"They Have Locked Us In": The Impact of Trauma, Liminality and Protracted Displacement on the Mental Health of Eritrean Refugees Living in Israel

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Abstract

Multiple studies have found that refugees significantly underutilize mental health services. Yet, little is known about how refugees who live in contexts of protracted displacement cope with and recover from violence, trauma and chronic stress. The unique experiences of refugees living in Israel, particularly those fleeing the violence of Eritrea, are even less understood. This thesis sought to explore Eritrean refugees' distinctive explanatory models of mental health — their own ideas or theories of what may have caused their predicament, the consequences of their psychological distress, and the type of care they believed they needed to recover. In-depth interviews were conducted with 34 Eritrean refugees aged 26–40 having been identified as suffering or having suffered from psychological distress. Participants reported experiencing severe violence and upheaval in Eritrea, during flight, and struggled with daily life in Israel which was regarded by participants as a demeaning environment marked by confinement, poverty, injustice, insecurity, isolation, and endless up-rootedness. For participants, liminality was not simply a juridical status or a spatial/temporal experience, but also an ontological experience that significantly constrained their opportunities and shaped their sense of self, identity, and well-being. Reported coping strategies were rooted and shaped by the Eritrean cultural context, systems of knowledge, values, and cultural perspectives. They included concealment, silence and forgetting, engaging in religious and spiritual practices, seeking social support, and, for some, accessing formal health and psycho-social services. My findings underscore the profound effects of protracted displacement, with participants noting the anxiety, stress, uncertainty, and inability to build their lives brought forth by their liminal status. Findings also reveal the ways in which structural considerations in Israel, particularly law and policies, negatively impact upon the daily lives of Eritrean refugees, contributing to their ongoing distress. Taken together, these elements may deplete refugees' coping resources and undermine their natural processes of recovery and healing. My thesis' findings justify the need to re-think traditional models of trauma and recovery, integrate spirituality and cultural healing into interventions, consider how structural realities impact daily experience, and account for refugees' unique perspectives on distress within the care process.

Résumé

Plusieurs études ont déjà démontré une sous-utilisation significative des services en santé mentale par les réfugié-e-s. Néanmoins, on sait encore peu de choses sur les façons dont les réfugié-e-s qui vivent dans un contexte de déplacement prolongé font face à la violence, au trauma et au stress chronique et comment ils et elles parviennent à se rétablir. Les expériences singulières des réfugié-e-s vivant en Israël, particulièrement celles et ceux qui ont fui la violence en Érythrée, sont encore moins bien comprises. Cette thèse explore des modèles explicatifs de santé mentale spécifiques aux réfugié-e-s érythréen-ne-s — leurs propres idées ou théories sur ce qui a pu causer leur situation, les conséquences de leur détresse psychologique et le type de soin qu'ils ou elles croient avoir besoin pour se rétablir. Des entrevues approfondies ont été menées avec 34 réfugié-e-s érythréen-ne-s âgé-e-s de 26 à 40 ans souffrant ou ayant souffert de détresse psychologique. Les participant-e-s ont rapporté avoir connu un contexte de graves violences et de désordre politique lors de leur fuite de l'Érythree, et avoir rencontré des difficultés dans la vie quotidienne en Israël, laquelle a été décrite par les participant-e-s comme un environnement dégradant, caractérisé par le confinement, la pauvreté, l'injustice, l'insécurité, l'isolation et un déracinement permanent. Pour les participant-e-s, la liminalité n'est pas un simple statut juridique ou une expérience spatio-temporelle, mais une expérience ontologique qui limite significativement leurs opportunités et qui façonne leur perception de soi, leur identité et leur bien-être. Les stratégies pour faire face à ce contexte qui ont été rapportées sont ancrées dans le contexte culturel érythréen et façonnées par lui, ainsi que par son système de savoirs, ses valeurs et ses perspectives culturelles. Elles incluent la dissimulation, le silence et l'oubli, le recours à des pratiques religieuses et spirituelles, la recherche de soutien social et, dans certains cas, l'accès à des services de santé et psychosociaux officiels. Les résultats de ma recherche soulignent également les effets profonds du déplacement prolongé chez les participants, qui ont rendu compte de l'anxiété, du stress, de l'incertitude et de l'incapacité de bâtir leur vie, conséquences de leur statut liminal. Les résultats révèlent également les façons dont les considérations structurelles en Israël, particulièrement les lois et les politiques publiques, ont un impact négatif sur les conditions de vie des réfugié-e-s érythréen-ne-s, ajoutant à leur détresse continue. Considérés ensemble, ces éléments risquent d'affecter négativement les capacités qu'ont les réfugié-e-s de faire face à leur situation et de compromettre le processus naturel de

rétablissement et de guérison. Les résultats de ma thèse justifient le besoin de repenser les modèles traditionnels du trauma et du rétablissement, d'intégrer la spiritualité et les pratiques culturelles de soin dans les interventions, de considérer comment les réalités structurelles affectent l'expérience de la vie quotidienne, et de rendre compte des perspectives propres aux réfugié-e-s sur la détresse associée au processus de soin.

There may be times when we are powerless to prevent injustice, but there must never be a time when we fail to protest.— Elie Wiesel

Acknowledgments

I dedicate this thesis, with profound gratitude, to the men and women who have let me into their lives and shared their experiences with me. I thank them for their extraordinary openness, their trust, and their strength. I hope that, in my small way, I am able to honour their stories and fight the unjust ways refugees are treated throughout the world. There is an enormous gap between the polished paragraphs and theoretical debates found in this dissertation and the realities and lives of the refugees I write about. I am still grappling with this gap and may not ever resolve it. I write these words, at the end of my PhD, to remind myself to not forget the *people* behind the words, using academic research and evidence to speak truth to power and make a positive difference in the lives of the people I encounter.

I am extremely grateful to the many people who have guided me throughout this journey. First and foremost, my supervisor, Dr. Myriam Denov, who has generously imparted me with her wisdom. Myriam's passion, professionalism, rigour, integrity and dedication to others have inspired me, challenged me, and moulded me into to the academic I have become. Myriam was the one who pushed me, in the beginning of the doctoral program, to publish my first paper and convinced me that my writing and ideas were good enough. She has provided me with endless encouragement and mentorship in the years since. Everyone deserves such an incredible guide and teacher.

Thank you as well to the members of my academic committee: our dialogue has shaped my understanding of the interaction between migration, culture, and mental health. Dr. Laurence Kirmayer introduced me to the field of cross-cultural mental health and the incredible intellectual community of the Division of Social and Transcultural Psychiatry at McGill. Dr. Julia Mirsky was there from the very beginning – asking me fruitful questions about my relationship with my subject matter and providing me with an open door for my own questions, big or small.

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Thesis Outline

My thesis, entitled *"They have locked us in": The impact of trauma, liminality and protracted displacement on the mental health of Eritrean refugees living in Israel*, is a manuscript-based doctoral thesis. As such, the thesis is presented as a collection of scholarly papers of which I am the first author. All three manuscripts have been submitted for publication as articles in peer-reviewed journals.

The outline of the thesis is as follows:

The first section clearly states the elements of my thesis that are considered original scholarship and provides a detailed account of its distinct theoretical, methodological, and empirical contributions.

The second section introduces the research by providing the rationale for the study and its significance. In this chapter, I provide the context and background framing the study, including a broad overview of the problems and stressors facing refugees, the prevalence of mental health conditions, and barriers to care. I clearly describe the research problem that prompted the study, along with the accompanying objectives and research questions.

The third section provides a comprehensive review of the relevant literature. In this chapter, I critically review the existing literature on refugee mental health while focusing on two themes related to my research topic: (a) the socio-cultural shaping of refugees' psychological distress and well-being, and (b) research methods in refugee mental health. I discuss the limitations of the existing literature as well as future directions for research, while tracing implications for my own study.

The fourth section presents the three manuscripts of my thesis. In the first manuscript, I explore Eritrean refugees' experiences of violence and flight, and describe how they cope with psychological distress. I then identify the ways in which Eritrean refugees understand, explain, and interpret psychological distress caused by war and violence-related trauma, loss, and

protracted displacement stressors. I co-wrote this manuscript with my supervisor Dr. Myriam Denov. The paper has been published in *Social Science and Medicine - Mental Health,* a top-tier journal with an international and interdisciplinary outreach and impact.
Full reference: Fennig, M. and Denov, M. (2022) The impact of trauma and protracted displacement on the mental health of Eritrean refugees living in Israel: An exploratory study of coping strategies. *Social Science and Medicine – Mental Health*, Volume 2, 100102. 10.1016/j.ssmmh.2022.100102

In the second manuscript, I explore the ways in which imposed liminality and protracted displacement are experienced by Eritrean youth. More specifically, I examine the ways in which liminality affects refugees' mental health, well-being, and ability to access needed services and supports. I co-wrote this manuscript with my PhD supervisor Dr. Myriam Denov. The manuscript has been accepted for publication, under the title "'They have locked us in': The impact of liminality and protracted displacement on the mental health of Eritrean refugee youth living in Israel." It will appear in the *Research Handbook on Children and Conflict*, an edited volume which I am co-editing alongside Dr. Denov, for Edward Elgar Publishing.
Full reference: Fennig, M. and Denov, M. (in press) "They have Locked us in": The Impact of Liminality and Protracted Displacement on the Mental Health of Eritrean Refugee Youth Living in Israel. In Denov, M. and Fennig, M. (eds.) *Research Handbook on Children and Armed Conflict*. London: Edward Elgar.

During my doctoral fieldwork, I was confronted first-hand with the methodological complexities of conducting cross-cultural mental health research. These complexities were particularly pronounced when I attempted to adapt the GHQ-12 to the particular culture and context of Eritrean refugees residing in Israel. The challenges I encountered during the cross-cultural adaptation process led me to devote the final manuscript of my thesis to this topic. In this manuscript, which is currently at the last stage of review for *Transcultural Psychiatry*, I provide a transparent, critical account of the realities of cross-cultural adaptation, including a forthright discussion of the challenges I encountered and the errors I made. My overall argument is that translation is not a merely technical problem – as it is often characterized in medical and

psychological scholarship – but rather a highly nuanced and complex task that greatly influences the validity of cross-cultural findings.
Full reference: Fennig, M. (in press). Cross-culturally adapting the GHQ-12 for use with refugee populations: Opportunities, dilemmas, and challenges. *Transcultural Psychiatry*.

In the discussion chapter, I present a scholarly discussion of all the findings presented in the three manuscripts and suggest three pathways by which the protracted displacement environment may increase refugees' susceptibility to mental health problems. In the conclusion, I assess how the objectives of the research were met and discuss the implications of my findings for mental health research, practice, and policy.

Contribution to Original Knowledge

My thesis makes important theoretical, methodological and empirical contributions to knowledge and contributes to two separate fields related to my topic of research: forced migration research and cross-cultural mental health.

Theoretical contributions: In my dissertation, I conducted a critical ethnography to investigate the ways in which trauma, protracted displacement, and liminality affected Eritrean refugee youths' mental health, wellbeing, and coping strategies. By documenting Eritrean refugees' distinctive explanatory models of mental health — their own ideas or theories of what may have caused their predicament, the consequences of their psychological distress, and the type of care they believed they needed to recover — my thesis contributes to knowledge and theory regarding both universal and culturally-specific aspects of trauma and resilience processes. My findings also contribute to a more nuanced understanding of refugees' mental health by locating specific patterns of psychological distress within particular systems of healing and ontologies of the individual. It provides a novel conceptual framework from which to approach and understand the mental health of refugees — one that acknowledges the deep interrelationship between refugees' psychological well-being and the cultural and socio-structural systems in which they are immersed.

Methodological contributions: This thesis contributes to ongoing scholarly discussions and debates relating to the measurement of trauma and psychological distress. It critiques and demonstrates the deficiencies of the dominant approach to mental health measurement (which relies heavily on standardized psychological scales). At the same time, it contributes to a growing understanding of the practical, methodological, ethical, and epistemological challenges and opportunities presented by the cross-cultural adaptation (CCA) approach, in this case, with individuals who have a refugee background. The study contributes to a growing body of evidence suggesting that the assessment of individuals from refugee backgrounds presents its own specific characteristics and challenges, which need to be taken into account to ensure the validity of cross-cultural findings. Moreover, it provides evidence-based recommendations to researchers and practitioners wishing to cross-culturally adapt psychological measures.

Empirical contribution: Findings of my thesis also provide empirical evidence of the adverse impact of structural factors in Israel—particularly laws and policies—on refugees' mental health. It does so by bringing in the voices of Eritrean refugees themselves, a perspective that is often missing from scholarly discussions and research. In so doing, my thesis renders visible the often obscure linkages between anti-immigration policies, liminal legal status and poor health outcomes. Taken together, findings of this thesis indicate that precarious displacement environments—characterized by chronic stress, anxiety, trauma, uncertainty, and above all a lack of safety—may deplete refugees' coping resources and undermine their natural processes of psychological recovery. In turn, this depletion adversely affects both their capacity to heal from past traumas as well as their ability to negotiate the many challenges of life in protracted displacement.

Introduction

Rationale

Worldwide, tens of millions of refugees are fleeing extreme forms of violence and seeking shelter and safety in high-income countries (United Nations High Commissioner for Refugees [UNHCR], 2022). Yet, the psychological distress—the hidden wounds of these many million—often remain unattended and poorly understood by mental health professionals (Munz & Melcop, 2018; Silove, Ventevogel, & Rees, 2017). Meta-analyses indicate elevated risks of general psychological distress and psychiatric disorders among refugees as compared with age-matched populations in high-income countries (Fazel, Wheeler, & Danesh, 2005). Although mental health services and interventions are increasingly available in host countries, studies conducted in the Netherlands (Laban, Gernaat, Komproe, & De Jong, 2007; Lamkaddem et al., 2014), the United States (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009), Canada (Fenta, Hyman, & Noh, 2006; Kirmayer et al., 2007; Thomson, Chaze, George, & Guruge, 2015), and the United Kingdom (McCrone et al., 2005) suggest that refugees underutilize mental health services compared with majority groups. Moreover, the literature on mental health interventions and the delivery of services reveals that refugees are among those least likely to receive quality mental health care (International Organization for Migration [IOM], 2015; Munz & Melcop, 2018; Slobodin & de Jong, 2015), that is, care that is considered "safe, effective, timely, efficient, equitable and people-centered" (World Health Organization, 2016, p. 2).

Barriers to access and a lack of appropriate supports within existing services for refugees can arise because of a myriad of factors including legal, economic, and geographical challenges (IOM, 2015; Parajuli & Horey, 2020). Not yet sufficiently explored or understood, however, is the complex influence of cultural variables on refugees' service use and engagement with mental health services (Kirmayer et al., 2011). Cultural barriers exist both within the health care system and at the individual level. Some of these barriers include culturally distinctive beliefs about psychological distress and mental health, cultural incompatibility between refugees and mental health practitioners or interventions, the stigma associated with seeking mental health care, and the mistrust of mental health providers (Feldmann, Bensing, de Ruijter, & Boeije, 2007; Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016; Kirmayer et al., 2011; Thomson et

al., 2015). Yet, despite the high need for culturally appropriate mental health care, there is a limited body of cross-cultural research examining refugees' local ways of expressing and coping with psychological distress.

Moreover, refugees are often impacted by large scale social-structural forces such as restrictive migration control policies (Shachar, 2020; McDonnell & Merton, 2019; Hamlin, 2012). These restrictive policies include the provision of time-limited, rather than permanent protection, the confinement of asylum seekers, increased border surveillance, and the outsourcing of procedures for determining refugee status to other countries. As a result of such policies and practices, individuals and families fleeing war and persecution find themselves "outside the circle of legality" (Crépeau et al., 2007), forced to wait months, often years, for the regularization of their status in a state of liminal legality (Chacon, 2015). However, little is known about how refugees experience discrimination and marginalization associated with their liminal immigration status, and how these experiences impact their mental health and well-being.

The plight of Eritrean refugees residing in Israel, the population and context of my research, offers a vivid example of this international problem. Due to the government's suppressive dictatorship, there are nearly half a million Eritrean's living in exile (UN, 2016), with approximately 21,690 adults seeking asylum in Israel (PIBA, 2022). Many have experienced profound losses and have also been exposed to multiple traumatic experiences (Gebreyesus et al., 2019; Regev & Slonim-Nevo, 2019, Nakash et al., 2015; Van Reisen, & Mawere, 2017). For example, Nakash and colleagues (2015) examined the mental health status of 90 men who sought asylum from Eritrea (n=65) and Sudan (n=25) and accessed the Open-Clinic in Tel-Aviv, Israel. They found that exposure to multiple traumatic events was both extremely common and associated with PTSD symptoms. Moreover, continuous post migration stressors, such as lack of stable immigration status and access to basic rights, detention, restrictive and inconsistent asylum policies, anti-refugee discourse, discrimination and poverty-related suffering affect the functioning of refugee individuals and families residing in Israel (Fennig, 2021; Gebreyesus et al., 2018; Shamai & Amir, 2016; Slonim-Nevo & Lavie-Ajayi, 2017). Such stressors are likely to exert their toll on the mental health of the collective Eritrean community (Nakash et al., 2015).

Despite this high burden of distress, the few existing empirical studies on the health access and care of refugees in Israel have reported that refugees are significantly underserved in the healthcare system (Gebreyesus et al., 2017; Gottlieb et al., 2012; Kiat, 2017; Mor et al., 2017). For example, in a recent non-randomized and cross-sectional comparative study on the characteristics of refugees seeking psychiatric versus medical help, Kiat and colleagues (2017) found that participants, regardless of group status, reported suffering from high levels of psychological distress. Despite their psychological distress, only 28% of participants were treated by a mental health professional, suggesting a profound underutilization of specialized mental health services. Rather than approaching mental health specialists for support, the majority of participants relied on informal sources, including non-governmental organizations (27%), helpers or healers from within the community (15%) and religious leaders and groups (19%). These realities not only point to ongoing structural and health inequities, but also indicate that in order to begin to understand and improve refugees' access to effective and appropriate interventions cultural and contextual issues need to be adequately discussed and addressed.

To date, however, research and service planning efforts in Israel have been primarily guided by a Western conceptualization of mental health (Anderson, 2018). A scholarly review of relevant literature on mental health services in Israel provided no results of assessment measures that include Eritreans' local concepts of mental health or empirically-based-frameworks for understanding how Eritrean's conceptualize emotional distress or how this community copes with adversity. Therefore, very little is known about Eritrean refugees' explanatory models of psychological distress, their preferred strategies for seeking help, and the ways in which their social and cultural contexts affect their knowledge, view, and treatment of psychological distress symptoms. Given this, numerous questions remain unresolved. These include what are the roles of informal care, practiced by family, friends and religious leaders, in the prevention and alleviation of psychological distress? How are Eritrean refugees coping with experiences of trauma and its related psychological distress? What cultural barriers may explain the underuse of conventional mental health services?

Objectives

In light of the high risk of psychological distress among refugees, as well concerns regarding access to mental health services, knowledge of specific cultural and structural factors that may impede or facilitate appropriate access and use of services is of utmost importance. As such, the objectives of my exploratory dissertation research were:

> (1) to examine the on-the-ground, lived experiences of psychological distress and well-being, from the perspectives of Eritrean refugee adults living in Israel. This includes the ways in which they understand, explain, express, experience and react to distress and well-being.
>
> (2) to ascertain how research methods and interventions can be cross-culturally adapted to align with refugee population's culture and context.
>
> (3) to increase the capacity of social workers and mental health care systems to respond to the needs of refugees.
>
> (4) to contribute to mental health knowledge and theories regarding universal and culture-specific aspects of trauma and resilience processes.

Primary research question: How do culture and context shape the way Eritrean refugees living in Israel express, experience, and make sense of psychological distress and well-being?

Sub-questions: How do Eritrean refugees identify, describe and interpret psychological distress and well-being? How do Eritrean refugees cope with psychological distress and what are their associated help-seeking behaviors? What is the role of informal care systems—including family, friends, neighbours and local religious and community institutions—in recognizing and responding to psychological distress and enhancing well-being?

Review of the Relevant Literature:
The Socio-cultural Shaping of Refugees' Psychological Distress and Well-being
and
Research Methods in Refugee Mental health

In the following section, I situate my dissertation research in the context of previous research and scholarly debates to demonstrate how my proposed study advances upon what is already known. To do so, I present a critical synthesis of relevant empirical research, divided according to two relevant overarching themes: (a) the socio-cultural shaping of refugees' psychological distress and well-being and (b) research methods in refugee mental health.

I first review the fundamental theories underlying my thesis and explain why these approaches, which are not traditionally applied in the refugee mental health field, were chosen and how they contributed to my work. Subsequently, I discuss the methodological challenges involved in cross-cultural research, while focusing on two methodological gaps within the field of refugee research which are addressed in my doctoral project: (1) a shortage of studies that combine methods to cross-culturally adapt quantitative psychological scales; (2) a shortage of ethnographic studies that focus on how refugees themselves understand and conceptualize emotional distress and resilience.

1. The socio-cultural shaping of refugees' psychological distress and well-being

In the absence of a widely accepted, overarching theory of forced migration, research and interventions in refugee mental health have been largely rooted in a bio-medical model of mental health that focuses on ‘pathological conditions, the diagnosis of disorders, epidemiological studies and the treatment of symptoms through pharmacological or psychotherapeutic interventions’ (Ryan *et al.*, 2008, p. 2). Within this model, refugees' psychological distress is understood as stemming primarily from cumulative exposure to war related violence, and post-traumatic stress disorder (PTSD) is the outcome of paramount interest (Miller & Rasmussen, 2017). This, in turn, has led to a prolific amount of studies based on Western concepts that are assumed to be locally applicable (Pacione *et al.*, 2013)

However, today, there is a wide recognition that *all* forms of emotional distress are locally shaped (American Psychiatric Association, 2013; Kirmayer & Bhugra, 2009). Recent studies have shown that diagnostic constructs and interventions developed in Euro-American contexts, such as post-traumatic stress disorder (PTSD) and 'talk therapy', are not necessarily culturally relevant when working with clients from other societies (Fung and Lo, 2017). While there are several aspects of psychological distress that are universal, ethno-cultural factors play an important role in refugees' responses to trauma and displacement (Kirmayer et al., 2011). As Hernandez et al. (2009) highlight, 'culture influences what gets defined as a problem, how the problem is understood and which solutions to the problem are acceptable' (p.1047). Moreover, large scale social-structural forces such as policies of deterrence (Nickerson et al., 2011; Silove et al., 2007), racial discrimination (Noh et al., 1999; Nakash et al., 2012) as well as the numerous obstacles to accessing healthcare (Ruiz-Casares et al., 2010), have been shown to endanger refugee mental health and effect the context in which mental illness is developed and treated.

Accordingly, there have been important counter perspectives to the trauma model (Beiser et al., 2002; Kostelny, 2006; Miller & Rasmussen, 2017) as well as a growing recognition among forced migration scholars of the need for a new model for understanding and interpreting refugees' distress to enable more culturally, historically and systemically specific notion (Akeeson, & Denov 2017; Miller & Jordans, 2016; Ingelby, 2005). This recognition requires greater attention to cultural theories and socio-structural approaches that provide new lenses through which to approach and understand the diverse pathways by which organized violence affects individuals.

Below, I provide an introduction to two alternative theoretical frameworks that have guided my thesis – Arthur Kleinman's (1988) theory of explanatory models (EM) and Paul Farmer's (2004) conceptual framework of structural violence. These two theoretical frameworks, which are not traditionally applied in the refugee mental health field, were chosen because they illuminate the socio-cultural context of psychological distress and healing, which have allowed me to move beyond intra-personal explanations found in bio-medical theories. Drawing upon literature in social science, social medicine, and public health I begin with a general description of each theoretical framework and then provide a more field-focused assessment that highlights strengths

and limitations of each framework as it relates to refugee mental health. The end result of the analysis is an integrated psycho-cultural-structural model of understanding refugee mental health which guided my study.

