für Menschen, die krank sind, gar nicht machbar sind.

xii Also das ist erstmal überhaupt eine riesige Hürde um erstmal herzukommen. Und auch Angst vor der Behandlung. Wie wird das Aussehen, was passiert da mit mir. Ich finde man erlebt direkt erstmal eine Erleichterung, wenn ich keinen Kittel anhabe. Also auf jeden Fall Angst vor dem Stigma, was denken andere, wenn das jemand mitbekommt. Und dann auch wichtig, Familie.

xiii Jegliche Art von Sexualität, die außerhalb der legitimierten Ehe stattgefunden hat, völlig egal durch was verursacht und völlig egal ob freiwillig oder nicht, gilt als absolute Schande. Das heißt, Frauen nicht nur droht eine Verstoßung, sondern sind auch verstoßen worden. die erzählen nicht nur irgendeine stupide Angst, bei der ich noch überlegen kann, wie real ist die tatsächlich, sondern tatsächlich die kommen hier mit Dokumenten, die die Familie des Mannes ihnen in die Hand gedrückt hat, die Sie unterschreiben müssen, dass sie auf keinen Fall vergewaltigt worden sind während ihres Gefängnis Aufenthaltes, ansonsten darf der Mann nicht weiter mit ihnen verkehren. Die kommen und berichten, dass der Ehemann sie verstoßen hat, weil er nicht ausschließen kann, dass die Frau vergewaltigt wurde. Dinge, die können wir uns gar nicht vorstellen. Und das spielt überhaupt keine Rolle, ob die Frau dem Sexualkontakt zugestimmt hat, ob es ein gewollter war oder ob es ein Gewalt Erlebnis war einmal sexuell geschändet, bist du untragbar für uns.

xiv Zugänglich theoretisch schon für Flüchtlingsfrauen. Also jetzt müssen wir unterscheiden, wenn die noch in dem Status sind, also Flüchtlinge, vor der Anerkennung, gibt es in der Regel keinen Zugang. Weil das im Asylbewerberleistungsgesetz gar nicht vorgesehen ist. Das muss immer mühsam beantragt werden. Der muss vom Gesundheitsamt eine Fachärztin oder ein Facharzt draufschauen, ob das tatsächlich notwendig ist. Also die Hürden sind sehr hoch. In die Regelversorgung zukommen ist sehr schwierig, bis gar unmöglich.

xv Da habe ich quasi eine geringere Anzahl von Genehmigungen für Psychotherapie und sobald die Leute eine Anerkennung haben, fallen sie ja da raus. Das heißt dann ist die Krankenkasse zuständig. Und das ist dann oft auch ein Bruch. Wir haben dann Klienten, die haben eine Genehmigung für Psychotherapie bei den Sozialämtern erhalten, beginnen eine Psychotherapie, und nach 4-5 Stunden ist dann die Anerkennung da, weil dann das Bundesamt-Interview vorbei ist und man denen eine Anerkennung erteilt. Dann müssten die Kosten übernommen werden von der Krankenkasse. Aber die Krankenkasse sagt dann, den Psychotherapeuten können wir zahlen, aber nicht den Dolmetscher. Und dann haben wir sozusagen in dem Moment eine Infragestellung der Behandlung.

xvi Die eher umgesetzt werden von nicht staatlichen Organisationen. Und da liegt dann das Manko. Und das liegt hauptsächlich daran, dass viele Leute nicht staatlich an was arbeiten und einfach sehr viel Kraft verloren geht, weil der eine weiß nicht von dem anderen, es gibt keine Synergieeffekte. Das fehlt tatsächlich.

xvii Drehtür-psychiatrie, wo die Leute in der Krise wenige Tage, manchmal vielleicht auch für ein paar Wochen reinkommen, wieder entlassen werden, viel außer Medikamentöse Behandlung konnte in der Zeit gar nicht gemacht werden, vielleicht so ein bisschen wo non-verbale Kommunikation mehr im Vordergrund steht, weil einfach keine Dolmetscher da sind. Und manche sind dann ein paar Wochen später schon wieder in der Klinik. Das geht dann so weiter.

[xviii] Und da liegt im Endeffekt auch das große Problem. das ist nicht nur ein deutschlandweites Problem ist, sondern ein EU-weites Problem. Es gibt ja diese Aufnahmerichtlinie der EU, dass besonders vulnerable Patienten identifiziert werden müssen, um dann entsprechend eine Behandlung zu bekommen. Darunter fallen auch Leute, die Gewalt erfahren haben, die die im Krieg waren und psychische Belastung zeigen. Das wird in Deutschland aber nicht umgesetzt. Diese Identifizierung. Und die fehlt im Endeffekt, weswegen es ein Loch gibt zwischen: es kommen Leute her, wissen nicht was sie machen, wissen gar nicht was es für ein Angebot gibt, weil sie nicht identifiziert werden und entsprechend weiter verwiesen werden.

[xix] aber die Frage ist halt trotzdem immer, wenn die Leute feststellen, "Oh ja, ich habe Bedarf", dann sollten halt auch die therapeutischen und die ärztlichen Kapazitäten dann zur Verfügung stellen um diese Angebote und Behandlungen auch durchzuführen.