1.1. Culture Matters: How Culture Influences Refugees' Mental Health and Coping Strategies

1.1.1 Explanatory Model Framework

The study of the relationship between culture and mental health has been shaped by pioneering scholars and theories across multiple disciplines (Kirmayer, 2018). Among the most prominent is the theoretical framework of Arthur Kleinman, Professor of Medical Anthropology and Psychiatry. Kleinman holds a relativist approach, emphasizing the central role of culture in psychological distress, in contrast to the universalist perspective, which underscores the universality of diagnostic concepts and underlying processes (Canino & Alegria, 2008; Shweder, 1984). The central premise of Kleinman's (1988) explanatory model (EM) framework is that the cultural context of individuals and groups shapes their experience and expression of psychological distress, which consequently impacts their decisions regarding appropriate help-seeking methods and approaches to treatment. Kleinman holds an emic approach to inquiry, which holds that distress and healing must be evaluated from within a culture and its context to be properly understood. After a culturally specific understanding is reached, cross-cultural comparisons of symptoms, disorders and risk factors should be conducted in order to better understand universal aspects of psychological distress and illness as well as cultural dimensions (Kleinman, 1980).

Kleinman's orientation is grounded in the distinction between ‘disease’ and ‘illness’ first conceptualized by Eisenberg (1977). According to Kleinman (1988), illness is the manner in which the individual and his or her family and wider social network perceives, experiences and responds to distress caused by pathopsychogocial processes, wherein "disease is what the practitioner creates in the recasting of illness in terms of theories of disorder" (p.5). This distinction is seen in Kleinman’s (1980) concept of the explanatory model (EM), which focuses

on the meaning of illness and is defined as: "Notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (p. 105). These notions include the perceived cause, onset, course, symptoms, treatment and outcome of illness. Kleinman (1980) emphasized that similar to clinician's bio-medical model of disease, people have their own understanding of their illness, they have an idea or theory of what may have caused their predicament, the consequences of the condition, and what type of care they need in order to recover and get functional (Kirmayer & Bhugra, 2009). However, in contrast to EMs held by professional practitioners, which are expected to be at least relatively stable and coherent with scientific theories of disease causation, lay explanatory models are mostly idiosyncratic, situational and are characterized by "vagueness, multiplicity of meanings, frequent changes and lack of sharp boundaries between ideas and experience" (Kleinman, 1980, p.107).

The distinctive explanatory models of patients and practitioners are rooted and shaped by specific systems of knowledge, values, cultural perspectives and social roles. Thus, as Kleinman (1987) notes: "they are historical and socio-political products" (p.88). Kleinman (1987) called for a renewed attention to the patient's lived experience of their condition and symptoms and recommended eliciting patients' EMs through an exploratory process of qualitative enquiry. By understanding the patient's social world and their illness within that world, the practitioner is able to understand what is at stake for the patients, their families, and, at times, their communities, and by doing so build understanding and promote more empathetic, ethical and effective care (Kleinman & Benson, 2006).

Similar to Geertz (1973), who wrote about the cultural variations of the self, Kleinman (1980) draws on his extensive field studies in Taiwan to demonstrate that in contrast to the concept of individuality, which is at the heart of much of biomedicine and psychological theory, in many non-Western cultures the notion of the self is defined in relation to others and the outside world. Furthermore, Kleinman (1980) argues that biomedical knowledge is itself a cultural product and an outcome of cultural practices. He highlights the challenges and potential dangers of applying Western categories, concepts, and interventions to other ethno-cultural groups and criticizes the assumption that psychiatric categories and diagnoses developed from one culture can be carried over to another, calling it *category fallacy* (Kleinman, 1988).

1.1.2 Contribution: Attention to context and meaning

The impact of Kleinman's theoretical framework on mental health research with refugees has thus far had specific traceable effects, both intended and unintended. First, Kleinman has contributed to a more nuanced and contextualized understanding of refugees' distress, locating their emotional suffering within the particular systems of healing and ontologies of the individual. The EM framework has provided a basis for researchers to go beyond the narrow conceptualization of war-affected populations as bearers of disease and examine the way they themselves experience and conceptualize distress and healing. Researchers working within the EM framework have documented various local concepts of mental distress held by war-affected populations, and have demonstrated that while these local conceptualizations may overlap with mainstream psychiatric categories, they are unique and by no means identical (Hinton & Lewis-Fernandez, 2010, Ventvogel et al., 2013, Kaiser et al., 2015, Miller et al., 2009).

These local conceptualizations have been termed in the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) "cultural concepts of distress" (CCD) and have been defined as "ways cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions" (American Psychiatric Association (APA), 2013). The term CCD was introduced in the DSM-5, in an attempt to aggregate the different terms used by cross-cultural mental health researchers to refer to and describe culturally-specific modes of expressing explaining, and diagnosing psychological distress. CCDs include cultural syndromes, popular or folk illness categories, idioms of distress, and illness explanations or attributions (Lewis-Fernández & Kirmayer, 2019).

Idiom of distress is a concept originally developed by Nichter (1981) to draw attention to the manner in which different cultural groups communicate or manifest distress, both verbally and non-verbally (Lewis-Fernández & Kirmayer, 2019). A large body of scholarship examines idioms of distress within war-affected populations (Abramowitz, 2010; De Jong & Reis, 2010; Hinton & Lewis-Fernández, 2010; Kidron & Kirmayer, 2019; Kohrt & Hruschka, 2011; Miller et al., 2009; Rasmussen et al., 2011; Ventevogel et al., 2013). Some of these studies have adopted

an ethnographic approach in an effort to better understand trauma-related idioms in a particular cultural context (Hinton, Barlow, Reis & de Jong, 2016; Kidron & Kirmayer, 2019; Kohrt & Hruschka, 2011). Others have utilized an epidemiological approach to compare psychological trauma idioms with mainstream psychiatric categories, such as PTSD and depression, in an attempt to: (a) identify indicators of distress not captured by psychiatric disorders, (b) examine the overlap of CCDs with mainstream psychiatric categories, (c) examine the validity of CCDs against psychiatric disorders, and (d) create culturally sensitive measures of distress (Hinton & Lewis-Fernández , 2010; Lewis-Fernández & Kirmayer, 2019; Rasmussen et al., 2011; Miller et al., 2009).

Another type of CCD described in the DSM-5 involves cultural explanations or explanatory models (EM). These refer to an individual's "ideas about the causes of the problem; about the problem's psychological, somatic, social, and/or spiritual effects over time; and about what would be the most appropriate and efficacious treatment" (Hinton et al., 2016, p. 65). Cultural explanations are "mediated by cognitive-social interpretive processes that are shaped by culture from their earliest inception" (Kirmayer & Ban, 2013, p.104). In the case of torture and violence in the context of war, for example, refugees may draw on implicit casual theories that are related to wider social and cultural systems of knowledge and practice to explain both events and afflictions (Kirmayer, Ban & Jaranson, 2018). Instructive in this regard is Barber's (2008) study which compared the ways in which Bosnian and Palestinian youth who experienced substantial political conflict "made sense" of violence. The Palestinian youth, who understood their war-related experiences in relation to their political affiliation and resistance, were able to integrate the suffering they experienced into a coherent narrative. By contrast, the narratives of Bosnian youths, who viewed their war-related experiences as "senseless", were full of the trauma and they showed worse outcomes for depression and posttraumatic stress. These examples, as well as many others, highlight that the models that individuals use to make sense of their experience are both interpersonal and intrapersonal - they are highly shaped by individuals' family, community and local socio-cultural contexts and have effects on illness experience, coping and help-seeking.

1.1.3 Contribution: Understanding refugees' unique ways of coping and seeking help

In addition to understanding how refugees understand, experience and express distress, Kleinman's theoretical framework has propelled useful research on refugees' unique ways of coping and seeking help. Coping is understood as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). These efforts range from seeking professional help to denial of the problem (Lazarus & Folkman, 1984). The scholarship on healthcare utilization suggests that culture, combined with economic and social structural factors, plays a major role in the process of influencing whether refugees seek help, what types of help they seek, and what types of coping strategies they use (Kirmayer et al., 2007). For example, the ways in which one makes sense of or interprets their trauma-related symptoms (e.g. a certain type of spirit possession), will profoundly influence their motivation to seek out of treatment and the type of treatments used (Hinton, Lewis-Fernández, Kirmayer & Weiss, 2015).

In a number of refugee cultures, mild forms of psychological distress are understood as personal or moral problems, more appropriately dealt with on one's own or through various practices and institutions that are relational, communal and spiritual in nature (Eastmond & Selimovic, 2012; Savic et al., 2016; Shannon et al., 2015). Moreover, for many refugees, prayer and spirituality are used as coping strategies (Bryant-Davis & Wong, 2013), and the role of local faith communities—such as congregations, mosques, temples and spiritual/religious leaders—as sources of support for psychological distress appears central (Ager et al., 2015; Khawaja et al., 2008; Ní Raghallaigh & Gilligan, 2010).

For example, two recent studies employed qualitative methods to explore coping strategies used in the pre-migration and post-migration phases amongst 10 adult Eritrean refugees residing in Switzerland (Melamed et al., 2019) and 23 female Eritrean refugees residing in Norway (Abraham, Lien & Hanssen, 2018). Both studies found that religious beliefs and social support are critical factors that assist Eritrean refugees to cope. For instance, participants in both studies related mental health to faith and described spiritual or church support as a first-line treatment for problems associated with psychological distress. The qualitative results of Melamed and colleagues (2019) also reveal the importance of trusted friends and family who are responsible

for recognizing distress, mobilizing, and providing care for those in need of help and support. In addition, the results of Abraham et al. (2018) highlight the importance of cognitive strategies used by the participants. These include normalizing psychological problems, as well as focusing on future aspirations.

Indeed, in the book *Patients and Healers in the Context of Culture*, Kleinman (1980) draws on his extensive field studies in Taiwan to demonstrate that healing activities transpire, only minimally, within the clinical encounter. Conversely, the majority of therapeutic activity occurs between the individual and his or her family and community in what Kleinman (1980) terms the "popular sector of health care" (p. 50). Still, little is known about how these support systems work among refugee communities and how they may facilitate or hinder access to more formal sources of mental health care.

1.1.4 Limitations of the explanatory model framework

While acknowledging the significant contributions of the EM framework, some scholars have highlighted its limitations. Young (1981) argues that the EM framework is based on a "hypothetical Rational Man rather than real people" (p. 317). He argues that the majority of people do not have logical and coherent explanations for their suffering, and/or they may hold different explanations that change throughout the course of illness (Young, 1981). Indeed, as a result of various circumstances refugees' illness narratives are often fragmented, incoherent and multiple (Kirmayer, 2003). An analysis which is solely based on refugees' causal attributions of their illness may be limiting since it will only reveal "a small portion of the many representations that come into play with regards to illness and health-related behavior." (Groleau, Young & Kirmayer, 2006, p.676).

Other scholars have questioned the appropriateness of the clinically oriented EM framework for the analysis of phenomena that are essentially social (Weiss, 2018). Although the EM framework acknowledges the role of social determinates on health outcomes, the theoretical focus on clinical events and individual interactions may work against a more structural, political, and economic analysis (Metzl & Hansen, 2014; Napier et al., 2014; Young, 1981).

Furthermore, although the inclusion of culture in refugee mental health research and clinical guidelines has led to undeniable advances in knowledge, in some instances it has unintentionally led to modes of generalization and essentialization that have been less enabling. Scholars have raised concerns that studying 'local concepts' of distress may be inappropriate due to the complex and dynamic nature of culture and local knowledge (Ventevogel et al, 2013). Indeed, authors have highlighted the importance of distinguishing between CCDs and psychiatric disorders (Lewis-Fernández & Kirmayer, 2019). While some CCDs may involve syndromes that resemble psychiatric disorders (including specific etiologies, vulnerabilities, symptoms and expected remedies) other CCDs are better understood as modes of expression or communication that cover a wide spectrum of distress ranging from everyday concerns or adaptive responses to stress to trauma symptoms or severe psychopathology (Lewis-Fernández & Kirmayer, 2019).

A limitation of CCD research is that it may easily result in an exoticized and rigid vocabulary list that is detached from the broader understandings of distress and well-being (Nichter, 2010). This process of de-contextualization may also lead researchers and clinicians to medicalize and pathologize sub-clinical distress by reducing local CCDs to Western psychiatric categories (Kaiser et al., 2015). For example, in their work in post-genocide Cambodia, Kidron and Kirmayer (2019) demonstrate how *Baksbat,* a local idiom of distress often understood by survivors as an indicator of normal post-conflict distress, was transformed by clinicians and humanitarian workers into a local idiom of trauma and at times a gateway diagnosis of PTSD.

Moving away from a disorder-centric view of distress and understanding, both the personal and social meanings and experiences of trauma and distress among refugee populations, is of paramount importance. In today's globalized world in which traditional boundaries between cultures are becoming more blurred and fluid due to mass communication and transnational migration, it is also important to account for the ways in which Western models of health (e.g. the bio-medical model) and global CCDs (like PTSD) interact with local ideas of health and wellness (Lewis-Fernández & Kirmayer, 2019). This is especially true for refugees whose representation of illness and treatment are often altered in the migration and acculturation process as well as their ongoing interaction with the host society (Nadeau et al., 2017).

1.2. Embodied Violence: Structural Violence and Refugees' Mental Health

1.2.1. Structural Violence

Socio-structural approaches offer an important contribution to the conceptualization of refugee mental health by bringing to light global and local power relations and their influence on refugees' health and wellbeing (Grønseth, 2013). Central to such approaches is the concept of "structural violence", first introduced by sociologist and Peace Studies scholar Johan Galtung (1969). This concept describes how large-scale forces–economic, political, legal, religious and cultural–limit individuals' and communities' ability to reach their full potential both in terms of life acceptancy and professional aspirations. Galtung (1969) moves beyond the narrow definition of violence as a physical act to include other forms of violence, including psychological violence and indirect violence, which he terms "structural violence". While by conventional definition violence can be traced back to a person or actor, structural violence posits that violence is built into the structures of society, revealing itself as unequal power and consequently as unequal life chances. Due to its hidden and rather ordinary nature, violence of this sort is almost invisible and therefore much harder to target and erase. As Galtung (1969) notes: "structural violence is silent, it does not show–it is essentially static, it is the tranquil waters" (p. 173).

Paul Farmer (2004) has re-introduced the concept of structural violence in order to revive and spark new discussion about social forces that negatively impact disease distribution and access to health care services. He uses the phrase "materiality of the social" to demonstrate how complex social processes such as inequality eventually become embodied biologically as negative health outcomes (Famer, 2004, p. 308). Farmer criticizes the social sciences, namely psychology, epidemiology, sociology and anthropology, for the erosion of social awareness. He argues that academic inquiry which focuses solely on current events and the "ethnographically visible" runs the risk of analytic reductionism (Farmer, 2004, p. 305). In his analysis he demonstrates that health is a deeply political issue and therefore requires an "anthropology of structural violence" that simultaneously draws on history, biology, and political economy to be fully understood (Famer, 2004, p. 305).

1.2.2. Contributions: Exposing hidden political and economic processes

In the field of refugee mental health, several studies have demonstrated how structural violence is built into seemingly objective and fair administrative systems and policies, and how this violence eventually becomes embodied as emotional distress and illness. One example, is Fassin and d'Halluin's (2005, 2007) critical ethnography of the asylum process in France, which highlights the hidden violence exerted in the refugee status determination (RSD) process– commonly seen as a rational and fair method for decision-making. In their analysis they demonstrate how, in the recent political climate of disbelief, the physical and psychological scars of refugees have become not only a symptom in need of treatment but also a source of evidence of the violence and persecution refugees have endured. In this process the accounts of refugees are discredited while the Western diagnosis of mental illness associated with traumatic experiences becomes the main avenue through which refugees evoke compassion and achieve legitimacy. Thus, rather than protecting people who fear persecution, the RSD process may in fact deny refugees' embodied truth of violence and contribute or cause psychological problems.

Similarly, several studies have explored the relationship between restrictive refugee policies such as mandatory detention (Entholt et al., 2018; Steel et al., 2004; Silove et al., 2000), voluntary repatriation (Von Lersner et al., 2008; Ghanem, 2003; Hammond, 2004) and dispersal (Fazel et al., 2012; Warfa et al., 2006) and adverse mental health outcomes. Other studies have explored the various pathways from which social forces ranging from poverty (Beiser et al., 2002; Fazel et al., 2012) to xenophobia and racism (Fernando, 2005, 2017) have become embodied as individual distress among refugee and migrant groups.

These studies demonstrate how violence is deeply embedded in migration policies and public and political discourses, so much so that it has become an unquestioned 'common sense' (Castles, 2004). Atak and Crepeau (2013) use the notion of 'securitization' to explain this process. They demonstrate how in a process of social construction issues such as migration and asylum, which are normally considered an area of regular politics, are transformed into an area of security. In this process asylum is "described as an existential threat to fundamental values of society and the

state, a construction which helps in convincing a relevant section of society that exceptional measures are needed in response to this existential threat"(p.227). Indeed, anti-terrorism and security concerns are often put at the forefront of migration policy at the expense of refugee's rights and health (Crepeau et al., 2007; Bryan & Denov, 2011). The conceptual model of structural violence has allowed researchers to examine the violence exerted by these ostensibly moral and necessary processes and critique and combat them (Rousseau & Kirmayer, 2010).

1.2.3 Contribution: Rights-based analysis

Farmer's (2008) theoretical focus on human rights, particularly economic and health rights, provides a framework from which to challenge conventional neoliberal doctrines in refugee mental health which view health as a commodity rather than a public good (Farmer, 2004, 2008). He argues that an analysis based on economic and social rights underscores the importance of securing equitable access to education, food, health, and other resources as a means of promoting the wellbeing of marginalized groups (Farmer, 2008). Similarly, a significant number of scholars researching refugee mental health have embraced a rights-based model and have called for greater attention to the social and economic rights of war-affected populations (Denov & Blanchet-Cohen, 2014; Steel et al., 2012). Scholars highlight that as a consequence of exclusionary policies, war-affected populations are often denied social and economic rights including access to basic healthcare services (Gottlieb et al., 2012; Rousseau et al., 2008). Other groups, such as trafficking victims, are often provided access to health care and trauma counselling only if they cooperate in the criminal investigation and prosecution of traffickers (Goodey, 2004).

1.2.4 Contribution: Linking scholarship with activism

Another important contribution of structural violence is its engaged approach to inquiry, underscoring the need to accompany conceptual analysis with concrete political engagement that challenges the idea of "a purely descriptive and objective social science." (Rylko-Bauer & Farmer, 2017, p. 18). Unlike armchair critical thinkers who have been criticized for not offering any clear road map to political action (Kirmayer & Pedersen, 2014; Whitley, 2014), Farmer

(2008) is a pragmatist who sees the potential for a socially just health system in the future. He uses the framework to criticize the "ironic detachment, textual subversion, and arcane methodological disputes" of scholars from the humanities and social sciences, who have focused on discussing and describing health inequities rather than taking action (Farmer, 2008, p. 13). This critique underscores that the debate on structural violence, human rights and health must be linked to advocacy and action (Rylko-Bauer & Farmer, 2017).

Researchers from the field of refugee mental health have argued that the understandings gained from such an approach can lead to more just immigration and refugee legislation, policies, programs and practices. Indeed, scholars have found the scientific documentation of mental health distress to be a vital tool in speaking up against the human rights violations of refugees (Silove et al., 2007). Similarly, Rousseau and Kirmayer (2010) have argued that a firm commitment to advocacy is key to establishing ethical refugee mental health research. They note: "No matter how carefully and respectfully information is collected, if it is not coupled with vigorous efforts to use it to transform the situation of ongoing violence, then the weight of complicity may be too much to bear" (p. 66)

1.2.5 Limitations of the structural violence framework

While the conceptual framework presented by Farmer has made important contributions to the refugee mental health field, it also holds several limitations. First, some authors argue that invoking the concept of structural violence in migrant health research can be analytically limiting due to its inherent abstraction (Quesada et al., 2011). Wacquant (2004) and Nichter (2008) warn that grouping different levels and forms of violence under one umbrella term can reduce agency associated with structural violence and, as a result, complicate identifying actors responsible for specific forms of oppression.

Second, scholars have called for an expansion of the conceptual framework to include how structural violence operates at a local level. As Bourgois & Sheper-Hughes (2004) note: "We need to specify empirically and to theorize more broadly the way everyday life is shaped by the

historical processes and contemporary politics of global political economy as well as by local discourse and culture"(p. 318).

Third, while understanding how refugees' agency is constrained by structured and institutionalized inequality is clearly helpful in refuting victim-blaming, the structural violence framework leaves very little room for exploring and understanding grassroots resistance and social action. Scholars have criticized the framing of refugees as "passive victims suffering from mental health problems", or as objects of larger economic, political and social forces (Watters, 2001, p.1709). A wealth of research has documented the diverse ways refugees exercise their agency and make active choices that contribute to their own healthy development (Blanchet-Cohen & Denov, 2015; Lacroix et al., 2015; Dryden-Peterson, 2006). Furthermore, as Redeker Hepner (2015) argues, the act of seeking asylum is in itself a form of agency, as it represents an individualized attempt to resist violence and reach a safe haven.

Lastly, Farmer's (2008) call to prioritize economic and social rights over civil and political rights may be limiting when analyzing the issue of refugee mental health. Some scholars argue that the most significant barrier towards the realization of refugees' human rights is their inability to secure membership in any political community (DeGooyer et al., 2018). Refugees lack "the right to have rights", as Hana Arendt (1968) highlighted more than sixty years ago. According to Arendt specific rights such as education and health can only be upheld if there is a state that can guarantee that these rights will be respected. Recent studies have demonstrated that in many states public services are conditional upon registration with a government authority, thus inhibiting access for individuals who fall outside that category (Crépeau, 2013).

1.3 Conclusion: **An integrated socio-cultural approach**

Cultural theories and socio-structural approaches are complementary frameworks that aim to sensitize researchers to the wide range of variables that need to be taken into consideration when examining the mental health of refugees. They highlight distinct and interrelated aspects that can act to broaden and deepen the exploration and understanding of refugees' mental health and wellbeing.

In respect to my own research, each of these frameworks provides a lens for exploring the lived experiences and coping strategies of Eritrean refugees residing in Israel in relation to psychological distress and help seeking. Cultural theories such as Kleinman's EM framework provide my research a 'bottom up' approach to inquiry, a guiding framework from which to explore local (emic) perceptions of psychosocial issues among individuals, families and communities that have fled adversity in Eretria and currently reside in Israel. It offers a lens through which to examine local opinions and responses to trauma and displacement from within the cultural systems of meaning and healing in which they are embedded. The assumption is that refugees themselves are agents of their own behavior, always interpreting, constructing and reconstructing social realities (Weiss, 2018).

However, focusing on "culture" alone, does not recognize the dynamics of power and inequality that continuously shape these peoples' reality and experience of illness. Failure to consider these forces may lead to a narrow, reductionist and even harmful analysis. Analyzing refugees' mental health experience and behavior through, a socio-structural approach–such as Farmer's conceptual framework of structural violence–can therefore add to the analysis by examining how refugees' behaviour and choices are constrained by oppressive social forces in Israel. It provides a 'top down' approach to inquiry, examining how oppressive social forces eventually become embodied as individual distress. In the Israeli context, such large-scale forces include restrictive and inconsistent asylum policies, anti-refugee discourse, exclusionary and hostile attitudes as well as the numerous obstacles to accessing healthcare (Slonim-Nevo & Lavie-Ajayi, 2017; Gebreyesus et al., 2018; Nakash et al., 2012; Feinstein, 2012; Kritzman-Amir, 2009).

Brought together, these frameworks form a psycho-cultural-structural model of understanding refugee mental health that have helped me explain and make-sense of participants' complex experiences. By providing an analysis that includes both local conceptions of mental health and systemic socio-structural factors, these frameworks have added significant depth to my research.

2. Research methods in refugee mental

In recent decades, there has been a remarkable increase in research on the effects of political violence and forced migration on refugees' mental health. With this increased interest, a debate has emerged on how best to elicit, measure, and understand the psychological experiences of war, flight, and displacement (Silove et al., 2017; Ahearn, 2000). An enduring methodological challenge characterizing research on the mental health of war affected communities is the desire to explore the local 'emic' perspective of a particular community and, at the same time, conduct cross-cultural comparisons of symptoms, disorders and risk/protective factors in order to better understand cross cultural similarities and universal aspects of distress, trauma and resilience (Kirmayer & Ban, 2013). Researchers have warned of the complexities of studying mental health and related constructs from a cross-cultural perspective, and of the potential harm of employing context-insensitive methods and instruments that may not capture the local needs and lived realities of conflict-affected populations (Van Ommeren, 2003). In response, scholars have advocated to increase attention to inductive ethnographic methods that allow communities to better identify and manage a range of mental health priorities (Whitley, 2014; Miller et al., 2006; Mitchell & Sommer, 2016). Others have approached this challenge by employing integrated/mixed-method approaches to cross-culturally adapt quantitative assessment measures (Weine et al., 2014).

The recognition that culture and context are central to the understanding of refugee mental health requires researchers to develop and adapt research methods so that they are locally appropriate and relevant to participants' lives. For this to happen there is a need to think outside the box by engaging with new and innovative approaches to refugee research. Below, I offer a critical analysis of quantitative and qualitative research methods prominent in the refugee mental health field and employed in my doctoral project, namely: quantitative assessment instruments and qualitative ethnographic methods. After presenting each method, I explore their respective strengths and weaknesses, and discuss the issues and difficulties that arise when conducting cross-cultural research with war-affected populations. Finally, I examine the ways these methods can intersect and complement each other, as well as the ways in which they link to my own work.

2.1 Quantitative assessment instruments

A significant amount of research on refugee mental health comes from the field of mental health epidemiology. In this field, there are various methodological challenges, including assessment of "caseness" and sampling strategy (Silove et al., 2017; Steel et al., 2009). Although a comprehensive review of this literature is beyond the scope of this paper, in this section I provide a review of one important method that has gained significant attention: the use of quantitative mental health instruments. Rooted in a post-positivist paradigm and a realist approach to research, these instruments are intended to quantify war-affected adults' and children's exposure to distressing events and measure their emotional and behavioral responses (Green & Thorogood, 2014; Ahearn, 2000). Researchers using these instruments take an etic approach to investigation, applying "the concepts of a behavior and techniques for measuring that behavior from one culture to another" (Flaherty et al., 1998, p. 257).

2.1.1 Strengths and limitations

In settings of war and conflict, the use of assessment instruments can make important contributions to the promotion of mental health and well-being. First, by detailing the prevalence rates of mental health disorders, researchers can advocate for the necessity of services since such studies generally attract attention from policymakers and funders (Tol et al., 2013; Kohrt et al., 2011). Second, assessment measures are used in analytic epidemiological studies, to confirm relations between mental health and other variables, such as gender, exposure to violence, immigration status and continued adversity. They also allow to make comparisons with other populations with or without refugee background (Bolton et al., 2009). This data may inform policies and programs that focus on improving conditions in the resettlement environment (Miller & Rasmussen, 2017). Finally, assessment measures are often used to evaluate the impact of programs and services, and in doing so can help ascertain which therapeutic modalities are more effective (Rasmussen et al, 2015).

However, some scholars have argued that epidemiological data generated by standard Western instruments may produce misleading conclusions and generalizations—under-reporting refugees' mental health needs or pathologizing what can otherwise be understood as a normal reaction to

devastating adverse events (Silove et al., 2017; Pacione et al., 2013; Kohrt et al., 2011). They point to dramatic inconsistencies in the prevalence rates of psychiatric disorders in conflict-affected populations, namely: post-traumatic stress disorder (PTSD) and depression (Hollifield et al., 2002). For example, the prevalence rates of PTSD in conflict-affected populations have been found to vary significantly across post-conflict settings, from 0.1% in Tibetan refugees (Sachs et al., 2008) to 99% in regions such as Sierra Leone (Kaz et al., 2000).

While reasons for such inconsistencies may be partly due to variance in the types of traumatic exposure, the timing of studies, or problems in randomization or sampling (Silove, 2012), a significant factor affecting the accuracy of results has been attributed to using research instruments that have not demonstrated reliability and validity with populations affected by conflict (Rasmussen et al., 2015). Indeed, due to the shortage of assessment instruments specifically validated with refugee populations, most of the collection of epidemiological data on refugee mental health has been conducted through non-local measures of psychiatric disorders that were developed and tested in Western settings (Tol et al., 2013). Using standard Western diagnostic instruments with war-affected populations has given rise to multiple methodological challenges (Ventevogel, 2016). These challenges include: the use of measures for purposes that they were not intended for (e.g. using a PTSD measure intended for prevalence studies for a study of treatment planning) (Kohrt et al., 2011); the application of cutoff scores that were established with Western populations or clinical refugee samples, and are not necessarily comparable in other settings (Rassmussen et al., 2015; Ventevogel,2016); or the lack of systematic and reliable translations that may distort the meaning of the original scale and may in fact fail to measure the same constructs as the original instrument (Stolk et al., 2017; Davidson, 2010; Van Ommeren et al., 1999).

Moreover, researchers argue that using measurement instruments designed to capture syndromes as they are defined in North American and European nosology may result in imposing foreign concepts that may have limited validity in the population being researched (Ventevogel, 2016). Indeed, the growing awareness of the role of culture and context in mental health has led scholars to criticize the assumption that psychiatric categories and diagnoses developed from one culture can be carried over to another culture, calling it a *category fallacy* (Kleinman, 1988).

Moreover, researchers using Western-based instruments may end up missing other ways war-affected groups experience and communicate distress (Weaver & Kaiser, 2015). While in many contexts and cultures war-affected populations will indeed report symptoms of PTSD and other disorders if asked, this does not mean that these concepts are meaningful to them or compatible with their own concepts of emotional distress (Miller et al., 2009).

Researchers have found that in many war-affected populations other problems and symptom complexes that are not captured in existing measures may be more strongly associated with impaired functioning and thus perceived by local populations as more pressing (Kaiser et al., 2015; Betancourt et al., 2009; Miller et al., 2009; Hollifield et al., 2002). However, the nature of quantitative instruments restricts responses to levels of agreement with predetermined questions (Bolton, 2009). As a result, research using these instruments is often restricted to confirming or refuting the researchers' hypotheses as to what the mental health needs are and how they are expressed, and there is limited opportunity to discover new or unknown issues (Betancourt et al., 2009).

2.1.2. Addressing Challenges

Scholars have addressed these challenges in a variety of ways. Some studies have focused on creating a more systematic approach to the translation and validation of available instruments (Flaherty et al., 1988; Van Ommern & De Jong, 1999; Kohrt et al., 2011). However, systematic strategies of translation have important limitations including the loss of nonverbal nuances that are important to oral societies, the reliance on translators who may be part of the educated elite, and the issue of construct validity (Ellis et al., 2007).

Others have employed translated instruments that were previously validated with conflict-affected populations but that have not been used in the specific study population (Nakash et al., 2017; Nillson et al., 2008; Van Ee et al., 2016; Jasinskaja-Lahti et al., 2006). However, as noted above, rigorously developed and validated measurements for use with refugee populations remain limited, especially with regard to refugee children (Gadeberg & Norredam, 2016; Davidson, 2010; Hollifield et al., 2002). Furthermore, the measurements available may not

capture the experiences of the specific population in question. For example, while the HTQ, an instrument specifically designed for use with adult refugee groups from diverse cultures, contains an ethnographic section that can be used to modify the instrument to the local context, in practice researchers apply it generically, rarely incorporating culturally specific items (Rasmussen et al., 2015).

An additional strategy employed by scholars is the cultural and contextual adaptation of standardized mental health instruments (Panter-Brick et al., 2017; Weaver, 2016; Kohrt et al., 2011; Jordans et al., 2009; Shoeb et al., 2007; Bolton, 2001,) or the development of new measures designed for use with specific refugee populations (Jayawickreme et al., 2009; Miller et al., 2006; Westermeyer, 2000). This is often done by employing a sequential mixed-methods approach (Bolton, 2009; De Jong & Van Ommeren, 2002). For example, in Kabul, Miller and colleagues (2006) collected narrative data from the war-affected population to construct the Afghan Symptom Checklist, a measure that was then administered to the local population. Quantitative instruments developed through this process can better capture the complexity and variance of local expressions of distress and resilience (Panter-Brick et al., 2017). However, reliance solely on local instruments and indicators may limit the possibilities for aggregation in meta-analyses and comparison of outcomes between settings (Rassmusen et al., 2014; Tol et al., 2013). Moreover, creating new instruments can be a time-consuming and expensive effort, particularly in conflict-affected contexts in which resources often are limited (Hollifield, 2002). Tol and colleagues (2013) suggest that a potential solution to standardization may lie in the use of the same mixed methods across settings. In this way, the content of the measures is different but comparisons are still possible.

2.2 Ethnographic methods

A growing number of scholars from the refugee mental health field are employing ethnographic methods to better understand the psychological distress and well-being of war-affected populations (Ahearn, 2000). Researchers using these methods often hold a social constructivist worldview (Creswell, 2007). They seek to elicit respondents' emic perspective through qualitative methods such as in-depth interviews, focus group discussions, and participatory

observation, which is considered the cornerstone of the ethnographic approach (Hammersley & Atkinson, 2010). Ethnography requires intense long-term field work, in which researchers strive to immerse themselves in a specific social, economic, and political context (Holmes & Castañeda, 2014). The main goal is to explore how participants make sense and give meaning to their mental health within their socio-cultural contexts (Groleau et al., 2009). As such, the researcher's preconceived notions and frameworks are set aside, privileging instead war-affected populations' subjective perspectives and the various ways they experience and express their mental health (Akeeson & Denov, 2017; Whitley & Crawford, 2005). In placing the observed behaviour in cultural context, what Clifford Geertz (1973) has called "thick description", qualitative studies strive to capture the complexity and multiplicity of social phenomena. The main focus of qualitative research in this field has been the exploration of lived experiences of war-affected communities with particular emphasis on local mental health concepts and help-seeking behaviors, and their importance to local people (Akeeson & Denov, 2017; Grayson, 2017; Ventevogel et al., 2013; Rasmussen et al., 2011; Hinton & Lewis Fernandez, 2010; Miller et al., 2009; Betancourt et al., 2009; Farwell, 2001).

One of the strands of ethnography that has gained significant attention in the refugee field is critical ethnography (Fassin & d'Halluin, 2005; Eastmond, 2000). In the refugee mental health field researchers have adopted this methodological approach to bring to light underlying and obscure operations of power and control that impact health and healing (Eastmond, 2000). Critical ethnography achieves this by focusing "on the world views and practices of organizations (by studying up) and the lives and cultural histories of people impacted by institutions (by studying down)" (Panter-Brick & Eggeerman, 2017, p.2). For example, Fassin and d'Halluin (2005) used interviews, participant observation, and analysis of official documents to explore and critique the asylum process in France. In their analysis they argue that diagnosis of mental illness associated with traumatic experiences has, in many instances, become the main avenue through which refugees evoke compassion and achieve legitimacy.

2.2.1. Strengths and Limitations

Ethnographic methods hold multiple advantages when conducting research with refugees and displaced persons. One of the main advantages lies in the contextualization of mental health experiences (Whitley, 2014). The dialogic non-judgmental methods allow for an in-depth investigation of multiple levels and perspectives related to health and inequality - from individual health experiences and behaviors to cultural, social, historic, and economic forces that produce and maintain distress (Holmes & Castañeda, 2014). They are therefore ideal for understanding complex power-imbued processes that affect refugees' health and well-being (Holmes & Castañeda, 2014; Eastmond, 2000). The thick descriptions generated in qualitative studies enable researchers to demonstrate how various mental health beliefs and behaviors are embedded within cultural frames of reference (Whitley, 2014). Researchers from various disciplines have undertaken extensive long-term ethnographic work in order to examine the ways loss, displacement, and violence shape both individual experiences and social life (Zarowsky, 2004; Kidron, 2009; Hammond, 2004; Grayson, 2017; Hyndman & Giles, 2017). In addition to contributing to the development of more culturally sensitive and appropriate interventions, these studies demonstrate the importance of understanding distress and healing within socio-cultural contexts, and, in so doing, challenge the dominance of the bio-medical model in responding to refugees' distress (Miller, 2016; Akeeson & Denov, 2017). However, as with any self-report data (quantitative and qualitative), data collected from interviews may represent what participants remember and want to recount rather than what actually may be the case. Credibility may be achieved by accounting for discomforting evidence; triangulating interviews with data from other sources and member checking (Lincoln & Guba, 1985).

Another advantage of ethnographic methods lies in the domain of trust and access. Researchers employing qualitative ethnographic methods typically conduct their field work over extended periods of time, thus gaining the trust of the community and building a sense of rapport with research participants (Green & Thorogood, 2014). Due to their past experiences with research and their ongoing marginalization and oppression, refugees are often particularly distrustful of researchers and take great caution when disclosing information (Mackenzie et al, 2007). Gaining trust is therefore a central methodological concern as it significantly impacts access to the community and subsequently the truthfulness and accuracy of the data collected (Miller, 2004). However, scholars caution that the close relationships often gained in long-term qualitative

research can give rise to ethical problems, particularly surrounding issues of voluntary consent (Mackenzie et al, 2007). Although the refugee participants provide information willingly, such willingness may be based on the ambiguous relationship between researchers and participants inherent to ethnographic fieldwork (Hugman et al., 2011; Fassin, 2013).

Some scholars have questioned the practical utility of qualitative research in health policy and practice, claiming it is time-consuming, subjective, localized, anecdotal, and overly critical (Parker & Harper, 2006; Whitley, 2014). As a result, qualitative research, and critical research in particular, is often relegated to the margins of health research field (Hart et al., 2017). For example, the British Medical Journal (BMJ) has recently rejected publishing qualitative studies, arguing that they are of low priority as they are "unlikely to be highly cited" and "lacking practical value" (Greenhalgh et al., 2016, p.i563). In a response, some scholars have proposed strategies for increasing the generalizability of qualitative studies (Grouleau et al., 2009). They argue that if the goal of qualitative researchers is to influence decision-makers and effect social change, data should be representative of war-affected populations and, ideally, allow for the identification of global patterns (Landau & Jacobsen 2004). Others, however, have highlighted the difficulties that arise when "ethnography goes public" (Fassin, 2013, p. 625). They note that in the process of translating ethnographic studies to condensed policy briefs and media soundbites the rich ethnographic data may lose its complexity and subtlety (Fassin, 2013; Mackenzie, 2007).

2.3. Conclusion: Addressing methodological gaps within the field of refugee research

In the review presented above, I have explored two main methods that have been employed in refugee health research: quantitative assessment instruments, and qualitative ethnographic methods. I have examined the comparative benefits and drawbacks of each method and discussed the unique challenges that arise when using these methods in research with war-affected populations. Irrespective of the methods used, refugee studies is a field with considerable methodological challenges. In addition to the complexities of conducting cross-cultural research, research with refugee populations needs to address multiple methodological and ethical concerns such as issues of literacy, informed consent, trust and access, fair subject selection, and the risk

of causing refugees further distress as a result of revisiting traumatic events (Gifford et al., 2007; Ellis et al., 2007; Block et al., 2012; Allden et al., 2009; Akeeson et al., 2014).

Moving forward, it is important to examine how these methods can complement each other to address these concerns. Indeed, a number of researchers have argued that the complexity of refugees' mental health experiences combined with the challenges associated with this type of research requires innovative approaches combining both qualitative and quantitative methods (Schweitzer et al., 2008. Tol et al., 2013; Miller et al., 2006; Bolton et al., 2009). Researchers in the refugee field are increasingly using a mixed methods approach to offset the weaknesses of each method, as evidenced by Weine's (2014) recent review which found 29 original research articles that combined quantitative and qualitative methods to investigate refugee mental health. The rationales for combining methods include breadth, triangulation, and complementarity (Cresswell & Plano, 2018; Morgan, 1998). Scholars have noted that moving beyond the quantitative-qualitative divide allows researchers to gain a fuller picture of the complex life situations of refugee and displaced populations (Warfa et al., 2012; Bolton et al., 2009). Others, however, have cautioned that differences in epistemology may give rise to tensions that may not be easily resolved (Green & Thorogood, 2014; Whitley et al., 2011).

To conclude, two major methodological gaps within the field of refugee research have been identified: a shortage of ethnographic studies that focus on how refugees themselves understand and conceptualize emotional distress and resilience (Eggerman & Panter-Brick, 2010); and a shortage of studies that combine methods to yield both measurement and meaning (Weine et al., 2014). This knowledge gap is particularly evident in the Israeli context, in which only a limited number of studies have focused on the distinct mental health challenges of refugees (Lurie, 2009; Nakash et al., 2015). Of these studies, the majority use quantitative measures to determine prevalence and correlations (Yuval et al., 2017: Nakash et al. 2015; Slonim Nevo & Regev, 2016). In my research, I demonstrate how employing multiple techniques – expert translations, a focus-group discussion, a survey, and piloting – can help to attain a cross-cultural and conceptually equivalent measure.

Manuscript I: The Impact of Trauma, Flight and Protracted Displacement on the Mental Health of Eritrean Refugees Living in Israel: An Exploratory Study of Coping Strategies

Fennig, M. and Denov, M. (2022). The impact of trauma and protracted displacement on the mental health of Eritrean refugees living in Israel: An exploratory study of coping strategies. *Social Science and Medicine – Mental Health*, Volume 2, 100102. Link: https://www.sciencedirect.com/science/article/pii/S2666560322000421

Abstract

Multiple studies have found that refugees significantly underutilize mental health services. Yet, little is known about how refugees who live in contexts of protracted displacement cope with and recover from violence, trauma and chronic stress. The unique experiences of refugees living in Israel, particularly those fleeing the violence of Eritrea, is even less understood. This study sought to explore strategies of coping used by Eritrean refugee men and women living in Israel. In-depth interviews were conducted with 34 Eritrean refugees aged 26-40 having been identified as suffering or having suffered from psychological distress. Participants reported experiencing severe violence and upheaval in Eritrea, during flight, and struggled with daily life in Israel. Reported coping strategies were rooted and shaped by the Eritrean cultural context, systems of knowledge, values, and cultural perspectives. They included concealment, silence and forgetting, engaging in religious and spiritual practices, seeking social support, and, for some, accessing formal health and psycho-social services. Our findings underscore the profound effects of protracted displacement, with participants noting the anxiety, stress, uncertainty, and inability to build their lives brought forth by their liminal status. Findings also reveal the ways in which structural considerations in Israel, particularly law and policies, negatively impact upon the daily lives of Eritrean refugees, contributing to their ongoing distress. Taken together, these elements may deplete refugees' coping resources and undermine their natural processes of recovery and healing. Our findings justify the need to re-think traditional models of trauma and recovery, integrate spirituality and cultural healing into interventions, consider how structural realities impact daily experience, and account for refugees' unique perspectives on distress within the care process.

1. Introduction

The atrocities and grave human right violations committed by the Eritrean government - unlawful killings by security forces, mandatory indefinite conscription, forced labor, mass arbitrary detention, enforced disappearances, torture and other forms of ill-treatment - have led to the forced displacement of 0.6 million Eritreans (UNHCR, 2021). This context of state violence has made Eritrea - a country with an estimated population of five million - one of the world's fastest-emptying nations. Many of those who take the perilous journey toward the Middle East and Europe for safety and refuge are young people aged 18 to 24 (United States Department of State, 2021).

The UN (2016) considers Eritrea one of the most repressive dictatorships in the world, which has been termed 'Africa's North Korea.' With no clear end to the dictatorship in sight, international attention has recently turned once again to the region with the outbreak of armed conflict in Ethiopia's Tigray region in November 2020. Media reports and official pronouncements from governments have estimated that the conflict has resulted in the death of thousands of civilians, internal displacement of thousands of Eritreans within Tigray, large-scale famine, rape, and 63,000 Eritrean refugees once again fleeing their homes, this time to Sudan (USAID, 2021).

A significant portion of Eritrean refugees have sought asylum in Israel. Eritreans currently make up Israel's largest refugee population, with approximately 21,650 children and adults residing in the country (PIBA, 2020). In Israel, Eritreans have been living in protracted displacement for a decade. While they are recognized in Israeli law as 'non-removable persons', they are denied basic rights and any prospect for regularization of their status (Ziegler, 2015). As a result of their liminal status, Eritrean refugees in Israel are excluded from the country's nationalized health care system, are not entitled to receive social services, and have difficulty integrating into the labor market (Kritzman Amir & Schumacher, 2013). They do not hold identification documents, and therefore cannot pursue higher education. In addition, they are barred from many essential day-to-day activities, including obtaining driver's licenses, registering a business, and getting a public transportation card that provides discounts (Hotline for Refugees and Migrants, 2020). Underscoring their liminality, this population is simultaneously locked 'inside' and 'outside'

Israeli society: they are unable to return to Eritrea, and or to emigrate further west as they are obliged to remain *inside* the country's borders. And yet, they are simultaneously kept *outside* of mainstream Israeli society, prevented from meaningful integration through a series of deliberate laws and policies (Kritzman Amir & Schumacher, 2013). This highlights the important structural realities, and examples of structural violence (Farmer, 1996; Starzmann, 2010), that profoundly shape and frame the experiences of Eritrean refugees in Israel.

For Eritreans in Israel, the long and perilous smuggling and trafficking route from Eritrea to Israel has involved profound mental and physical challenges, including poverty, violence, and loss of loved ones (Yohannes, 2021). In the Sinai Desert, the final leg of the route from Eritrea, thousands of Eritrean men women and children have been held captive by criminal groups in what are known as the 'Sinai torture camps' (Humphries, 2013). Essentially hostages, they arrived in these camps in multiple ways. For some, *en route* to Israel, they were sold by their smugglers to Egyptian traffickers in Sinai. Others were kidnapped in eastern Sudan and taken to the Sinai camps. For this latter group, Israel was not their ultimate planned destination (PHR, 2016). While in the camps, the Eritrean population was held against their will and tortured for months to pressure their families in Eritrea to pay ransom money to their captors. During their captivity, they were subjected to sexual assaults, rape, and torture, including being chained for days or months, starvation, beatings, burning, and threats of organ harvesting (Yohannes, 2021; Nakash et al., 2015).

Although a significant portion of Eritrean refugees residing in Israel successfully adapt in the face of these traumatic experiences, empirical evidence indicates extraordinarily high levels of health-related problems (Moran et al., 2019), including mental health problems (Mayer et al., 2020; Nakash et al., 2015; Kiat et al., 2017; Youngman et al., 2021). Moreover, the prolonged nature of displacement in Israel with its associated uncertainty about the future and persistent anxiety, is regarded as a major contributing factor to mental health deterioration of the Eritrean community (Fennig, 2018; Gebreyesus et al., 2018).

Despite the substantial burden of mental illness, studies have consistently found that refugees residing in Israel struggle to obtain mental health care (Kiat et al., 2017). These findings are

mirrored in other OECD countries including the United States (Asgary & Segar, 2011), Australia (Byrow et al., 2019), The Netherlands (Laban et al., 2007); Switzerland (Kiselev et al., 2020) and other European countries (Lebano et al., 2020). Moreover, when refugees do present for treatment, symptoms tend to be more severe, which further complicates timely identification and treatment (Jongedijk et al., 2020).

Access to much needed mental health services can be particularly difficult for refugees with extended insecure status who might not be legally entitled to public health services, including mental health care (Byrow et al., 2019). However, even in host countries where specialized mental health services are granted by law, such as some Western European countries, refugees and asylum seekers have difficulty accessing appropriate care for reasons ranging from administrative requirements, to an inability to pay the related costs (HUMA Network, 2009). These structural barriers are often compounded by socio-cultural barriers such as racism, discrimination, language, stigma, and culture-related differences in symptom presentation, making it even harder to receive and access care in practice (Lebano et al., 2020; Kiselev et al., 2020).

Overcoming barriers to care, and reducing ethno-racial disparities in the delivery of mental health services continue to be ongoing challenges. Examining and understanding refugee coping strategies may be important steps to addressing such challenges. Coping strategies are understood as "behavioral and cognitive efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding an individual's resources" (Lazarus & Folkman, 1984, p. 141). Coping strategies range from seeking formal mental health treatment, to denial of the problem (Lazarus & Folkman, 1984). The ways in which refugees cope with stress is, however, significantly influenced by their *explanatory models of mental health*—ideas or theories of what may have caused their predicament, the consequences of the condition, and the type of care they believe they need in order to recover (Kleinman, 1988).

Refugee coping strategies are important for their significant impact on trauma-related mental health outcomes. Most studies on this topic have focused on resettlement countries in Europe and North America that provide refugees secure legal status, and access to rights similar to those

enjoyed by nationals (Seguin & Roberts, 2017). Very little research has explored the coping strategies of refugees living in *contexts of protracted displacement*, despite that these are the settings in which most refugees in the world today are living (UNHCR, 2021). UNHCR (2004) describes protracted displacement situations as those "in which refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile." (p.1). Research from resettlement countries may not be generalizable to these settings, because of differences in refugees' access to basic rights, local integration, access to healthcare, and available support systems, which significantly impact refugees' coping options (UNHCR, 2004). As such, there remains a knowledge gap regarding how to effectively build existing supports, such as traditional healing and community support systems, for war-affected refugee populations living in contexts of protracted displacement (Tol et al., 2020).

To address this gap, we draw on qualitative data with a sample of Eritrean refugees living in protracted displacement in Israel. We explore Eritrean refugees' experiences of violence and flight and how they cope with psychological distress. We then identify the ways in which Eritrean refugees understand, explain, and interpret psychological distress caused by war and violence-related trauma, loss, and protracted displacement stressors. We demonstrate the profound effects of protracted displacement and liminality, and the ways in which structural considerations in Israel, particularly law and policies, negatively impact upon the daily lives of Eritrean refugees. These elements may deplete refugees' coping resources and undermine their natural processes of recovery and healing. As a result, we advocate for the need to rethink traditional models of trauma and recovery, consider the impact of structural realities on refugee well-being, integrate spirituality and cultural healing into interventions, and account for refugees' unique perspectives on distress within the care process. Ultimately, by drawing on the voices of Eritrean refugees living in Israel, it becomes possible to garner a greater understanding of the unique coping mechanisms of a marginalized population who have been largely ignored in research, policy and practice.

2. Methods

2.1 Setting and Structural Realities:

Throughout the paper, we use the term 'refugee' to describe individuals who have fled persecution in Eritrea and are currently residing in Israel. However, it is important to note that the majority of Eritreans living in Israel have not been granted refugee status and are defined by Israeli law as as ‘infiltrators’. This highly charged juridical category which "dates back to border-crossings into Israel by Palestinian Fedayeen in the 1950s"(Ziegler, 2015, p. 172), has been strategically used by the state to construct refugees as a security, demographic, and economic threat (Paz, 2011). The state's vigorous resistance to describe Eritreans as refugees or asylum seekers has resulted in intentional "epistemological and classificatory confusion" (Willen 2010, p.508), and has further entrenched a common perception that Eritreans residing in Israel are ‘criminals’ rather than ‘genuine’ refugees.

Israel is home to approximately 30,500 asylum seekers, of which 71% are from Eritrea and 20% from Sudan (PIBA, 2020). The Israeli immigration regime is fundamentally different than those of other high-income countries in that it prioritizes Jewish immigration and denies almost any possibility of non-Jewish refugee integration and naturalization in Israel. Although Israel is a signatory of the United Nations 1951 Refugee Convention and 1967 Protocols, it has not incorporated these treaties into its domestic law, nor has it enacted primary legislation governing the treatment of asylum seekers (Zeigler, 2015). Israel maintains a Refugee Status Determination (RSD) process, which was controlled by UNHCR before 2009 and, since then, by the Israeli government. Yet, the vast majority of asylum claims in Israel are rejected or not assessed, and the RSD system is considered to be unfair and ineffective (UNHCR, 2017). Importantly, Israel's refugee recognition rate stands at less than 1%, with only 13 asylum seekers from Eritrea recognized as refugees - the lowest rate among Western countries (HIAS, 2020).

Refugees who have not applied for asylum, alongside those with pending or rejected applications, are in the same ‘legal boat’: they are subjected to the rights-restrictive policy of temporary protection, also called by the State of Israel as “temporary delay of deportation” (Zeigler, 2015). This policy grants Eritreans 'conditional release visas' which they have to renew every 6 months. The policy provides protection from deportation, yet denies access or rights to the labor market, education, organized healthcare or social services, and can end at any time

(Kritzman-Amir & Shumacher, 2013). The limited treatment services that refugees and asylum seekers do receive are provided by NGOs and volunteer-run clinics. In this sense, for refugees and asylum-seekers, Israel becomes a living paradox - a high-income country that is experienced as a context of protracted displacement.

In addition to their precarious status, Eritrean refugees have been severely affected by the multiple anti-immigration laws and policies in Israel that work to both to deter refugees from entering Israel, and to encourage those who have entered to leave the country. Among others, these include the 3rd and 4th amendment to the Anti-Infiltration Law (1954), which allowed the indefinite holding of refugees in 'Holot' - an 'open' facility that, in practice, operated as a detention facility. In addition, the Deposit Law obligated employers of refugees to deposit 20 per cent of refugees' monthly wages in a government-held fund until they left the State of Israel. Moreover, the Assisted Voluntary Return (AVR) program provided a US$3,500 stipend to refugees who agree to leave Israel to an unknown 'third country' (Ziegler, 2015). Many of these laws have been struck down by Israel's courts. However, these laws and policies show the structural realities that shape the refugee experience and have left a legacy of violence that continues to impact refugees' everyday lives.

This research project was launched to develop more effective models of treatment from the bottom-up, beginning with the expressed needs and experiences of Eritrean refugees themselves. In particular, it sought to explore the ways in which they understand, explain, express, experience and react to psychological distress and well-being. The study was conducted over a six-month period between November 2019 and May 2020 and was a partnership of the first author, a researcher at McGill University, and Aid Organization for Refugees and Asylum Seekers in Israel (ASSAF). ASSAF is an independent, non-profit Israeli organization that promotes the human rights of asylum seekers through public advocacy work. ASSAF also offers psycho-social support services to the asylum-seeking community including individual treatment, support groups, and humanitarian aid, such as food packages and financial assistance.

2.2 Recruitment:

Participant recruitment was facilitated through ASSAF. With ASSAFs assistance, emails were sent to ten organizations and clinics that support refugees. The emails explained the nature of the research and requested permission to distribute flyers and contact potential participants. The researchers reached out to a range of organizations providing services to refugees (adult education, counselling, daycares, health clinics) to achieve a community sample rather than a clinical sample. We sought to include those who had accessed formal mental health services and those who had not, as well as to ensure diversity in terms of age, gender, family composition, employment status and educational background. Participants were recruited largely through face-to-face solicitation and flyer distribution conducted by the first author. Those who expressed interest in the study were later contacted by a research assistant of Eritrean origin who provided further details in Tigrinya. Two remaining participants were recruited through referrals from professionals working in refugee health.

2.3 Ethical Considerations

Study procedures were approved by the Research Ethics Board of McGill University. Participants completed two consent forms: one for the screening phase, and a second for the in-depth interview. This iterative consent approach allowed the researchers to explain the procedures for each phase and remind participants of the voluntary, confidential, and anonymous nature of their participation, and that they were free to withdraw their participation at any time. The informed consent process clearly stated that participants would be asked to share intimate details about their lives, particularly their experiences with trauma and emotional distress. It was made clear to participants that they could refuse to talk about any issues, and that they could decline voice recording. All participants were provided a list of referrals where they could receive psychiatric or psychological services free of charge. Participants who were identified in the screening or interview as particularly vulnerable received further assistance and support from the research team in connecting with relevant services.

2.4 Procedure:

Data was collected by the first author, who spoke fluent Hebrew and English, alongside two Eritrean research assistants (RA), one male and one female, who spoke Tigrinya, Hebrew, and English. With the exception of three cases, participants were matched with a same-gender interpreter. In-depth interviews were conducted with 34 Eritrean refugees - 15 men and 19 women - living in Israel. Participants were aged 26 to 40 (M=31), reflecting the demographic of the refugee community in Israel. Age at departure from Eritrea ranged from 15 to 30, with a mean of 18 years. Participants had been living in Israel for an average of 8 years, with a range of 7 to 12 years. Sixty per cent of participants were married with at least one child, 34% were single, and 6% were divorced, with children. Thirty-two participants self-identified as Christian, one as Muslim, and one as Pentecostal. Participants' formal education varied from 14 years to no education, with a mean of 10 years. With the exception of two participants, all of the participants were employed.

To be included in the study, participants had to have been exposed to trauma and either currently suffering from mild to moderate psychological distress or have suffered in the past. Respondents suffering from severe psychological distress were excluded from the study. Level of distress was determined in an initial screening phase in which an adapted version of General Health Quesstioner-12 (GHQ-12: Goldberg, 1978) was administered while exposure to trauma was determined by self-identification. For differentiating between individuals with and without psychological distress, we used a cut-off score of 3. Eligible participants were then invited to complete a sociodemographic measure and participate in an in-depth interview using a semi-structured interview guide modelled after the DSM-5 Cultural Formulation Interview (APA, 2013), including the Migration supplement (see Appendix A and B). Interviews elicited information on participants' perceptions of cause, manifestation, and possible treatment or support for mental health problems. Interviews were conducted in the offices of ASSAF in Hebrew/English, and where needed, accompanied by simultaneous translation into Tigrinya by a research assistant. Each interview lasted between one and two hours.

Data analysis was inspired by a grounded theory approach (Glaser and Strauss, 1967). Rounds of data collection were followed by interim analysis with the the results used to generate and modify subsequent data collection. The data analysis process first involved line-by-line coding,

paying particular attention to in vivo codes—codes that participants use themselves to divide the world (Glaser & Strauss, 1967). Conceptual codes such as 'coping strategies' or 'health beliefs' were then added. Axial coding was then used, with the aim of developing subcategories that specify the properties and dimensions of each category. Finally, additional themes were generated by engaging in *constant comparative analysis (*Glaser & Strauss, 1967), deliberately searching for similarities and differences across interviews.

There are several study limitations. First, the small sample size precluded examination of variation among Eritrean refugees – who may hold a variety of differing coping strategies and attitudes based on gender, education, age, and other demographic factors. The sample size also significantly limits the generalization of our findings to other refugee populations. Second, our exclusion criteria (those who were suffering from severe mental illness) were put in place to protect participants from potential harm. However, it prevented us from exploring their subjective experiences and thus limits our results. Finally, the social and cultural positions of the first author and the RAs who conducted the interviews may have had an influence on participants' responses. It is possible that participants tailored their responses according to their perception of the kinds of feelings it would be culturally appropriate for them to share with the interviewers.

3. Findings:

In this section, we first highlight participants' accounts of the violence-related trauma and loss experienced in Eritrea and during flight. We then address participants' explanatory models and coping strategies - the ways participants perceived, experienced, and responded to past trauma and protracted displacement. To ensure anonymity, participants cited below have been given pseudonyms.

3.1 Understanding Trauma and Flight

Miller et al. (2002: 342) note that one cannot understand refugees' experience of displacement without having knowledge of their lives prior to displacement, since "life prior to exile becomes a central reference point among refugees for the evaluation of their present life circumstance."

As such, we present participants' experiences endured prior to their arrival in Israel, including conscription and abuse in Eritrea, as well as the realities of flight.

3.1.1 Conscription and abuse in Eritrea

The majority of participants fled Eritrea between the ages 16 and 20, attempting to escape severe human rights abuses, alongside indefinite conscription to the Eritrean national military service - which is compulsory for both men and women from the age of 17. Growing up under the dictatorship of Isaias Afwerki, participants shared stories of abuse and oppression, painting a grim picture of daily life in a country with no freedom of expression, opinion, association, religious beliefs, and movement. As expressed by one study participant: "In Eritrea, from the beginning, from when we were born, there was almost always violence" (Male, age 36).

Participants reported being direct targets or witnesses to violence including forced disappearances, sexual violence, extrajudicial executions, and arbitrary killings. Due to the government's vast network of espionage, aiming to crush dissent and opposition, participants' reported living in constant fear, withholding their true opinions and feelings, even from close friends and family members:

> Having thoughts of our future life is already dangerous and unsafe in Eritrea. Eritreans are not allowed to their own thoughts, not even to share them with their close ones because the regime censors and controls everything... The right to your own thoughts and opinions of a person is a crime in Eritrea. If people are caught having these thoughts, they face disappearance, prison, and torture (Male, age 31)

Participants spoke of relatives and neighbors being locked up indefinitely in underground cells or metal shipping containers where they were often subjected to extreme heat, torture, and cruelty. These factors, combined with other personal reasons, led participants to flee Eritrea in search of safety.

3.1.2 Experiences during flight

While participants were not asked to provide details of their flight, all of them did so to varying degrees. After fleeing Eritrea and moving northward by foot and in overcrowded vehicles along diverse routes - Sudan, Ethiopia, Libya - all of the participants reported arriving in Israel through Egypt's Sinai Peninsula. Thirteen participants (8 men and 5 women) reported being either a victim or a witness to severe levels of violence *en route* to Israel:

> There was an electric shock, there was a torture, there was a... they wasn't giving us enough food, they was coming every morning and they was lying us and they was beating us in our foot. And many many more things happened when I was in Sinai so because of that and what the life here, the difficulties in Israel, is too hard for me to live in Israel. (Male, age 33)

> They were forcing me also to work when I was in Sinai, I was working 8 hours or 9 hours. They wasn't paying me, it was by force. And I was carrying blocks in my shoulder and there is still now scars from that. It was bleeding but they don't care, they don't pay, they don't care. They just ask you to pick or to carry more blocks in your shoulder. There was a lot of tortures there also in Sinai… (Male, age 33**)**

Many Eritreans were forced by their smugglers to call family members and relatives to pay tens of thousands of dollars for their release. Yohannes was 17 when he was held captive in Sinai for three months until he was able to secure a ransom:

> And, there was a lot of difficulties because you have to give money for them… because I didn't have anybody to pay, I didn't have the money in my hand. So I have to collect the money, and until you collect the money there is torture and beaten up by them and they was torturing us a lot. In the end, we managed to collect the money and I pay them and I managed to come to Israel. **(**Male, age 28)

In addition to torture and abuse, participants reported being deprived of food, water and sleep:

> We came and it was very hard. I came, I was 17. And I'm a girl, it's also hard. We don't have food, we don't have enough water. They give us water with gasoline. They put this for the car. If you drink it like this you can't drink a lot. Just a little. I was sick, really sick. (Female, age 26)

Even after being released from the 'torture camps' in the Sinai desert, participants reported facing further terror and abuse. Tekle was 18-years-old when he left Eritrea. After being held captive in the Sinai desert, he was shot by Egyptian border guards at the Egyptian-Israeli border and then tortured in Cairo:

> The Egyptian army shot me, and I still have here, what's called a bullet. In those times, it was much harder. I went of course back to Egypt, I was in Cairo. I went through a crazy life and, yes, also there, they use an investigation whip. They also, the Egyptian army took me to an investigation. There were big dogs, black, that they tie up with a chain, and they are trying to eat you. They tie up your eyes so that you're too scared to tell the truth and it was very scary. Even though I am strong now, and everything's okay, it works, it effects. They said: the bullet should've been in your forehead. You should die. So that affects you strongly (Male, age 29).

Research studies often focus solely on the experiences and realities of refugees once they have resettled. However, as can be revealed through the voices of our participants, experiences of flight provide important context to their migration and post-flight lives, uncovering significant violence and trauma. To ignore circumstances of flight is thus to overlook key memories and experiences that deeply shape and influence resettlement.

3.2 Participants' understanding of the impact of past trauma, flight and displacement on mental health

During interviews, participants revealed four themes related their understanding of the impact of flight and displacement on their mental health. These included: external events and stressors, psychological causes, somatic causes, and spiritual and supernatural causes.

3.2.1 External Events and Stressors:

All participants reported that external events and stressors were causes of participants' mental health symptoms. These stressors were divided into two sub-themes: past traumatic events in Eritrea and during flight, and ongoing displacement-related stressors.

Past trauma in Eritrea and during flight:

Past traumatic experiences in Eritrea and during flight to Israel were one of the most commonly cited causes of mental health symptoms, reported by more than 50 percent of the participants interviewed (n=22). Memories of torture and abuse haunted participants a decade after flight:

> So because of that (experiences in Sinai), here, I sometimes remember and they come all over again to my life and sometimes when I am sleeping, I feel that I am.. I see myself that I am in Sinai in the same place where I was.. And in the night, I have all the thoughts and I feel that I'm back to Sinai and someone from those people is, he's coming to beat me again. (Male, age 33)

> Myself, I'm OK, thank God, but I have a problem in my family because my wife she has stress. She was hospitalized more than three months... They say that she had problems before with Sinai and the Arabs. She paid a lot of money. And there was a lot of hitting. Yes, since then she doesn't feel well. (Male, age 35)

Protracted displacement-related stressors in Israel

Participants described multiple stressors related to their protracted displacement in Israel. Displacement stressors were reported by all but one participant (n= 33). These included liminal status, separation from family members, prolonged detention, perceived discrimination and racism, work stress, health stress, and violence within the Eritrean community. The majority of participants reported three to four different types of stressors.

The most prominent stressor, reported by all participants, was their liminal status which contributed to a chronic sense of uncertainty, and anxiety for the future. Time and again, participants shared their feelings of being figuratively trapped — unable to go back to their home country, or to move forward by integrating into Israel society or establishing residency elsewhere. Feelings of being 'trapped' or 'confined' by Israel's asylum system emerged often, resounding through metaphors of prisons and jails:

> And in Israel, it's like someone locked the door and can't find the key. That's how we live in Israel. They locked us in. (Participant 22, female).

> For example, I have been living for 8 years in Israel, but I cannot do anything. I walk around the streets, but I feel that I'm in jail. I cannot leave Israel. I cannot build something for myself." (Participant 25, female).

Displacement stressors were often viewed by participants as exacerbating their symptoms and adversely impacting their ability to heal both the physical and psychological pain caused by trauma and torture. Dawit explains that because of his liminal status he is forced to work long hours in physical labor, which in turn, triggers his debilitating PTSD symptoms:

> So because of the memories and the flashback and the pain that reminds me what I went through…that I have to work because I have a family, and I have to work 10 or 11 hours. I have to stand for long and although I am tired, although I need rest, I can't because I have family. I have to pay for bills for my children, for the apartment, for the rent…(Male, age 33)

3.2.2 Psychological Causes

Forty-four per cent (n=15) of participants noted that the origin of their symptoms was often psychological in nature. They reported the central role that intrusive rumination played in the onset of their symptoms. These were expressed via idioms of distress, a concept originally

developed by Nichter (1981) to draw attention to the manner in which different cultural groups communicate or manifest distress, both verbally and non-verbally. Idioms noted by participants often described 'over-usage' of the mind including: 'thinking too much,' 'a lot of thoughts', and 'not being free in the head'. Aaron, for example, described how excessive thinking can lead one to 'explode', a metaphor he used throughout his narrative to describe suicide and mental illness:

> If you think every day, every minute, and you keep it all in your head, in the end, you will explode…Right when I get up in my bed, they come into my head, even before I wash my face. I come like this. With all the thoughts in my head. (Male, age 37)

Similarly, Eden described how her symptoms of sharp chest pain and loss of breath come when she 'thinks a lot':

> All of a sudden it comes, and I feel like I am dead. I can't talk. Like this. Until it goes out. It gives me a lot of mess, a lot of mess. And sometimes if I'm tired, if it's hard for me, if I think a lot it comes. It's with me all the time. It bothers me. It's a real problem. (Female, age 26)

The content of these thoughts varied. For some, they consisted of traumatic events in Sinai, while for others they consisted of present concerns relating to life in Israel and anxiety for the future. Often it was a combination of all three:

> Like, what is going to be with my status? What is going to be in the future? How can I continue on in this life? Understand? And what will be with my family? Parts of my family are stranded in Sudan, in Libya, through the sea they got to Italy, Germany… They are scattered everywhere (Male, age 32)**.**

3.2.3 Somatic Causes

Somatic causes, relating to the body, were another explanation provided by eleven participants. Participants reported that initially they attributed their symptoms to a bodily disease:

> In the beginning, I also felt dizzy so I thought it was low blood pressure or anemia, but when I went to the doctor, the doctor told me my blood test is normal. So I thought what could it be? I thought maybe it's AIDS so I went to do a HIV test. They said the HIV is also okay so I always wonder what it could be. (Male, age 40)

Participants most often reported headaches as their main symptom of concern. Other symptoms reported included both mental symptoms (forgetfulness) and somatic symptoms (dizziness and poor sleep).

Many participants reported presenting first with somatic symptoms and completing various medical examinations to ascertain disease. Only after receiving negative results, did they accept the doctor's explanation indicating that the origin of their somatic symptoms was psychological: "I went to the doctor and I asked him maybe I have something here? Maybe it's because of my back? No, it's just because of your head, he told me" (Female, age 26).

3.2.4 Spiritual and Supernatural Causes

Thirty-two per cent (n=11) of participants reported that spiritual and supernatural events, such as cursing, possessions, poisoning, and 'evil eye', played a dominant role in mental illness. Saare emphasized that individuals suffered from mental health symptoms because of possession or poisoning:

> But according to what I understood, here I want to explain it to you well, there is a difference between people who entered a bad mental state because of all kinds of things that they went through in life…because all kinds of poisons. And this exists, and I believe in this 100 percent. (Male, age 29)

Possession by demonic entities was one of the beliefs that came out in the interviews. According to this belief, there are religious figures called *Debtera,* who have the ability to invoke the devil or demons, called *Diablos* or *Saytan*, and cause them to enter a person's body. The demon then

takes hold of the person and causes them to be mentally ill. Semret described a relative who was believed to be possessed:

> So, they want to send him back to the country, he doesn't go to the hospital, he doesn't go to the doctor, he doesn't believe in that. Himself, this person, and also his family, he believes that it's the diablos. He tells me to do this and this. He doesn't believe in psychiatrist, he doesn't believe in pills, that's it he only believes in what I told you, in the Diablos. (Female, age 30)

Mental health issues were interpreted as also being caused by *Buda*—or possessor of the evil eye—*Tabib*. The power of *Buda* is hereditary, passed from one generation to the next. *Buda* are believed to have the power to curse people with their eyes, causing demonic entities to afflict and 'possess' the individual:

> I had a neighbor who was in a very bad mental health state… They said it was "the devil's eye". Yes, after the wedding it started, someone put the eye on her or something like that…It went on for years (Female, age 30)

Not surprisingly, the traumatic experiences inherent to flight and displacement were reported to have important effects on participants' overall mental health. Mental health symptoms and issues were linked to external events and stressors, or to psychological, somatic, or spiritual causes. The multiple reported causes of mental health distress and symptoms are informative, as they shed light on the varied means of coping and subsequent interventions required to address them.

3.3 Coping with psychological distress

Participants employed a variety of strategies to cope with their psychological distress and associated symptoms. These were categorized under four broad themes: concealment and attempts to silence and forget; engaging in religious, spiritual and supernatural practices; seeking social support; and accessing formal health and psycho-social services.

3.3.1 Concealment, Silence and Forgetting

Researchers have noted that for populations affected by war and displacement, the use of concealment strategies, silence and forgetting are often regarded as a culturally appropriate means of dealing with trauma and distress. For example, Rosalind Shaw (2005) has noted the importance of social forgetting in post-conflict Sierra Leone. 'Forgetting' is said to be a cornerstone of reconciliation processes and a form of collective healing. Similarly, Doucet & Denov (2012) show the ways in which war-affected women considered forgetting as a positive way of dealing with their painful wartime experiences. In a similar vein, sixty-two percent (n=21) of our participants reported coping with their problems through the use of concealment, silence or forgetting. Participants actively refrained from talking about traumatic events, strong emotions, and symptoms. Participants made conscious efforts to conceal their emotions, even from close friends and their own family members:

> When I talk, I mean, I try to swallow it. I mean not to cry and not to take out everything. But when I am alone, I mean I feel that I am with God and I take out everything, I cry and I pray, and afterwards I feel better. (Female, age 36)

Participants tended to talk to friends and neighbors about general problems, but reportedly kept silent went it came to deeper feelings and thoughts:

> I can only talk about general problems if I have special problems, I keep it inside. (Female, age 32)

Many participants, perceived concealment and silence as preventive measures, as a strategy to avoid or preempt stigma. People with mental illness were often called derogatory terms such as *Tsulul* (crazy), and subjected to negative judgments, and stigmatization. Fitsum, who worked as a cultural mediator in a health clinic, explained how the stigma attached to mental illness can be more harmful than the problem itself:

> So what I am trying to tell you is that if the community will know that a patient is receiving mental health treatment then it can cause him even worse than the illness he has…But what's even worse than this, is if he finds out or if he sees that the community is talking about him. (Male, age 35)

Silence was an especially prominent coping mechanism among women who reported experiencing intimate partner violence (IPV). Three out of the six women who reported to have suffered from IPV, asserted that the interview was the first time they had disclosed their abuse. They preferred to cope with their psychological distress in silence to avoid community gossip, and public shaming:

> I take it out like this by crying because there is nobody else I can share this with. And I don't trust. There is nobody I trust and I don't have time for it. If you share within the community they put you down and they talk about you. They will always talk even if you don't share but ...You feel loneliness, especially women (Female, age 26).

For many participants, silence appeared to function as a form of self-protection from anxiety, intrusive imagery, and painful memories:

> It takes me back to the memories of when I left home, what caused me to leave home, everything I went through. It reminds me of everything, it causes me to say: I have no future. That's it... I'm trying not to think about that now because it can harm my day to day life, my health. So I try not to think about it. I fight it (Male, age 30).

> Since then, I try not to think. What does it mean not to think? You can't not think because a person is constantly thinking. Like, not too much and not to endanger myself. That's what I do, that's what I do now (Male, age 32)

Yet, in the long term, many participants reported that they were unsuccessful in suppressing their thoughts and emotions:

> Sometimes I try, what do I care, I'm living, so I try to forget. But I never can, no. (Male, age 37).

> Perhaps if we had a good life in here we would have been able to forget what we went through and it would have remained just as history (Participant 4, female)

3.3.2 Engaging in Religious, Spiritual and Supernatural Practices

Spiritual and supernatural thoughts and practices as sources of healing and support were reported by 91 percent of participants (n=31). These were divided into two sub-themes: spiritual belief and practices; and spiritual and traditional treatments.

Drawing on Spiritual Beliefs and Practices

Participants' spiritual beliefs were the most-commonly reported resource for coping and making sense of the emotional suffering brought by torture and other past sources of trauma. These included private religious practices - praying, listening to Hymns (*Mizmor*), reading the bible, as well attending church. Participants reported that their faith provided meaning for traumatic experiences, and a sense of purpose. Spiritual beliefs and practices also had a calming effect, reducing stress and symptoms:

> After that my life was like, quiet. For four months, I had like, a depression probably. It's called depression. But I didn't know that. I was silent. (elongates word: siiiilent). And then, what helped me get out of it? Someone saw me, my condition, and he said- "come, let's go to church, ours, the orthodox". And it really helps, it really helped me…It really opened my mind, in those days. It helped me, it really helped me. (Male, age 29).

Spiritual beliefs and practices reportedly provided participants with a spiritual element of hope (*Tesfa*) that was needed after nearly a decade of living in limbo in Israel. Abrihet reflected on her church attendance: "Going there it gives you belief that everything is possible, that you can make it. And this is what I get in the church, to stay in hope." (Female, age 36). Similar to Abrihet,

many participants described the community's makeshift churches, adorned with Christian paraphernalia, as the first, and often only, line of support and treatment for mental health challenges as Habtum notes: "Here what helps.. I'm religious, my religion. It helps me to pray, to talk to God. There is no other help." (Male, age 29)

Using Spiritual and Traditional Treatments

Participants reported utilizing spiritual and traditional treatments to cure mental health symptoms. These included treatment with *Maychelot* (holy water) and traditional treatment in the case of Buda possession. Some of the participants attributed the changes they saw in their mental health to treatment with holy water, as expressed by Bisrat who received holy water treatment in the church:

> I want to talk about something that helped me. I had two miscarriages. I had nightmares I used to dream that something black is coming and choking me and I would wake up and I was really stressed. When I started going to church and to get treatment from my faith it really helped me. I was able to get pregnant again and to give birth. I'm not sure if it's true but because I believe in it, it helped. (Female, age 32)

Participants reported that individuals suffering from severe mental health symptoms were often sent back to Eritrea to receive treatment at local *Maychelot* sights. Goitom, who suffers from severe PTSD symptoms, shared the following:

> The problem is, I don't really get along with my friends because in the past they wanted to send me without my knowledge, send me back [to Eritrea] (Male, age 40)

Similar to Goitom, in the majority of incidents the decision to send individuals back to Eritrea for treatment was made by relatives and childhood friends, and not by the individual. The reasons included: barriers to accessing mental health care in Israel, dissatisfaction with conventional treatment, exacerbation of the individual's psychiatric symptoms, the assumed efficacy of the treatment, and the lack of family in Israel:

> There is no family, they don't have family. They sleep outside and they do all kinds of things. Because of this they send them back and because of what I told you. So yes, if they have a mental illness, the majority they are sent back. (Female, age 31)

> And afterwards we saw that there is no improvement. So we decided that we cannot go on like this and we have to send him back to Eritrea. So his mother will take him to the Maychelot in Eritrea and that she will try to make him healthy again. So each of us spent $200. We collected more than $10,000 and we went to the ministry of interior. We decided that they know his condition. We decided that he will return (Female, age 35)

Treatment would often include long periods of fasting, eating special foods, praying and being submerged in holy water. During the treatment, the inflicted individual is placed beneath a waterfall, since it is believed that the weight of the water hitting the body can cast out the illness or evil spirit. Healing sessions occurred twice daily: before sunrise, and in the evening, for seven, fourteen or twenty-one consecutive days. These treatments would include intense praying by the priest and the inflicted person. In cases in which individuals were believed to be possessed by an evil spirit, they needed to be physically restrained. Saare described a scene that he witnessed in Eritrea:

> There was a woman there that exactly had *deftara* and we tied her up. The priest came, brought holy water from there, he conducted a prayer for several hours…And then we tied her up so she wouldn't run away, we caught her. And then the priest started pouring water on her and at the same time he would pray. And she would talk and say all kinds of things, like I told you earlier, although she had *deftara*. And this priest was really good and smart and strong. And then...But the lady started feeling better after 3 days. I mean she started giving respect to her mother. And then we did this for two weeks and the lady came out of there like a new person. I can't forget this. Although I was 15 or something I will not forget it. (Male, age 29)

Participants emphasized the curative powers of the treatment. Recalling his experiences with *Maychelot* which was used on his brother, Fitsum noted: “Listen the *Maychelot* is something amazing. I saw in front of my two eyes." (Male, age 35).

Another treatment involved folk healing in cases of *Buda* (evil eye). Participants explained that in cases of *Buda,* treatment using bio-medical medicine are regarded as unacceptable and can even cause death. Bilen described an example she witnessed in Israel:

> What happened? What happened? So they told her 'She is sick'. So, the policemen said 'give her to us, we will take her to see the doctor'. But in our community if a Buda catches you, they don't give you an injection. They said 'NO! We don't agree that you give her an injection! If she gets an injection she will die immediately. ' (Female, age 35)

In cases of *Buda,* the ill person needs to be taken to traditional healing that is facilitated by a priest (*Keshi*). During the treatment, the priest would freely converse with *Buda/Tabib* occupying the afflicted person’s body, forcing the spirit to leave the person's body:

> And then he swears on all kinds of things. And then the priest warns him "If you look at her one more time...OK now I'm leaving you alone but next time I can kill you. I will kill you. I have the power to do so." And then he frightens him, he warns him, and then the Buda leaves the body at this time and you become a new person, a totally new person. And then you start recognizing your surroundings, and recognizing your brothers and sisters (Male, age 29).

Participants noted that decreased stigma was an important reason explaining Eritreans’ preference for religious and spiritual practices over formal mental health services. The sparse mental health services in Israel that refugees are eligible to access were considered by many to be reserved for those suffering from severe mental illness.

3.3.3 Seeking social support

Coping through social support provided by family, friends and peers was reported by 44 per cent of the participants (n=15). Participants reported turning to others for financial support, and advice on day-to-day problems. In the absence of immediate family members, participants often sought support from friends and relatives:

> Because I live with my friends, during the day I get by fine with myself, I know what I'm doing, everything's fine with me. But at night, I don't know what I'm doing and then if they see me, they take care of me." (Male, age 40).

Similarly, Habtum who cannot work due to his health condition, noted that he receives assistance from friends and community members: "they know how I'm living here in Israel, that it's hard for me. They talk and then they take out some money and help you." (Male, age 29).
These participant narratives emphasize the *instrumental* support that participants received from their networks. *Emotional* support - receiving from others care, affection, comfort, and security from others – however, was rarely mentioned.

Participants also reported informal community initiatives that Eritrean refugees collectively organized to support vulnerable members of the community who were suffering from emotional distress:

> Every week we would.. like a meeting, like there is in every wing of the building, 300 people. So, we would sit in a circle, someone would talk, someone would talk about what he has, someone would be thankful for what he has…It strengthens one another a little bit... (Male, 29)

> We have a lot of groups, on Whatsapp on Telegram, we talk. If there is someone that doesn't have an apartment, that his landlord kicked him out, or that he doesn't have. So everybody looks for an apartment. (Female, age 31)

Mutual support was deeply rooted in Eritrean history of collective and communal living and responsibility for each other. Yet, at the same time, participants reported that the social support

and mutual assistance that characterized life back in Eritrea had weakened following a decade of protracted displacement. Semret explained:

> In Eritrea when you are eating, you must open the door to say- everyone come in. But in here, the community, they are using their own, they aren't saying- come eat. Even they make for one, for themselves. But in Eritrea even if we are two families, we made for 10. Lunch for 10, dinner for 10... The problem is now, everybody is locking their door. Everybody is suffering inside only. (Female, age 30).

3.3.4 Accessing formal health and psycho-social services

Nearly 50 per cent of participants (n=16) reported accessing formal health and psycho-social services for help to manage their symptoms. Participants often presented their somatic symptoms first to general practitioners or physicians in emergency rooms, which later led to referrals to mental health clinics or psychiatric hospitals:

> I did all the exams for my head and they said that they don't see anything with my head. So they said that only Abarbanel [psychiatric hospital] can help. And because I was suffering, I had no choice but to take the pills. (Female, age 33).

Some participants, all of them women, spoke about the benefits of formal mental health services. They specifically emphasized the benefits of speaking to someone from outside the Eritrean community:

> Yes, you get afraid [to talk to Eritreans]. But with them they listen to you. They give you space to talk and they ask you to talk it out. Almost one year and 6 months there was someone who was talking to me in UNITAF [NGO that operates subsidized daycare centers for children of migrants and refugees]. In the beginning I was talking about everything. I was talking it out, I was feeling pleasant. Because she was listening to me quietly and I was speaking freely. And also when I left from her I was able to talk to Eritreans also. I felt relieved, relieved. (Female, age 32).

In other instances, participants reported participating in formal mental health treatment, including periodical meetings with therapists. and taking psychiatric medication. However, it was viewed as largely ineffective:

> Pills, but, ehh, it only helps me sleep… Pills, they give me pills but that can't change the problem with my community, a pill… (Male, age 28).

In many cases, the inconsistency of the treatment with participants' beliefs led them to disengage, not comply, or terminate treatment:

> I'm still a patient at Gesher [mental health clinic for refugees]. For two years now I am a patient there. Last time they gave me an appointment again. So I didn't want to go there anymore because every time...You can tell a dog, if you tell him come then you need to give him food. I mean if you just tell him to come then he will not come again. So that's how I feel. That they don't help (Female, age 33).

Participants were not passive in their attempts to improve their mental health symptoms and challenges. Instead, they actively engaged in and sought out multiples means to cope with their plight – whether through concealment and silence, religious practices, spiritual treatments, social support, and formal mental health services. Coping mechanisms reflected Eritrean values and culture, as well as their social context, and the limited formal mental health support available to them in Israel. As outlined further below, however, the impact of structural realities of Israeli refugee law and policy must be considered when understanding participants' coping strategies.

4. Discussion

The purpose of this exploratory study was to gain a better understanding of Eritrean refugees' interpretations of the effects of trauma, torture, loss, and protracted displacement, as well as their subsequent coping strategies. Coping strategies were rooted and shaped by the Eritrean cultural context - systems of knowledge, values, and cultural perspectives. Engaging in religious and

supernatural practices to cope with protracted limbo and adversity was common among participants, underscoring the prominence of the Eritrean Orthodox church for the refugee community. Spiritual beliefs and practices were important sources of emotional and cognitive support, while traditional treatments, such as *Maychelot*, were a source of healing and care. The positive impacts of faith-based coping are consistent with recent studies with Eritrean asylum seekers that point to the salience of spirituality in the daily lives and wellbeing of Eritreans (Abraham et al., 2021).

Like previous research, our data strongly support the argument that mental health services must become more closely attuned to spiritual belief and practices (Whitley, 2012). This is further supported by the finding that religious practices were viewed as more accessible and less stigmatizing than formal mental health services. It is noteworthy, that the phenomenon of sending individuals with severe mental illness for local treatment in Eritrea, identified in this study, has not been reported in other studies, calling for additional research to understand its beneficial and harmful outcomes.

Participants' coping strategies were influenced by the ways they understood traumatic experiences and symptoms. These understandings both differed and coincided with the biomedical or biopsychosocial models of illness, commonly privileged by western-educated clinicians. Eritreans often understood their symptoms to be a result of pre-migration experiences of war-related violence and loss, as well as ongoing displacement stressors such as poverty, detention, and intimate partner violence. However, participants also described causes that did not readily align with Western models. These included supernatural causes such as possession by demonic entities (*Diablos)* or evil eye (*Buda/Tabib),* or viewing their distress as a result of 'thinking too much.' Our findings suggest that these cultural attributions may play a role in the preference and acceptance of certain types of mental health treatment and may affect refugee patients' adherence with treatment.

At the same time, supernatural explanations were reserved for *others* and were not used by participants to explain their *own* distress. One possible interpretation of this finding is that possession or evil eye were associated with behaviors such as hallucinations and impaired reality

testing, that could conceivably be indicative of a psychotic illness. Since our sample did not include individuals suffering from severe mental illness, participants spoke of neighbors and relatives rather than themselves. It is difficult, however, to directly map the participants' classification against psychiatric taxonomy, particularly since identifying cultural syndromes was not the focus of this study.

Our findings also show that structural factors, related to the protracted displacement environment, taxed and burdened Eritrean refugees' coping resources, adversely affecting their ability to recover from violence, trauma, and chronic stress. This suggests that the structural and sociocultural contexts of coping may be an important factor to consider in efforts to understand and treat refugees' mental health problems.

The use of suppression, concealment, and silence were prominent coping strategies. Many participants reported attempting to suppress their thoughts and emotions in order to manage their distress. Yet, for many, in the long-term, attempts at 'forgetting' and 'silencing' were largely unsuccessful. A possible explanation for the lack of success may be related to the context of protracted displacement, which renders refugees' attempts to suppress or even recover from trauma and torture-related psychopathology futile. One of the basic tenets of trauma-recovery is the establishment of safety. According to Herman (2015) "this task takes precedence over all other, for no other therapeutic work can possibly succeed if safety has not been adequately secured" (p. 159). For participants, however, establishing spaces and contexts that were both physically and psychologically safe was close to impossible. Participants were continuously exposed to powerful forms of structural violence, including suppressive laws and policies, and accompanying social and political stressors such as discrimination, detention, uncertainty regarding temporary status, and a lack of access to basic resources, all of which precluded a sense of safety and belonging. These forms of structural violence were experienced alongside significant mental health symptoms. While participants' efforts to silence their thoughts and emotions may have been regarded as a means to protect their overall health and well-being, the cumulative burdens of displacement stressors and structural violence appear to have nonetheless limited their ability to entirely suppress or process traumatic memories and cope with the daily challenges of protracted displacement.

Social support networks can often operate as buffers for trauma and suffering (Sippel et al.,2015) and despite some limitations, these networks were important coping resources for many participants. However, the tendency to conceal emotions and the lack of trust in others meant that the forms of social support that participants sought out and/or received, were mainly *instrumental* rather than *emotional* forms of support, which, at times, left participants struggling with feelings of isolation and loneliness.

Taken together, our findings indicate that protracted and precarious displacement environments - characterized by structural violence, chronic stress, anxiety, trauma, uncertainty, and above all a lack of safety - may deplete refugees' coping resources and undermine their natural processes of psychological recovery. This in turn, has the potential to adversely affect both their capacity to heal from past traumas, as well as their ability to negotiate the many challenges of life in protracted displacement. This pattern is consistent with a growing literature on the mental health implications of precarious legal status, which has similarly revealed the ways which unequal social structures such as liminal status, displacement and exclusion cause "existential and health-related ruptures in people's lives and bodies" (Mattes & Lang, 2021, p. 2; El-Shaarawi, 2015; O'Reilly, 2018). However, further research is needed to elucidate the multiple pathways by which the protracted displacement environment may increase refugees' susceptibility to mental health problems. Moreover, since the present study did not sufficiently unpack the gendered realities of life in protracted displacement, there is a need for greater attention to this important area of study, especially given female participants' comments on IPV. In addition, a deeper analysis and exploration of power relations, particularly as they relate to race, is essential.

5. Conclusion and Implications

This exploratory study is one of the first studies to explore how Eritrean refugees in Israel perceive their mental health needs and their attempts at coping with trauma and distress. Several unique culturally embedded coping strategies emerged, as well as distinctive explanatory models of mental health. Taken together, the findings underscore the importance of understanding the cultural dimensions of trauma and coping. They also evoke important questions about what

psychological treatments are appropriate for refugees who continue to live in protracted displacement situations characterized by chronic stress and lack of safety.

Our findings hold important implications for clinical assessment and intervention with Eritrean refugees and other war-affected populations living in protracted displacement. The centrality of spiritual coping and the importance of the Eritrean Orthodox church in the Eritrean refugee community underscore the importance of integrating spirituality and cultural healing practices into the care process. We recommend implementing a model of care in which primary care providers and mental health practitioners work collaboratively with traditional and faith healers (both in Israel and Eritrea) to deliver appropriate care. Collaboration may include mutual referrals, consultation about complex cases, or even offering both traditional and psychiatric treatment within the same consultation (for example, implementing screening services in churches). A collaborative model such as this may increase to access to evidence-based treatments, raise awareness amongst mental health practitioners of refugees' spiritual needs, and minimize harmful practices (Asher et al., 2021).

At the same time, if meaningful healing is to occur, safety needs to be established. This requires fundamental changes to address ongoing structural violence, particularly oppressive laws and discriminatory policies that further marginalize and harm refugees' health and well-being. Participants' powerful descriptions of constantly drifting between the anxiety of being in eternal limbo because of their liminal status on the one hand, and the frustration and pain associated with being 'locked in' and unable to advance or build a life, on the other. Here, we can see the structural violence laws and policies that force Eritrean refugees to remain inside the country's borders in perpetual limbo, and yet, at the same time, because of these same laws and policies, are kept outside of mainstream society, cast as 'infiltrators'.

It is important to note that western mental health interventions that address trauma and coping, such as CBT, typically focus on changing maladaptive behaviors, thoughts, and feelings. These types of interventions tend to locate the source of suffering – and subsequent solutions - in the individual. In doing so, these types of interventions fail to consider how outside structures impact or may even exacerbate individual experiences. In the case of Eritrean refugees in Israel,

part of the suffering – and the solutions - lie in the structural realities - laws, policies, and practices – as well as the intersectional power dynamics surrounding race, that extend far beyond the individual. As such, to focus solely on the individual is to inadvertently attribute blame and responsibility to the refugees themselves, while ignoring the prominent role of structural considerations in instigating change, health, and healing. These findings not only call for major structural changes in support of refugees, but also have important implications for other contexts where liminal status is an issue, as well as the need to examine how structural considerations impact both liminality and refugee mental health.

Structural change requires substantial political will. It has been more than a decade since Eritrean refugees began seeking refuge in Israel. Since those early years, successive Israeli governments have shown a lack of political will to regularize refugees' liminal status and provide them with their fundamental rights. Although the recent change in government in 2021 provided a moment of optimism when the Israeli health ministry announced its unprecedented plan to extend the national health insurance to the thousands of African refugees living in its borders, this plan has been put 'on hold', and it seems unlikely to materialize (Peleg, 2021).

In the face of slow structural change, we recommend the promotion of initiatives that are community-based and community-led, which can provide important avenues for hope, resilience, and action. As demonstrated in our findings, refugees are not simply passive recipients of assistance. They are aware of their needs, and they often organize among themselves, whether through faith-based organizations or informal networks, to support vulnerable members of their community. Strengthening and supporting community-led initiatives are key. Yet conflict, violence and fear often rupture the social fabric that provides well-being. Therefore, a first important step would be to support refugee communities as they repair social support mechanisms and establish trust.

For some refugees, however, community-led interventions may increase anxiety around anonymity, judgement and stigma. As demonstrated in our findings, refugees' may prefer formal health and psycho-social services delivered by professionals who are 'community outsiders' and find them more effective. This highlights the importance of culture and context, and creating

therapeutic spaces that, in some cases, allow and even encourage clients to put some distance between themselves and their cultural group, where appropriate.

A final approach involves obtaining and addressing refugees' perspectives regarding their distress in the care process. This approach may improve outcomes by promoting empathy, strengthening the therapeutic alliance, and correcting the tendency of clinicians to prefer a biomedical explanation for illness (Weiss, 2018). It may also enhance positive expectancy since refugee patients believe that the intervention will target the problems that matter most to them.

Our findings serve as a reminder for clinicians that individuals react differently to extreme trauma and that these differences are of outmost importance in promoting deeper understanding and sensitivity to the diverse coping styles of refugees. As Hinton and Lewis-Fernandez (2010) highlight: "trauma does not occur in a vacuum: it develops and is understood in a particular cultural matrix" (p. 217). Future research should focus on examining further how refugees and other war-affected populations living in protracted displacement cope and heal from extreme trauma and the local shaping and presentation of psychological distress and well-being among these populations.

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Weaving Together a Cultural and Structural Analysis

In the first manuscript, I explored how Eritrean refugees in Israel perceive their mental health needs and detailed their attempts at coping with trauma and distress. Realizing that refugees significantly underutilize formal mental health services and are not receiving the care they need, I wanted in this project to hear from Eritrean refugees themselves how they perceive, explain, and cope with psychological distress. The project grew out of my interest in the broad area of cross-cultural mental health. Influenced by the writings of Kleinman (1987), Kirmayer (Kirmayer & Ban, 2013) and others, I became interested in understanding how researchers and mental health professionals can adapt interventions to make them fit better with each individual's cultural background. These interests and theories guided me as I developed my research questions and as I prepared for data collection.

Right from the first interview, however, I was exposed to the multiple layers of violence that shaped participant's lives. In interview after interview, participants spoke of the many ways in which violence – physical, symbolic, and structural – affected their daily lives and, importantly, their mental health. As a long-time activist and social worker who has worked with the refugee community in Israel for many years, I knew about the oppressive laws and policies of which the participants spoke. Yet, I was unaware of just how pervasive the structural violence was and how detrimental it was to refugees' mental health.

Despite the salience of structural violence in participants' narratives, when 'writing up' my data, I quickly returned to my preconceived 'cultural' agenda. Confused and overwhelmed by the daunting task of synthesizing and making sense of hundreds of pages of interview transcripts, field-notes and policy documents, it was easy for me to fall back on my initial research questions, focusing my attention on the cultural aspects of my participants' illness narratives. Skipping over important structural features of my participants' narratives, I focused instead on the more exotic spiritual and traditional treatments that participants utilized to cure their mental health symptoms – writing in detail about possession by 'Diablos' and 'Buda', or treatment by 'Maychelot'. It was only after an insightful conversation with Myriam, my supervisor, in which I discussed my preliminary codes and findings, that I was able to re-direct my attention back to the

overlooked theme of violence. Myriam urged me to pay attention to my participants' reality: *'What are your participants trying to tell you? What is important to them?'* Indeed, her advice was in line with the books and articles I was reading by Glaser and Straus (1967) on grounded theory, which similarly call researchers to gives priority to participants' perspective over their preconceived scholarly framework.

By carefully re-listening to interview recordings and re-reading transcripts with *these* questions in mind, I began weaving two major threads into the fabric of my thesis: (1) cultural dimensions of trauma and coping and; (2) a critical analysis of anti-immigration policies that both produce and perpetuate refugees' liminality while negatively impacting their health. I realized that these two threads were inseparable, and that only by weaving them together would I be able to provide an accurate and truthful account of refugees' lived experience. This realization led me to re-write my first manuscript, not merely focusing on culturally embedded coping strategies but also taking into consideration the ongoing structural violence, particularly oppressive laws and discriminatory policies, that further marginalize and harm refugees' health and wellbeing. In this manuscript, I realized that the 'Israeli refugee story' was part of a larger story – a story of millions of refugees stuck in protracted displacement, characterized by long-term and intractable exile and liminality.

The second manuscript of my thesis expands upon the notion of liminality and 'protracted displacement-related stressors in Israel' that are introduced in the first manuscript. In the 'findings section' of the first manuscript, I note that participants described multiple stressors related to their protracted displacement in Israel and viewed them as causes of their mental-health symptoms. However, due to a lack of space, I do not dive deeply into the realities and impact of liminality on participants' lives and mental health, nor do I expand upon each stressor.

This second manuscript is a natural continuation of the first. It provides an in-depth analysis of the ways in which liminality and long-term limbo unfold in refugees' everyday lives and how they impact overall mental health and well-being. Drawing on the theory of liminality, I provide readers a detailed account of the unique social and political contexts of Israeli law and policy. I

show the ways in which liminality is lived, experienced, explaining how it can eventually become embodied spiritually, psychologically, and biologically as negative health outcomes.

Manuscript II: “They Have Locked Us In”: The Impact of Liminality and Protracted Displacement on the Mental Health of Eritrean Refugee Youth Living in Israel

Fennig M., & Denov, M. (in press). "They have locked us in": The impact of liminality and protracted displacement on the mental health of Eritrean refugee youth living in Israel. In M. Denov & M. Fennig (Eds), *Research handbook on children and conflict*. London: Edward Elgar Publishing.

1. Introduction

> *I have been living for 8 years in Israel, but I cannot do anything. I walk around the streets, but I feel that I’m in jail. I cannot leave Israel. I cannot build something for myself (Participant 25, female).*

Since 2006, Israel has become a destination country for thousands of refugees who have escaped war, torture, and persecution. It is currently home to approximately 28,235 refugees, of which 73% are from Eritrea and 18% from Sudan (PIBA, 2022). In addition, approximately 8,500 refugee children are growing up in Israel, the vast majority of whom were born in the country (PIBA 2022). Despite having lived in Israel for over a decade, Eritrean refugees exist in a permanent condition of liminality as they are not provided with refugee status. Instead, they hold 'conditional release visas' - an “in-between” status which provides temporary protection from deportation, but denies almost any possibility of integration and naturalization in Israel (Ziegler, 2015). Moreover, Eritreans living in Israel are defined by Israeli law as ‘infiltrators’ - a highly charged term first used in the early years of Israel’s statehood to describe border crossings into Israel by Palestinian Fedayeen (Ziegler, 2015). Nonetheless, United Nations High Commissioner for Refugees’ (UNHCR) considers Eritreans to be in a refugee-like situation, therefore falling under its mandate (UNHCR, 2017). In this chapter, we refer to individuals who have fled persecution in Eritrea and are currently residing in Israel as “refugees” since they fit the UNHCR definition of being unable to return to their home country due to a well-founded fear of persecution.

As a result of their liminal status, all refugees in Israel are in constant threat of detention and deportation. They cannot work legally, and subsequently are forced to perform largely menial, low-status, manual jobs within the Israeli job market. In addition, they are denied access to healthcare available to Israeli citizens and other authorized residents, and are not entitled to receive social services. Given that they do not hold Israeli identification documents, they cannot pursue higher education and are barred from essential day-to-day activities - obtaining driver's licenses, registering a business, and even getting a public transportation card that provides discounts (Hotline for Refugees and Migrants, 2020). Eritrean refugees in Israel thus live in a context where they are *simultaneously locked 'inside' and 'outside'*: They are forced to remain *inside* Israel's borders, unable to emigrate further west, as no third country has agreed to admit them and to provide them with permanent residence rights[1], and they are unable return to Eritrea where they face imminent danger for their lives and liberty. And yet, at the same time, they are excluded from and kept *outside* of mainstream Israeli society, prevented from meaningful integration as a result of a series of exclusionary laws and policies. After more than a decade in Israel, this population remains in a state of 'permanent temporariness' (Bailey, 2002, p. 125).

While holding distinct features, Israel's migration policies and measures are not entirely exceptional, but are instead part of a growing global trend of securitization and criminalization of irregular migration, in general, and asylum seeking, in particular (McDonnell & Merton, 2019). Recipient countries have increasingly resorted to policies aimed at reducing the numbers of individuals seeking asylum within their borders. These 'policies of deterrence' include the provision of time-limited, rather than permanent protection, the confinement of asylum seekers, increased border surveillance, and the outsourcing of procedures for determining refugee status to other countries (Hamlin, 2012). In these settings, individuals and families fleeing war and persecution find themselves "outside the circle of legality" (Crepeau et al., 2007), forced to wait months, often years, for the regularization of their status in a state of liminal legality (Chacon, 2015).

[1] UNHCR operates a resettlement scheme which relocates refugees from Israel to western countries. However, this is an exceptional measure that is reserved for "people in life-threatening medical condition, survivors of torture lacking timely and effective rehabilitation services, children with special needs and women at risk"(UNHCR, 2022, p.1). While there are other complementary pathways, such as refugee sponsorship, these are also complex and only a minority are able to leave Israel through these avenues.

The vast majority of refugees in the world are now living in settings of prolonged displacement, whether in neighbouring countries (e.g. Lebanon), as well as in countries of resettlement (e.g. Australia) (UNHCR, 2021). For example, due to the Balkan border closures which were put in place with the intention of stopping mass flows of migrants into western Europe, there are more than 72,000 refugees and migrants stranded in Greece, Cyprus and the Balkans, including more than 22,500 children (UNICEF, 2022). The duration of refugee displacement varies greatly across settings: Kosovars spent several weeks in exile in 1999, while for Afghans, it is approaching 40 years (Devictor & Do, 2017). UNHCR (2004) has termed these situations of long-term limbo - five consecutive years or more - as 'protracted refugee situations'. UNHCR notes that these "refugees find themselves in a long-lasting and intractable state of limbo. Their lives may not be at risk, but their basic rights and essential economic, social and psychological needs remain unfulfilled after years in exile" (p.1).

Many refugees living in these situations of protracted displacement are youth, many of them unaccompanied. For the purposes of this chapter, we use the UN definition of youth, that is, the age group of 15-24 years. However, we recognise that 'youth' is a social construct that is highly dependent on local and contextual understandings (UN, 2023). It is during this critical developmental period, when youth are transitioning from adolescence to adulthood, that they are forced to flee, separate from their parents or guardians and cope with the realities of flight, migration, and protracted displacement (UNICEF, 2021). Youth, particularly those who are unaccompanied, are considered a highly vulnerable refugee subgroup. They are not only exposed to the same adversities as all youth are during conflict and flight, but face additional risks, including increased vulnerability to traffickers and exploitation, coping with loss and trauma, profound isolation, and financial hardship (Denov & Bryan, 2010). Experiencing violence and instability at this critical point in youth's cognitive and emotional development, alongside coping with displacement without family support, can have long-lasting negative effects on youths' mental health and life course (Jensen et al., 2019). While many youth demonstrate an ability to overcome the challenges of forced displacement, others are at increased risk of poor mental health outcomes including PTSD, depression and anxiety (Blackmore et al., 2020).

Despite its importance, little is known about how Eritrean youth in Israel understand and experience discrimination and marginalization associated with their liminal immigration status and protracted displacement, and how these experiences impact their mental health and well-being. In this chapter, we address this gap by drawing from qualitative data collected as part of larger ethnographic study of Eritrean refugee youth living in Israel. We explore the ways in which imposed liminality and protracted displacement are experienced by Eritrean youth. More specifically, we examine the ways in which liminality affects refugees' mental health, well-being, and ability to access needed services and supports. In doing so, we aim to extend the scholarship on liminality and protracted displacement beyond its dominant focus on policy and rights-related responses (e.g. Adelaman, 2016; Zetter & Long, 2012). While past studies have provided a deeper understanding of the legal, bureaucratic, and ethical dimensions of protracted displacement, relatively little is known about the ways in which liminality and long-term limbo unfolds in young people's everyday lives and how they impact their overall mental health and well-being.

By examining local perspectives and responses to protracted displacement, we are in conversation with a growing body of literature that has explored refugees' lived experiences in 'waiting spaces' such as Direct Provision in Ireland (O'Reilly, 2020), residential care in Finland (Kohli & Kaukko, 2018) and more elusive spaces such as those occupied by youth subjected to immigration control in Britain (Alssop et al., 2014). Ultimately, we demonstrate the ways in which the mental health of refugee youth is deeply connected to the unique social and political contexts of Israeli law and policy. Moreover, Eritrean refugee experiences in Israel, and subsequent support and interventions must be understood and developed in relation to the broader context of protracted displacement and liminality.

2. Understanding Liminality: Israel and the Production of *'Liminal Personas'*

The mental health of Eritrean refugees needs to be understood in the context of liminality. The concept of "liminality" was first introduced by anthropologist Arnold van Gennep (1960) and later developed by cultural anthropologist Victor Turner (1967). Van Gennep (1960) suggested that individuals move between a series of passages from "one age to another and from one

occupation to another" (p.3). Rites of passage, according to Van Gennep, can be divided into three stages: separation, liminal period, and re-assimilation. Turner (1967) focuses on the second stage – liminality - the time of transition, in which people are "no longer classified and not yet classified" (p. 96), and thus find themselves in an 'in-between position'. He emphasized the importance of understanding the experiences of liminality when people are "neither here nor there", when they are "betwixt and between the positions assigned and arrayed by law, custom, convention and ceremony" (Turner, 1967, p.95).

In forced migration scholarship, the concept of liminality is often invoked to draw attention to refugees' exceptional legal status, as individuals who have been deprived of their citizenship and do not fit into the fixed legal categories of the nation-state system (Malkki, 1995). As political theorist Hanah Arendt (1973) argued in her seminal essay, *The Origins of Totalitarianism*, human rights - which are meant to be afforded to any human being by virtue of being human - are, in fact, intrinsically tied to the nation-state. As such, refugees who are no longer citizens, no longer part of an organized political community in which they can claim their rights, exist in a state of 'in-between-ness', and are deprived of "the right to have rights" (Arendt, 1973, p.298).

Approaching and understanding protracted displacement through the prism of liminality is important for several reasons. First, it provides a more nuanced understanding of these spaces of long-term limbo where refugees struggle to realize their human rights. Second, it enables an exploration of the ways in which liminality negatively affects refugee youth's mental health, and access to health care services. Liminality, as suggested by O'Reily (2020), is not only a spatial or temporal experience, but also an ontological one: "an internalization or 'living-out' of a liminal situation, the experience of feeling like and being perceived as a liminal being" (p. 140). Following O'Reilly, we argue that the analytic power of liminality lies in its ability to render visible the often obscure linkages between anti-immigration policies, liminal legal status, and ill health. It allows an examination not only of the historical roots and political dynamics of protracted displacement, as has been done in previous studies (Chatty & Mansour, 2011), but also facilitates an understanding of refugees' everyday experiences of these spaces - how they

are lived, and how they may eventually become embodied biologically as negative health outcomes.

In Israel, Eritrean refugees exist in a permanent condition of liminality. Although Israel is a state party to the United Nations 1951 Refugee Convention and 1967 Protocols, it has yet to enact national legislation governing the treatment of asylum-seekers,(Zeigler, 2015). Some scholars argue that the lack of official law regarding asylum issues stems from the state's desire to avoid international obligations towards Palestinian refugees and their claims for territory, compensation, and the right of return (Yaron et al., 2013). Its important to note that although Israel has absorbed hundreds of thousands of Jewish refugees since its establishment in 1948, Jewish refugees are defined by Israeli law as '*olim*' (immigrants) rather than 'refugees' and are not treated as refugees by the state (Zeigler, 2015).

Israel maintains a Refugee Status Determination (RSD) process, which prior to 2009 was controlled by UNHCR and, since then has been controlled by the Israeli government. Nonetheless, the vast majority of asylum claims in Israel are rejected or not assessed, and the RSD system is considered to be unfair and ineffective (UNHCR, 2017). As a result, refugee status has been granted to only a small fraction of individuals - 72 cases out of approximately 80,000 individuals who have sought asylum in the country over the last 15 years. This means that the recognition rate of refugees in Israel currently stands at less than 0.1% (PIBA, 2022). Israel's failure to consider and examine asylum applications means that the current liminal status of Eritrean refugees remains indefinite.

In the absence of refugee status, most refugees in Israel receive a "temporary permit" which they must renew periodically, ranging from every few weeks, to every six months. This liminal status provides them very few rights beyond a general policy of non-deportation. As noted in the introduction, refugees' liminal status does not entitle them access to basic assistance such as health, social security and welfare services with the exemption of life-threatening conditions. The limited health and social services that refugees and asylum seekers do receive are provided by NGOs and volunteer-run clinics who have limited resources and treatment at their disposal. Although thousands of Eritrean refugees in Israel are survivors of torture, the state does not have

a mechanism for the identification and rehabilitation of victims of torture and only 250 refugees have been granted rehabilitation services (ASSAF & IRCT,2016).

Moreover, refugees' liminal status does not confer the right to work. Although the state committed to the High Court of Justice not to enforce the prohibition on employing refugees, their right to work remains ambiguous and significantly impacts Eritrean refugees' ability to successfully integrate into the labour market (Kritzman-Amir & Schumacker, 2012). In addition, when refugees lose their jobs, they are left with no medical insurance and are not entitled to receive unemployment benefits and severance pay. They are also not entitled to paid sick leave, income tax breaks, assistance in rent payment, legal assistance and all the other social rights to which residents of Israel are entitled. Despite their vulnerability and meagre income, the state places arduous taxes on them including the Deposit Law which was in effect from 2017 until 2020. This law obligated employers of refugees to deposit 20 per cent of a refugee's monthly wages in a government-held fund until they left the State of Israel, driving many refugees into even deeper poverty (Workers Hotline, 2019).

Additionally, refugees liminal status does not exempt them from immigration detention. Upon crossing the Israeli-Egyptian border, the majority of Eritrean refugees were detained for several weeks to months, in Ktiziot or Saharonim detention centres, located near the Egyptian border. Several years later, more than 13,000 refugees were again imprisoned, this time in Holot, a detention centre which operated between 2013 and 2018. Under the various amendments of the Anti-Infiltration Law, the Holot facility was located near the Israeli-Egyptian border and held only male asylum seekers from Sudan and Eritrea. The Israeli government defined the facility as one that was 'open', as those detained within it were free to exit its gates during certain hours of the day. However, in practice, Holot functioned as a jail-like facility, and similar to other Israeli detention facilities, it was was operated by the Israeli Prisons Service (IPS), and detainees freedom of movement was extremely limited (Lior, 2016).

Refugees' liminal status is especially detrimental to young women and girls who constitute approximately 20 percent of the total Eritrean community in Israel. Young women are at high risk for intimate partner violence, exploitation and abuse (Gebreyasus et al., 2018). Yet, despite

their vulnerability, they are not eligible to access social services and centers for prevention of domestic violence, with the only exception being cases in which women face immediate danger to their lives. In such instances, they are eligible for emergency protection in shelters, for a brief period of time. Moreover, although a significant percentage of female refugees in Israel are single mothers, they are not entitled to the benefits that Israeli single-parents are entitled to – such as alimony, tax benefits, income support benefits, and rent assistance (Assaf, 2016).

Taken together, all of these factors including keeping Eritrean refugees for years in the ineffective process of evaluating their claims, requiring the ongoing renewal of their temporary permits, refusing to provide basic rights, and denying any prospect of the regularization of their status - the Israeli state produces what Turner (1970) has termed *'liminal personas'* (liminal beings). Yet, the implications of liminality, particularly from the perspectives of the refugee youth themselves, are largely unknown. As such, in this research study, we explore and unpack the experiences and impact of liminality on a sample of Eritrean refugees who arrived Israel as youth. Prior to doing so, however, we address the study's methodology.

3. Methods

The study was conducted over a six-month period between November 2019 and May 2020 and was a partnership of the first author and Aid Organization for Refugees and Asylum Seekers in Israel (ASSAF). ASSAF is an independent, non-profit Israeli organization that promotes the human rights of asylum seekers through public advocacy work. Recruitment was facilitated with the assistance of ASSAF. Emails were sent to ten organizations and clinics that support the refugee community and were thought to have contact with potential participants.

Data were collected by the first author, who spoke Hebrew and English, alongside two Eritrean RAs, one male and one female, who spoke Tigrinya, Hebrew, and English. Participants who had been exposed to trauma and either currently suffering from mild to moderate psychological distress or have suffered in the past were eligible to participate in the study. In-depth interviews were conducted with 34 Eritrean refugees - 14 men and 19 women, all of whom had fled Eritrea as youth**.** At the time of interviews, participants were aged 26 to 35, with the vast majority aged

31 years and younger. Age at departure from Eritrea ranged from 15 to 25, with 32 of the 34 participants fleeing Eritrea between the ages of 16-20. Participants had been living in Israel for an average of 8 years, with a range of 7 to 12 years. Sixty per cent of participants were married with at least one child, 34% were single, and 6% were divorced, with children. Thirty-two participants self-identified as Christian, one as Muslim, and one as Pentecostal. Participants' formal education varied from 14 years, to no education, with a mean of 10 years. All but two participants were employed.

All study procedures were approved by the Research Ethics Board of McGill University. The informed consent process addressed that participation was voluntary, confidential and anonymous, and that participants were free to withdraw their participation at any time. Participants were also informed that interviews could result in distressing emotions and it was made clear to participants that they could refuse to talk about any issues and that they could decline voice recording. All participants were provided a list of referrals where they could receive psychiatric or psychological services free of charge.

Data analysis was driven by a grounded theory approach whereby rounds of data collection were followed by interim analysis, with the results used to generate hypotheses, and modify subsequent data collection (Glaser & Strauss, 1967). Two main data analysis "feedback loops" (Whitley and Crawford, 2011) were used: one following 15 interviews, and the other following 25 interviews. We then identified in vivo codes—codes that participants use themselves to divide the world. More conceptual codes, such as liminality, were then added. Finally, we generated themes by engaging in *constant comparative analysis (*Glaser & Strauss, 1967), looking across the whole data set to compare cases.

3. Findings

The realities and impact of liminality were at the heart of all of participants' testimonies. In particular, participants' narratives reflected stories of suffering, memories of past trauma and loss, alongside ongoing experiences of discrimination, marginalization, violence and humiliation, all of which were reportedly experienced as a result of their liminal status. Bodily experiences

and mental health symptoms were regarded as inseparable from the endless up-rootedness and impermanence that characterized participants' experiences. Particularly apparent in relation to liminality were participants' experiences of uncertainty and anxiety for the future, fear of detention, work-related stresses, racism and discrimination, health-realted stresses, and long-term family separation, all of which are addressed below.

3.1. 'Locked in': The uncertainty and anxiety of prolonged displacement and lack of status

Participants' liminal status contributed to a chronic sense of uncertainty and anxiety for the future. Time and again, participants shared their feelings of being figuratively trapped - unable to move 'forward' from their temporary legal status and re-build their lives, and simultaneously unable to move 'backwards' by returning to their home country. Feelings of being 'trapped' or 'confined' by the Israeli asylum system emerged repeatedly, resounding through metaphors of prisons and jails:

> And in Israel, it's like someone locked the door and can't find the key. That's how we live in Israel. They locked us in (Participant 22, female).

> I walk around the streets, but I feel that I'm in jail (Participant 25, female).

> On the one hand, you're looking back, and thinking what is going to happen with my country. On the other hand, on the life you're living here. Both of these thoughts are always in my head (Participant 7, Male).

Concern and anxiety about the future was closely related to participants' legal status. Stories shared by participants underscored the frustration, worry, and fear of having no sense of identity or belonging in the legal sense:

> The fact that I am in Israel for 9 years, I have no status, I don't belong to any country. Not to Israel and not to Eritrea. I am "up in the air" and it worries me (Participant 8, Male).

> What I am afraid of is the future of my children. First of all the children that are born here have nothing except the birth certificate that they get from the hospital which includes the date and the day when they were born. They have nothing...They don't have Eritrean ID and they don't have Israeli ID (Participant 4, Female).

From participants' perspectives, the Israeli government was constantly formulating and executing new laws and policies with the explicit goal of making refugees life difficult. This situation induced enormous anxiety among participants who expressed their worry about 'what was coming next' and the consequences of new policies for their family and themselves:

> Something that concerns me often is - what will happen in the future? You can't know what will happen here because the law changes every day... Because here, I think you also know, the government doesn't have a permanent plan. They're always changing their decisions. (Participant 14, Male)

3.2 Detention, Fear and Liminality

Over the past decade Israeli authorities have used refugees' liminal status as a pretext to detain or threaten to detain them indefinitely, with the explicit aim of encoraging them to leave the country. For example, Israel's former Interior Minister, Eli Yishai stated: "Until I can deport them, I'll lock them up to make their lives miserable" (Efraim, 2012, p. 1).

Eight participants, one woman and seven men, reported that the onset of their distress was related to their prolonged incarceration in detention centres in Israel, as well as the fear of returning to detention. One woman shared, how at the age of 17, after surviving torture and abuse during flight from Eritrea, she was incarcerated for two months in the Saharonim Detention Centre upon entering Israel. It was there, she explained, that her periodic symptoms of sharp chest pain and loss of breath began:

> We came to Israel, and it started. In the night I also get up and I do like this (takes a deep breath out). I sit. It was hard. In the beginning really really hard. " (Participant 17, Female)

The remaining seven male participants reported that their symptoms of distress were linked to their prolonged detention in Holot. These participants, who by that time had been living in Israel for more than 5 years, spoke about the day the Population Immigration and Border Authority ordered them to report to Holot, and their desperate attempts to escape incarceration. Many of them had already been incarcerated upon their entry to Israel, and were terrified of finding themselves behind bars again. M, who suffered from severe PTSD symptoms before his incarceration, worried about the impact of detention on his long-term mental health:

> I am one of the people who suffered [torture] in Sinai [during flight], also with money and issues and also from violence... As soon as the Ministry of Internal Affairs told me to go to Holot, I said - if I'm going to be in detention again, it's going to get worse. I was stressed out. I was worried it would get worse. (Participant 8, Male).

Another participant who hid from the immigration police for a year, spoke at length about his deep fear of returning to detention, liminality, and its association with his ongoing depressive symptoms:

> You're scared all the time, you don't have confidence. Maybe it's coming, maybe they're immigration, maybe this, maybe that (Participant 10, Male).

Despite their attempts to avoid arrest, all seven male participants ended up being detained for at least one-year in Holot - a facility was surrounded by two tall fences. As noted earlier, while operated by the Israel Prison Service, it was not defined by Israeli state officials as a prison because those detained are free to exit its gates during certain hours of the day (Lior, 2016). However, participants described the harsh reality of detention in Holot which included closed gates, insufficient and uncooked food, degrading and violent treatment by detention officers, and lack of medical attention and medicine:

> They would make it very hard on us in Holot. Very hard, very hard. They would, sometimes they would close the.. you couldn't go out, you couldn't do this… They would

> take people in front of us… it was very gross, very concerning.. I don't know, they take your friends, like, "unlimited" [time] (Participant 10, Male).

The harsh living conditions, disconnection from the outside world, and the psychological impact of being incarcerated like criminals, reportedly took a significant toll on participants' mental health. Participants reported suffering from a range of symptoms, including anxiety, sleep difficulties, depressive symptoms and suicidal ideation during their time in detention:

> I was very very sad, every day… I was very angry. I wasn't happy. Sometimes I would think like… It would cause me to make a decision, I don't know what, like to go to some country and die there.. Or like, how can I pass the time? To be there for a year, it's not easy. (Participant 14, Male)

While some participants reported that their symptoms improved upon release from Holot, many participants shared that they continued to suffer from emotional distress two years following detention:

> But in general, it started after I came back from Holot. In these past two years, I'm not… even though I work, I wander around, I hang out, I don't have any happiness from the inside, in my life" (Participant 7, Male).

Work-related Stresses and Liminality

One of the prominent stressors related to participants' liminality was related to their employment status. Refugees in Israel are legally prohibited from working and their 2A5 type visas explicitly state: "*this temporary permit is not a work permit*". However, following a 2011 Israeli High Court ruling, the Israeli government committed to not enforcing punitive actions against refugees' employers. Participants shared that this vague 'non-enforcement policy', led to confusion and exploitation, damaging their ability to effectively integrate into Israel's labour market:

> So you can't work with the visa we have, but what does that mean? You need to work in order to live… If not, you won't live (Participant 10, Male)

The combination of financial challenges and lack of designated work permits forced participants to work long hours in low-paid, menial jobs such as construction or cleaning. Participants spoke about that hardships of their physically straining work:

> It was a serious job and it was hard, hard, hard. I was in the sun the whole day, tying the metal, cement, and this and that.. I worked hard, also in the day and also at night. I would work at night, I would work 18 hours sometimes 15, 16. (Participant 10, Male)

The necessity to work long hours in physically arduous jobs impacted participants' physical and mental health, often aggravating the chronic pain and PTSD symptoms from past torture and forced labour:

> The doctor told me that I cannot pick heavy things, but I cannot tell to my boss because I work for him and he doesn't care. I have to work. And sometimes when I have to pick, I feel the pain in my shoulder. So despite the memories and the flashback and the pain that reminds me what I went through... I have to work 10 or 11 hours. I have to stand for long and although I am tired, although I need rest, I can't because I have family. (Participant 15, Male).

Due to their liminal status, participants were denied access to the protection and benefits other workers enjoyed, making them more vulnerable to exploitation and their employment conditions more onerous. One participant spoke of being exploited by his employer who failed to pay him:

> I worked in a restaurant and the guy had to pay me 5,700 shekel, so without paying me, he closed the place and went out of the country...These criminals, they know that the government doesn't care. (Participant, 8, Male)

Female participants, typically experienced work-related stress differently than male participants. While some female participants spoke of discrimination in the workplace and the physical toll of their job, the main concern expressed by many was their experience of intense social isolation. Although life in Israel brought some changes to traditional gender roles, child rearing and household tasks remained predominantly young women's responsibilities. The double burden of working long hours outside the home, as well as being responsible for the majority of tasks in the domestic sphere left many female participants struggling with feelings of isolation and loneliness:

> I don't even have time to connect with people because of the kids, because of work. I don't go out with friends because I don't have time for that. (Participant 23, Female)

Many female participants also spoke of the prolonged absence from their children whom they are forced to leave in daycare centres sometime until late night hours or even overnight. They shared with us the difficulty of being away from their young children:

> I had to work 8 hours like a mother in order to be able to take care of the children, to take care of the house. But I work more hours like a husband. ...And it feels hard not to have time to be with my child...(Participant 22, Female)

> Yes, the dilemma; To leave the children at daycare and go to work. If you don't work, you can't live (Participant 16, Female)

Embodying 'Infiltrators': Racism, Discrimination and Liminality

As noted in the introduction, Eritrean refugees are regarded in Israeli law as 'infiltrators'. Participants reported the ways in which race, discrimination, and their liminal status combined to make them believe they were not only 'outsiders', but also the true embodiment of 'infiltrators'. Participants reported systemic, structural and institutional forms of discrimination and racism, as well as everyday racist encounters at the micro level.

Racism was reported as an integral part of participants encounters with government officials and institutions. One institution which was highlighted by many participants as particularly discriminatory was the offices of the Ministry of Interior where participants were required to renew their visas in order to legally remain in Israel. As of June 2017, there are only two offices of the Ministry of Interior where the entire population of refugees in Israel can renew their visas: Benie Brak (located in centre of Israel) and Eilat (located in the southern tip of Israel near Jordan). As a result, refugees must undergo extremely long journeys and incur heavy financial costs to renew their visas. Many participants spoke of the onerous conditions in these offices, including degrading treatment, and ongoing humiliation:

> For example, in 2013 we went to renew our visa, me and my husband. They didn't give us the visa because they said, they asked him for his pay slip, but he said that he doesn't have it because he used to work 'black' (i.e. 'cash in hand') and it's not his fault. So they said: "What are you a thief? What are you doing? Where are you bringing the money from? Why are looking at me like that?" They said: "You are a motherfucker!', 'You are..'. Really bad words they used (Participant 26, Female).

Similarly, participants reported standing in line for hours to renew their visas:

> I'm going to the Ministry of Internal Affairs, to switch my Visa. I'm waiting in line, I'm a dialysis patient. Five, six hours I'm waiting in line. You try to tell them and they don't care. Even if you die, they don't care (Participant 11, Male).

> Going every two weeks to the Ministry of Interior and sitting for 4 hours, 5 hours just to get a Visa for two weeks...For a year, I went every two weeks. For a year (Participant 2, Male).

Participants commented that the racist attitudes towards Eritreans were not arbitrary, but rather the result of deliberate and exclusionary discourses and legal practices of Israeli politicians:

> The government made our lives so so so so hard. What does this mean?...Netanyahu [Israel's prime minister at the time of interview], he says, now they put us in his media. He says- they, the infiltrators, they work immigrants, they came and spoiled south Tel Aviv. They rape, they kill, they make a mess, only fighting, only bad things, he's blaming us, yes? I'm not saying that it's not true, it could be there is like 10 or 20 people like that, but you can't blame the whole nation [of Eritreans] (Participant 10, Male).

> They say, like, they rape, they kill, they screw each other over...Instead of helping integration within the community, you are trying to separate them. To scare the Israelis. And then they will be scared. (Participant 7, Male).

Overt forms of racism and discrimination not only occurred at the structural and/or institutional levels, but also occurred at the micro level, during everyday life encounters. S. describes her daily experiences of racial harassment to the point that her 4-year-old son was afraid to leave and enter their house:

> We were walking down the street one day and we hear: "Go to Africa! Go back to Africa". My son, 4 1/2-years-old, hears this. He asks: "What is she saying? What happened mommy?"... He is afraid as well. We have a neighbour every time she sees him, she yells "Africa! Blacks!", like this. And he really gets scared and runs into the house (Participant 17, Female).

Similarly, M, describes how White Israeli passengers on the bus avoided being touched by Eritreans:

> Let's say in the bus I saw a lot of people, like we want to help people, like in the bus when you saw old people, or if the mother with her child, I don't care if they are white.. When the child fell, they catch him… But they don't feel good when we catch their kids so we feel that, I don't know. Even the old people, even they say – "don't touch" (Participant 19, Female).

These everyday experiences of racism not only reinforced to participants' their liminal status and realities as 'outsiders', but also how racial slurs, and highly racially charged incidents reiterated the ways in which participants had become the real life embodiment of the "infiltrators", as is defined in Israeli law and policy.

Health-related Stresses and Liminality

Participants highlighted the connection between liminality and their inability to receive proper medical care. Since Israel does not apply the National Health Insurance Law to refugees, they cannot access public health services, except during emergencies or in life-threatening situations (PHR 2020). Due to their exclusion from the public health system, the vast majority of participants obtained private health insurance through their employer. However, since private health insurances are tied to a refugee's ability to work, many participants lost their health insurance once they became ill. In other cases, participants had to work despite their deteriorating health in order to be able to receive insurance:

> I didn't continue the treatment, because I didn't have a health insurance. For a year, I was like this... Then I started a job in a fish store. I worked there for almost a month, I don't know for sure... Then I collapsed over there. I went to the hospital, they told me- both your kidneys aren't working. You need to do dialysis. (Participant 11, Male)

Participants' exclusion from the public health system along with processes of privatization have left many with restricted and fragmented access to appropriate medical care, including chronic care management and preventive care. Participants with serious chronic health conditions, such as cardiovascular disease and kidneys disease, shared their frustration of not being able to receive the life-saving medical care they need:

> My problem is really hard for me. Also in, in, in my head, it stressed me out a lot...You know, an illness isn't easy. Sometimes I think - what will be tomorrow? I don't know. I'm also waiting for a transplant, a transplant. I sent a request here in Israel to the Ministry of Health but they aren't giving me, because I'm not a citizen. (Participant, 11, male)

> I was sick and I went through heart surgery. So the problem is according to my condition, I cannot do checkup when I feel sick or when I feel bad, I can only go to Yafo or Terem [voluntary run clinics that provide free health care to refugees and migrants] and in these places you cannot get the things that you need. Because I don't have insurance, I can't get the things that I need... (Participant 4, Female).

In addition to their exclusion from the public health system, participants' experienced multiple barriers to accessing effective healthcare including, administrative requirements, inability to pay related costs, racism, discrimination, language, stigma, and culture-related differences in symptom presentation. During his interview, G shared that when he first arrived in Israel, he received a letter recognizing that he was a victim of human trafficking and torture and, as such, was entitled to services, including shelter and rehabilitation. However, instead of providing him with a translation of the letter, and explaining to him his entitlements, following his release from detention he was placed on a one way bus by government officials to a park in South Tel Aviv. Upon arrival, he, like many others, spent days and sometimes weeks sleeping outside. It was only years later that he understood the meaning of the original letter. However, at that point, he was ineligible to receive care:

> The things is, I didn't know what street in there, I didn't know anything about it. They didn't inform me, they didn't give me any information that I have to go to a shelter. They gave me this letter, I know it's written about my story. And so what they say, they sent me to bus and they sent me to Levinsky Park and they just throw me in Levinsky and I slept there for three days... I didn't know if I had the option to go to a shelter, I think it would be helpful for me also, but I didn't know about it. (Participant 15, Male)

Long-term Family Separation and Liminality

Separation from family members was another prominent stressor reported by 14 participants. Although most of the participants were only 16, 17 or 18 when they fled Eritrea, due to the perils of the journey, they were forced to leave their parents and other immediate family members behind, expecting to reunite with them once they reached safety. However, in contrast to other

Western countries, Israel does not permit family reunification and refugees are unable to sponsor family members to Israel. Moreover, since refugees residing in Israel do not have formal status, overseas travel is prohibited. As such, separations which were originally meant to be temporary, extended for indefinite periods:

> We are three children and the parents are alone. They have no one. I fled when I was 17 years-old. My sister fled when she was 16. They have no one. They cry all day (Participant 25, Female).

Although the majority of participants had immediate family members living in difficult and insecure environments, either in Eritrea or elsewhere, they had not seen them since they arrived in Israel. Worry and concern about the health and safety of their families was a salient feature in participants narratives:

> I have a bad feeling because I don't meet my family and I am 12 years outside my country. It's really hard for me and I am mad at myself. It's really hard the fact that I don't talk to my family and that I can't visit my family. Even when my mother is sick I can't visit her and it really hurts. (Participant 22, Female)

Separation from family members was particularly salient in the narratives of five female participants who left their children behind in Eritrea. Similar to many Eritreans, these women could not bring their young children with them because fleeing by land was far too dangerous. All of these women shared the deep anguish and grief they felt due to their inability to care for their young children. For example, B one of the Eritrean mothers discussed:

> What bothers me first of all, the thing that bothers me the most is the fact that I have a son in Eritrea. The children I have here I can see them. If they are hungry I can give them food. If they are thirsty, I can give them water. I can take care of them. But the son I have in Eritrea, it bothers me a lot. I can't give him what he wants. (Participant 6, Female)

All of the young women characterized the separation from their children as the factor that most impacted their mental health in Israel. D, who had her first child when she was only 15, shared the deep guilt she felt for leaving her children behind:

> Sometimes I tell myself 'why did I leave my children? Why did I leave?' So I also say, at that time I thought 'I will flee, I will get out, I will be in a better situation and then I can take them. Now that I see the situation in Israel, I suffer. (Participant 27, Female)

All of the female participants compared their situation to that of other Eritrean women in Europe and elsewhere who, due to their secure status, were able to reunite with their children:

> Sometimes when I talk to my son in Eritrea he asks me 'why don't you come and get me?' All the other children were able to reunite with their parents and only I am left here alone. When he tell me this I get mad and I really feel stressed so I try to calm down. (Participant 5, Female)

> They just know that their mother is abroad. They don't know where I am exactly, they don't know what situation I am in exactly. For example, there are people that live in Europe, Canada or United States so they can do some sort of process to take them. So they [the children] think that I can also do that so they always wait. When I will come to see them? When I will come to take them?.. So every time I ask them 'what do you want? What clothes? What shoes?' They reply... they don't reply. They just want me to come and take them (Participant 26, Female).

4. Discussion

The findings of this chapter demonstrate that the mental health of Eritrean refugee youth is profoundly shaped and affected by conditions of imposed liminality. Liminality is not simply a juridical status or a spatial/temporal experience, but also an ontological experience that significatly constrained refugee youth's opportunities and shaped their sense of self, identity, and well-being. Life in Israel was regarded by participants as a demeaning environment marked

by confinement, poverty, injustice, insecurity, isolation, and endless up-rootedness. Moreover, participants viewed their state of liminality as inherently connected to their debilitating mental health symptoms. Our findings thus highlight the negative mental health consequences of living in a state of protracted limbo. These results are consistent with previous studies that have established an association between visa insecurity and negative mental health outcomes (Nickerson et al., 2019; Steel et al., 2011; Momartin et al., 2006).

Building on the evidence presented in this chapter, we suggest three core explanations for *why* liminality places such a significant burden on refugee youth mental health. First, ones liminal status appears to impact refugee youths' mental health through the heightened and continued perception of insecurity and impermanence. Worrying about the future, over which they had very little control, was a dominant concern for all participants in this study. Due to participants' liminal status and Israel's unpredictable immigration policies, participants lived in fear not only about what will happen in the distant future (*Where will I live 20 years from now? When will I next see my family?*), but also the very near future, even the next day (*Will the immigration police come to detain or deport me tomorrow?*). This chronic sense of anxiety about the future, affected participants' psychological health and daily functioning.

Second, are the realities of refugee exposure to trauma and risk. Our findings demonstrate that liminality is not only a risk factor in itself, but also it exposes refugees to additional risks such as detention, occupational hazards, labour exploitation, extortion, racism, violence and poverty. For many of our participants, these risks became interconnected, compounding and intensifying the impact of past trauma, ultimately exacerbating mental health symptoms. This is consistent with previous studies that have found that refugees who hold temporary protection visas face greater living difficulties, as compared to those with permanent protection visas (Li et al., 2016). Moreover, the impact of exposure to risks may be cumulative. An increased length of displacement is associated with poorer mental health outcomes, suggesting that with the passage of time, the mental health of refugees with precarious status may deteriorate due to the extremely stressful post-migration environment in which they live (Ryan et al., 2019).

Third, is the depletion of refugee youths' coping and protective resources. Participants in our study experienced extended separation from their families and support systems. Given that parents and other supportive adults often mediate or buffer the effects of difficult experiences in a child's life, youth who experience extended family separation may face greater risk to their mental health than other refugees because of the interplay between traumatic experiences and separation from significant emotional relationships (Fazel et al., 2012). Our findings support this notion, suggesting that extended family separation may reduce refugees' ability to cope with past trauma and ongoing risks resulting in maintenance or escalation of psychological distress.

5. Conclusion

In this chapter, we investigated the ways in which liminality affects refugee youths' mental health, well-being, and ability to access needed services and supports. We have shown the ways in which liminality is lived, experienced, and how it can eventually become embodied spiritually, psychologically and biologically as negative health outcomes. Taken together, our findings add to the growing literature highlighting the detrimental effects of protracted displacment and liminality on refugee youth's mental health. The Israeli experience offers important lessons for policy makers and health professionals worldwide. It calls for the implementation of more just immigration and refugee legislation and policies, including the establishment of fair and effective refugee status determination processes. There is emerging evidence to suggest that the regularization of refugees' status can have a dramatic impact on their mental health. For example, Nickerson and colleagues (2011) found that the conversion of refugees' visa status from temporary to permanent was associated with a significant decrease in refugees' negative psychological symptoms. In this sense, our findings suggest for youth who have been uprooted and displaced, regaining permanance both in the legal and ontological sense may be as important as concerns about the resolution of past traumas, or even more so.

Our findings also have important implications for practice. Eritrean refugee experiences in Israel and subsequent support and interventions must be understood and developed in relation to the broader context of protracted displacement and liminality. Western mental health approaches tend to focus interventions on the individual. However, not only do refugees experience

protracted displacement and liminality as a community, but also research has shown that for populations affected by war and genocide, a unilateral emphasis on the individual may miss the mark (Denov, 2020). As family and community support appear to be protective, focusing interventions that include both family and community are vital to long-term mental health and well-being. Moreover, refugees are acutely aware of their needs, and they often work together to support vulnerable members of their community (Fennig and Denov, 2022). As such, drawing upon existing community support, strength, and promoting community-led initiatives are key to providing appropriate and supportive care.

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Methodological Complexities of Conducting Cross-Cultural Mental Health Research With Refugees: Lessons From the Field

During my doctoral fieldwork, I was confronted first-hand with the methodological complexities of conducting cross-cultural mental health research with refugees: (1) Gaining trust and authentic access; (2) ethical issues and dilemmas with obtaining informed consent in a context of significant power differentials and linguistic/cultural barriers; (3) challenges and dilemmas with the translation and adaptation of psychological scales developed in Euro-American contexts; (4) the benefits and sensitivities that arise when working with refugee interpreters as long-term research assistants. However, when looking for guidance with these issues, I found almost no published studies and reports devoted to the distinct methodological challenges associated with conducting research with refugees.

Indeed, scholars have noted that the methodological challenges inherent to research with refugees may explain the tendency to exclude refugees as participants in health research with general populations (Premji et al., 2020; Ellis et al., 2007), as well as the paucity of intervention studies with refugee communities (Murray et al., 2010). In the few studies in which cultural adaptations and modifications *were* made, they are often only briefly addressed in published reports, as if they were only logistical or technical adjustments. Thus, for example, in a recent systematic review and meta-analysis, Charlson and colleagues (2019) found that studies on the prevalence of mental disorders in conflict-affected population "failed to report a robust process of translation, cultural adaptation, or validity testing of their instruments" (p.246).

Another important methodological issue often omitted from published articles is the role of interpreters in mental health research. In studies involving refugees, typically little or no information is provided about the interpreter's contribution to the research process. Researchers often only briefly acknowledge that an interpreter was involved in their study, and minimal attention is paid to the possible impact of their participation on the validity of the data gathered (Williamson et al., 2011) – even though working with interpreters in research with refugees is particularly sensitive. Indeed, a significant portion of interpreters working in refugee contexts are, in fact, refugees themselves and often share the same language, culture, ethnicity

and background of adversity as their clients (Crezee, Jülich, & Hayward, 2013; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Emerging research has indicated that when interpreters have a refugee background, they may require additional training and support, since they face unique and critical challenges in areas such as confidentiality, boundaries, and over-identification (Fennig & Denov, 2020).

Establishing trust and access is another important methodological challenge that often remains unaddressed in published studies. As Miller (2004) has highlighted, although the issue of access is a central methodological concern when conducting research with refugees, the vast majority of researchers fail to report "how they were able to enter the refugee communities in which they worked, or to what extent they were able to develop the sort of trusting relations that might have inclined the participants in their studies to provide truthful, accurate data"(p.218). Overall, the lack of attention to the unique methodological complexities of conducting cross-cultural mental health research with refugees is puzzling, given that by studying these accounts researchers employing both quantitative and qualitative methods would be better able to prepare for the complexities of field work with refugee populations and, ultimately, to produce more rigorous and accurate research.

In my study, the methodological complexities of conducting research with refugees were particularly pronounced when I attempted to adapt the GHQ-12 to the particular culture and context of Eritrean refugees residing in Israel. The challenges I encountered during the cross-cultural adaptation process led me to devote the final manuscript of my thesis to this topic. In this manuscript, I provide a transparent and critical account of the realities of cross-cultural adaptation, including a forthright discussion of the challenges I encountered, and the errors I made. By 'pulling back the curtain' and critically reflecting upon the methodological challenges involved in conducting cross-cultural research with refugees, I attempt to bring these issues out of the shadows and to offer possible solutions for addressing them.

My overall argument is that translation is not a merely technical problem—as it is often characterized in medical and psychological scholarship—but rather a highly nuanced, complex task that greatly influences the validity of cross-cultural findings. Thus, the study contributes to a

growing body of evidence suggesting that the assessment of individuals from refugee backgrounds presents its own specific characteristics and challenges, which need to be taken into account to ensure the validity of cross-cultural findings. It also provides evidence-based recommendations to researchers and practitioners wishing to cross-culturally adapt psychological measures.

Manuscript III: Cross-Culturally Adapting the GHQ-12 for Use with Refugee Populations: Opportunities, Dilemmas, and Challenges

Fennig, M. (in press). Cross-culturally adapting the GHQ-12 for use with refugee populations: Opportunities, dilemmas, and challenges. *Transcultural Psychiatry*.

Abstract

This article discusses the opportunities, dilemmas, and challenges involved in the cross-cultural adaptation (CCA) of psychological scales for use with refugee populations. It draws on insights derived from the research team's attempt to adapt the 12-item General Health Questionnaire (GHQ-12) to the particular culture and context of Eritrean refugees residing in Israel. Multiple techniques – expert translations, a focus-group discussion, a survey, and piloting – were employed to attain a cross-cultural and conceptually equivalent measure. During the CCA process, the research team encountered problems pertaining to conceptual non-equivalence, the structure of the measure's responses and scoring system, and acceptability. These problems required the team to move beyond semantic translation, by adapting certain items. This study demonstrates the compromises which need to be made in the adaptation process and indicates the potential bias which each of these compromises introduces. Despite its limitations, CCA does appear to significantly improve detection of mental health problems in refugee populations. Overall, the results of the present study provide support for the notion that the sensitive and appropriate assessment of individuals from refugee backgrounds requires adopting a rigorous, systematic, and contextual approach to instrument adaptation, with an emphasis on the integration of idioms of distress as well as the adaptation of Likert-type questions.

Introduction

Globally, the number of refugees and asylum seekers is the highest ever recorded (UNHCR, 2020). At the close of 2020, armed conflict, persecution, human rights violations and violence have driven more than 80 million people across borders in search of safety (UNHCR, 2020). Among the most profound disruptive consequences of conflict and global forced displacement

are mental health problems, particularly mild and moderate forms of depression, anxiety, and post-traumatic stress disorder (Blackmore et al., 2020; Charlson et al., 2019). Moreover, accurate *measurement* of these problems is crucial for establishing the burden of mental disorders in refugee populations, for conducting cross-cultural comparisons of symptoms, and for understanding "what works" in public health interventions and services (Tol et al., 2013). Indeed, the World Health Organization (WHO) Draft Global Action Plan "Promoting the health of refugees and migrants" (2019–2023) emphasizes the urgent need for reliable data to strengthen the evidence base of policies and programs focused on promoting the health of refugees and migrants (WHO, 2019)

Despite the importance of collecting robust scientific evidence, concerns have been raised about the cultural appropriateness of the traditional approach to measuring trauma and psychological distress in refugee populations. Currently, assessments conducted in refugee mental health research rely heavily on standardized psychological scales that were first developed in Western contexts and subsequently translated into local languages (Gadeberg et al., 2017; Hollifield et al., 2002, Gagnon et al., 2004; Davidson et al., 2010). Yet, dramatic inconsistencies in the prevalence rates of mental health disorders in conflict-affected populations were observed. These have been attributed to methodological errors in measurement, calling into question the common practice of simply translating Western assessment tools to non-Western cultures (Charlson et al., 2019; Steel et al., 2009).

Indeed, there is a growing consensus that the "single forward-and-back-translation procedure," popular in both research and practice, can result in poor translations when used on its own, and thus turns out to be an inadequate method for conducting and assessing quality in translated measures (Van Widenfelt et al., 2005; Kaiser et al., 2019). The gathering of data via poorly translated measures can, in turn, lead to misleading generalizations and conclusions, including under-recognition or misidentification of psychiatric morbidity, which may in turn result in the development and implementation of inapt, or even harmful, programs and policies (Allden et al., 2009).

Recognizing the drawbacks of mere translation, researchers have since demonstrated the value of employing an alternate, cross-cultural adaptation (CCA) approach which explicitly incorporates the local or 'emic' perspective of a particular refugee community into established assessment measures (Bolton et al., 2009). This approach rests on the assumption that cultural knowledge and practices shape the ways people perceive and express distress, and, as such, must be taken into account for measures to achieve local validity (Kirmayer & Ban, 2013).

However, the adaptation of scales is still nascent: no guidelines are available, and much of the adaptation process is constrained by the time and funding at the research team's disposal (Mendenhall & Kim, 2019). Moreover, few empirical studies have detailed the specificities of the CCA process, such as the steps taken by the research team to achieve equivalence between the original and the adapted questionnaires, or the changes made to items and response categories (Charlson et al., 2019). The dearth of empirical research on the adaptation process is puzzling; by studying these accounts, researchers would be better able to prepare for the complexities of cross-cultural research with refugee populations.

This paper aims to critically explore and reflect upon the challenges, dilemmas, and inevitable compromises involved in the cross-cultural adaptation of psychological scales for use with refugee participants. It draws on insights derived from the research team's attempt to adapt the GHQ-12 to the particular culture and context of Eritrean refugees residing in Israel. After describing the theoretical perspectives and debates underlying the study, the paper reports results from the adaptation process (which is part of a larger study exploring the on-the-ground lived experiences of psychological distress and well-being from the perspectives of Eritrean refugee adults residing in Israel). To critically assess if validity has been established, these results are then compared with interview findings derived from the second-phase of the study.

Our overall argument is that translation is not a technical problem – as it is often characterized in medical and psychological scholarship – but rather a highly nuanced and complex task that greatly influences the validity of cross-cultural findings. By pulling back the curtain on cross-cultural research with refugees, and providing a transparent, forthright, and critical account of the

realities of cross-cultural adaptation, the paper calls for a broader conversation about the complexities involved in translating individuals' emotional worlds across languages and cultures.

Theoretical background and debates: assessing mental health in refugee populations

Drawing on narrative theory and interpretive approaches, cross-cultural mental health researchers hold that cultural contexts shape how individuals and groups experience and express psychological distress (Kleinman, 1987; Mendenhall, Yarris & Kohrt, 2016). Correspondingly, for measures to achieve local validity, they must take account of local conceptualizations of mental health, particularly idioms of distress (Cork et al., 2019). *Idiom of distress* is a concept originally developed by Nichter (1981) to draw attention to the distinctive manners in which different cultural groups communicate or manifest distress, both verbally and non-verbally (Lewis-Fernández & Kirmayer, 2019). Since idioms of distress are salient to members of a specific community, they can be used to develop and adapt measures which will make sense to research participants and which will be consistent with local priorities (Jayawickreme et al., 2012).

Yet, there remains disagreement among cross-cultural mental health scholars as to the role of local conceptualizations of mental health in *instrument development*. On the one hand, those in favor of developing and using new local measures argue that refugees' local understandings of mental health should serve as the point of departure for instrument development. They insist that new measures can better capture the complexity and variance of local expressions of distress and resilience (Hinton et al., 2013). The development of these measures is often accomplished by employing a sequential mixed-methods approach (Bolton, 2009; De Jong & Van Ommeren, 2002). For example, Miller and colleagues (2006) collected narrative data from the war-affected population in Kabul to construct the Afghan Symptom Checklist, a measure which was then administered to the local population.

On the other hand, critics point out that creating new instruments can be time-consuming and expensive, particularly in conflict-affected contexts in which resources often are limited and immediate results are needed (Hollifield, 2002; Ellis et al., 2007). Accordingly, it may not be

feasible for cross-cultural researchers to develop a new instrument for each cultural community. Moreover, relying solely on local instruments and indicators may limit opportunities for aggregating findings in meta-analyses.

In the alternative cross-cultural adaptation (CCA) approach, local idioms of distress are incorporated into established assessment measures. Whereas mere translation solely focuses on achieving linguistic/literal equivalence, CCA takes both linguistic and cultural particularities into consideration, with the goal of producing a cross-cultural and conceptually equivalent measure (Bolton et al., 2009). To date, CCA has been employed in numerous countries and populations including Syrian refugees in Jordan (Panter-Brick et al., 2017), Iraqi refugees in the United States (Shoeb et al., 2007), and conflict-affected adolescents in Nigeria (Kaiser et al., 2019). Scholars supporting CCA highlight the need for "rapid action and results" in refugee contexts, deeming this approach more efficient and pragmatic than developing entirely new measures. Moreover, adapting standardized instruments can be advantageous when conducting studies involving the comparison of symptoms, disorders and risk/protective factors across cultures and settings (Rassmusen et al., 2014; Tol et al., 2013). Furthermore, transculturally adapting existing measures can facilitate the communication of research findings to actors beyond the academy who may support funding for mental health service development (Kaiser et al. 2013).

Nonetheless, CCA is a complex endeavor, requiring multiple steps and considerations (Epstein et al., 2015). This complexity stems, in part, from the difficulty of faithfully translating emotion words and mental-health concepts across languages and cultures. Researchers have demonstrated that some Western psychiatric categories are culturally determined and, as such, may not always fit with local cultural understandings and expressions of distress (Rasmussen et al. 2014). For example, Kohrt and Hruschka (2010) discovered that, in Nepal, there is no equivalent term for "post-traumatic stress disorder (PTSD)" as defined in Western cultures. Rather, psychological sequelae of torture, armed-conflict, and other negative life events are expressed through a wide range of idioms of distress. In such a scenario, simply translating items of a measure developed to capture the DSM-5 model of PTSD is of no avail. Instead, local idioms or new items need to be incorporated into the measure to capture how Nepalis make sense of psychological trauma.

In addition, there remains a lack of consensus regarding best practices for CCA (Epstein, 2015), particularly the desired degree of deviation from the original scale (Mumford et al., 1991). This continuing discussion relates to the conflicting objectives of CCA: on the one hand, the new measure should remain as close as possible to the original in content, format, and rationale; on the other hand, adaptations are necessary for the measure to perform, in the new context, the same tasks for which it was originally designed (Mumford et al., 1991). As Canino and colleagues (1997) asked in their now seminal paper: "How much local cultural diversity can be incorporated into an established diagnostic instrument before the degree of alteration renders the instrument incapable of measuring the original constructs for which it was designed?" (p. 163). These factors, combined with the lengthy time and significant cost of local adaptation and testing, make CCA a daunting task. Consequently, many researchers shy away from this critical element of cross-cultural research, which may impede the rigor of research and the validity of the final findings. It is against this backdrop that the present study was implemented.

Methods

Setting

The cultural adaptation process presented in this paper is part of a larger research project that was launched to address the unique plight of Eritrean refugees in Israel. The study was conducted over a six-month period, between November 2019 and May 2020. It was a partnership between the first author, a researcher at McGill University, and an Aid Organization for Refugees and Asylum Seekers in Israel (ASSAF), an Israeli non-governmental organization with a long-term presence in the country. ASSAF provides psycho-social support services to the asylum-seeking community in Israel, including individual treatment, advocacy, support groups, and humanitarian aid.

Due to the Eritrean government's repressive dictatorship, there are nearly 0.6 million Eritreans living in exile (UNHCR, 2020), with approximately 21,890 seeking asylum in Israel (PIBA, 2020). Many Eritrean refugees have experienced profound losses and have also undergone multiple traumatic experiences, such as torture, imprisonment, extreme deprivation, sexual and physical abuse, forced labor, human trafficking and witnessing violence or death (Gebreyesus et

al., 2019, Nakash et al., 2015; Van Reisen, & Mawere, 2017). In Israel, Eritreans have been living in a state of liminal legality for a decade. While they are recognized under Israeli law as non-removable persons, they are nonetheless denied access or rights to the labor market, education, organized healthcare or social services (Ziegler, 2015). They live in isolation at the margins of Israeli society, prevented from attaining meaningful integration by a series of deliberate laws and policies.

Among the Eritreans who have entered Israel, the vast majority come from Senafe and its surroundings; the capital, Asmara; and the Gash-Barka region in the west (Terdiman 2009). Most of the Eritreans in Israel belong to the country's largest ethno-linguistic group, Tigrinya, which account for about half of Eritrea's population, while some belong to Tigre, Afar, Bilen, Saho, and Rashaida (Terdiman 2009). Each of the nine different ethnic groups in Eritrea has its own language, customs, and traditions. Nevertheless, over time, profound intermingling between the various ethnolinguistic groups has taken place; as a result, some traditions are shared among groups (Bereketeab, 2010)

Tigrinya is spoken fluently by almost all Eritrean refugees residing in Israel, and is the primary language for most. It is presumed to have had derived from Ge'ez, a Semitic language, and is written using the Ge'ez script (Fidel), which is also used for Amharic in Ethiopia (Bereketeab, 2010). Slight differences exist between the different dialects of Tigrinya, and native speakers can generally tell whether a Tigrinya speaker comes from a certain region in Eritrea. The vast majority of Eritreans in Israel are Christian, almost all of whom belong to the Orthodox church. A minority of the community belong to the Catholic or Pentecostal churches, while a small percentage are Muslim (Sabar & Rotbard, 2015). Informal estimates indicate that 80% of Eritrean refugees are men (Gebreyesus et al., 2018). Approximately half of the Eritrean community reside in Tel Aviv and its neighboring cities (Tel-Aviv Yafo Municipality, 2021).

Although a significant portion of Eritrean refugees residing in Israel successfully adapt – despite the traumatic experiences they faced in Eritrea and en route to Israel – empirical evidence indicates extraordinarily high levels of problems related to mental health (Mayer et al., 2020). Moreover, the prolonged nature of displacement in Israel, with its associated uncertainty about

the future and persistent anxiety, is regarded as a major contributing factor to the mental-health deterioration of the Eritrean community (Fennig & Denov, 2022).

Procedure

Data was collected by the first author, an Israeli researcher at McGill University, who spoke Hebrew and English, alongside two Eritrean research assistants (RA), one male and one female, who spoke Tigrinya, Hebrew, and English. The present study began in 2019; before that, the first author had led a year-long training program with ASSAF for interpreters working in mental-health settings the refugee community in Israel, from December 2017 to December 2018. Relationships of trust and rapport was thus established with many refugees from the Eritrean community during this period, facilitating recruitment into the current study. Moreover, the lead author has over 10 years of research and work experience among African migrants in Israel, facilitating entry into the field and equipping her with valuable contextual knowledge.

Prior to the study's inception, research assistants were recruited from the interpreter training mentioned above. RAs were chosen for their extensive experience with interpreting in the mental health and psychosocial (MHPSS) field and their familiarity with the Eritrean community. Both RAs both came to Israel as refugees, belonged to the Tigrinya ethno-linguistic group, and, at the time of the study, had been residing in the country for approximately 9 years. They were trained for four days in the project's aims, methods, and techniques for recruitment, procedures, and issues of ethics and confidentiality.

The CCA process, which is the focus of the present paper, was part of the initial screening phase of the study, in which an adapted version of the General Health Questionnaire-12 (GHQ-12: Goldberg, 1978) and an adapted sociodemographic questionnaire were administered. The objective of this phase was to determine participants' eligibility to participate in the second phase of the study, which involved in-depth interviews. To be included in the latter, refugee respondents had to self-identify as having been exposed to trauma and as either currently suffering from mild to moderate psychological distress or having suffered in the past from psychological distress. In the initial research protocol, distress was to be determined

qualitatively, relying on refugee respondents' self-disclosure; however, the Research Ethics Board (REB) of McGill University requested that the research team either administer a screening instrument or have participants pre-interviewed by a qualified mental health professional. The REB wanted to ensure that respondents suffering from severe psychological distress be excluded from the study. In response, the lead researcher ultimately decided to determine the level of distress by administrating an adapted version of the GHQ-12.

With the assistance of ASSAF, participants were recruited using maximum variation sampling. Participants were recruited largely through face-to-face solicitation and flyer distribution, conducted by the first author and the RAs. A total of 39 participants took part in the screening phase of the study, of whom 34 proceeded to the interview portion of the study, while five individuals were excluded since they did not meet eligibility criteria. The in-depth interview portion of the study was conducted via a conceptually driven semi-structured interview guide with open-ended questions developed for the study and modelled after the DSM-5 Cultural Formulation Interview (CFI) (APA, 2013). Interviews elicited information on participants' definition of the problem and their perceptions of cause, manifestation, and possible treatment or support.

Data analysis was inspired by a grounded theory approach to develop emergent themes (Glaser and Strauss, 1967). Two main data analysis "feedback loops" (Whitley and Crawford, 2011) were used: one following 15 interviews, and the other following 25 interviews. We then identified *in vivo* codes—codes that participants use themselves to divide the world. More conceptual codes were then added. Finally, we generated themes by engaging in constant comparative analysis (Glaser & Strauss, 1967), looking across the whole data set to compare cases.

The sample of the screening phase consisted of 14 men and 16 women. Participants were aged 26 to 45 (M=33). Age at departure from Eritrea ranged from 15 to 30, with a mean of 18 years. Participants had been living in Israel for an average of 9 years, with a range of 7 to 14 years. Sixty per cent of participants were married with at least one child, 35% were single, and 5% were divorced, with children. Thirty-two participants self-identified as Christian, one as Muslim,

and one as Pentecostal. Participants' formal education varied, from 14 years to no education, with a mean of 10 years. All of the participants, except for three, were employed. Participants were paid 20 shekel (approximately 7 Canadian dollars) for participating in the screening and an additional hourly rate of 45 shekel (approximately 18 Canadian dollars) for participating in the interview.

Ethical Considerations

All study procedures were approved by the Research Ethics Board of McGill University. Research participants completed two consent forms: one for the screening phase, and another for the in-depth interview. This iterative consent approach explained the procedures for each phase and reminded refugees that their participation was voluntary, confidential and anonymous, and that they were free to withdraw their participation at any time.

All participants were provided with a list of referrals for receiving psychiatric or psychological services, free of charge. Participants who were identified in the screening or interview as particularly vulnerable received further assistance and support from the research team, who connected them with appropriate care services (e.g., social workers, shelters for domestic violence, community police).

Instruments

Translation and adaptation were completed for the General Health Questionnaire-12 (GHQ-12: Goldberg, 1978) as well as a sociodemographic measure used in previous studies on refugee mental health in Israel, which included demographic questions relating to gender, date of birth, religion, family status, employment status, income, years of formal education, years living in Israel (Nakash et al., 2017).

The GHQ-12 is a self-administered 12-item screening instrument for general (non-psychotic) mental health problems. Its application in research settings as a screening tool for psychological distress is well documented, with results demonstrating reliability and validity in community

samples in different cultural contexts (Hystad & Johnson, 2020; Anjara e tal., 2020). It consists of 12 questions assessing feelings of worry, stress, and inability over the past few weeks. Questions include: “Have you recently been able to manage your problems?” and “Have you recently lost much sleep over worry?” Items are rated on a 4-point Likert scale.

Our study used the original scoring by Goldberg, with response categories scored “not at all” and “no more than usual” as 0, “rather more than usual” and “much more than usual” as 1 (or the reverse depending on the question’s phrasing), giving a possible range from 0 to 12, with higher scores indicating more severe distress symptoms. To differentiate between individuals with and without psychological distress, we used a cut-off score of 3. Accordingly, people who scored 2 or under were considered to have good mental wellbeing; if they did not self-identify as having suffered in the past from psychological distress, they were excluded from the study. Respondents who scored 9 or higher were considered to be suffering from severe psychological distress and were also excluded from the study. This cut-off score is in line with reports from previous studies that employed the GHQ-12 to examine psychological distress in resettled adult refugees living in the community (Mölsä et al., 2014; Jordans et al., 2012).

Adapting the GHQ-12 - Rationale and Process

Rationale

To overcome certain methodological challenges, both study instruments underwent a rigorous cultural adaptation process. The lead researcher’s decision to employ this strategy was based on a number of important considerations.

First, prior to this study, no effective, culturally appropriate psychological assessment measures existed for Eritrean refugee adults. To be sure, important efforts have been made to assess the validity of a number of translated instruments for Eritrean populations (Netsereab et al., 2018; Amahazion, 2021; Almedom et al., 2007; Getnet & Alem, 2019). However, the majority of mental health studies with Eritrean refugees rely on translation/back-translation of instruments that have not been rigorously adapted for Eritreans (Mayer et al., 2020; Nakash et al., 2017; Leiler et al., 2019; Heeren et al., 2012; Kiat, Youngmann & Lurie, 2017).

Second, in order to enhance the study's feasibility given the limited timeframe and available resources, it was decided to adapt the GHQ-12 rather than to develop an entirely new instrument enhanced the study's feasibility. Although one of the main objectives was to use the final qualitative findings on local idioms of distress to develop a new screening instrument, the research team needed a reliable measure to determine if refugee respondents met inclusion criteria *before* commencing the interviews; as a result, the research team could not wait for the completion of the study to measure distress.

Third, while cross-cultural studies often rely on simple translation and back-translation of instruments, the rigor of the final product mostly depends on the translators' ability to identify and correct items which are incomprehensible, unacceptable, incomplete, or irrelevant (Van Ommeren et al., 1999). Although the research team valued the translators' professionalism, the lead researcher wished to put in place additional measures to avoid inadvertent mistakes in translation. Finally, while there existed a previous Tigrinya translation of the GHQ-12 (Kiat, Youngmann & Lurie, 2017), doubts had been expressed about the accuracy of certain items in this version (S. Gebremariam, personal communication, November 10, 2019).

The CCA Process

CCA was executed by following Van Ommeren and colleagues' (1999) five-step adaptation process, which has been widely used in cross-cultural mental health studies (Kaiser et al., 2019) (See Figure 1). The goal was to achieve equivalence along four dimensions: (1) Comprehensibility (linguistic equivalence) – the meaning of each item remains the same after translation; (2) Acceptability (technical equivalence) – the meaning and method of assessment is comparable in each culture with respect to the data that it yields; (3) Relevance (content equivalence) – the content of each item of the instrument is relevant to the phenomena of each culture being studied; (4) Completeness – the extent to which the item assesses the same concepts and ideas as the original (Van Ommeren et al., 1999; Flaherty et al., 1988).

First, each item was translated to Tigrinya by the study's bilingual RAs. Second, because Israel lacks mental health professionals proficient in Tigrinya, items were adjusted by a bilingual Eritrean student with a Bachelor's degree in psychology and experience with Western and Eritrean mental health concepts. Calling on trained mental health paraprofessionals – as opposed to clinical psychologists or psychiatrists – for the adaptation and validation of instruments is based on a procedure in previous studies in the context of limited availability of mental health experts (Kohrt et al., 2011; Bolton et al., 2001).

Afterwards, to make sure that the GHQ-12 included lay terminology that would be understood by all the participants (i.e., villagers speaking rather simple Tigrinya as well as more educated individuals coming from the city), the questionnaire items were evaluated by a focus group. The group was comprised of five young adults (*M* age = 27), all of whom had limited formal education. Next, the scale underwent back translation by a bilingual Eritrean interpreter who was not part of the research team and who was unfamiliar with the original items. The adjusted English version was then compared to the original English scale by the lead researcher to determine the completeness of the adjusted items. Finally, the modified scale was piloted on a small convenience sample of Eritrean participants who had no prior familiarity with the scale (n=10). Participants were individually asked to fill out the scale and report on any challenges they experienced.

At each step of the adaptation process, issues pertaining to the acceptability, relevance, and comprehensibility of each item in the GHQ-12 were assessed and recorded. Items that performed poorly on any of these equivalence measures were adapted. All adaptation procedures were conducted in English and Tigrinya. Hebrew, although used at times in informal conversations, did not factor into the CCA process.

Results

In the following section we report the changes that were made to the tools to address problems with conceptual non-equivalence, the structure of the measure's responses and scoring system, and acceptability (the Tigrinya version of the GHQ-12 is available upon request). To further

interrogate these changes and their appropriateness, findings from the interviews pertaining to Eritrean refugees' expression of distress are presented below.

The problem of conceptual non-equivalence

Participants in the focus group reported difficulty with understanding the GHQ-12 item referring to the experience of depression ("Have you recently been feeling unhappy or depressed?"). The study's RAs and the bilingual mental health paraprofessional stated that Tigrinya does not have an equivalent for the Western idiom of "feeling depressed." While, in the first stage of the adaptation process, the word *Chincket* (roughly translated as "distress") was used in the second stage this term was replaced by the bilingual mental health paraprofessional to *Kzane,* the formal Tigrinya term for depression. However, focus group participants were not familiar with the term Kzane and did not understand what it meant, later explaining that this term is rarely used and only employed by the educated elite or by health personnel.

The problem of non-equivalence, i.e., culture-specific terms, concepts, and expressions lacking equivalents in another culture, was overcome, in this case, by incorporating all possible phrases and terms that may be used by lay Eritrean refugees to describe depression-like problems and symptoms. To identify possible terms, the research team conducted a small-scale online survey among Eritreans (n=15) that inquired about the translation of the term depression ("How do you translate depression in Tigrinya?"). The survey produced nine different terms. The research team then checked and discussed the findings, removing any terms that did not share features with depression. The final terms included in the tool were *Zeyhgus* (roughly translated as "unpleasant"), *Kzane* (roughly translated as "depression") and *Chincket* (roughly translated as "distress"). The diverse answers generated in the survey demonstrate the lack of precise terminology in Tigrinya for "depression," which was interpreted by lay individuals in a multitude of ways. In the comparison of the adjusted English version to the original English scale, the fourth stage of the adaptation process, the researcher noted that although the Tigrinya idioms did not constitute a complete semantic or conceptual equivalent, the item retained the same ideas as the original and therefore determined it to be complete.

Interview findings both complement and complicate findings from the adaptation process. A pervasive theme throughout the interviews was the prominent role of local idioms in the expression of suffering. Participants reported rarely speaking about issues pertaining to mental health directly. Instead, they often expressed psychological suffering *indirectly*, through verbal and non-verbal idioms. Many of the verbal idioms were related to the mind, describing over-usage or exhaustions of its capacity such as: "*Bzuh mhasab" (thinking a lot)* and *"Ab aemroy selam ysen" (I don't feel peace in my head).* In addition, non-verbal somatic presentation of distress was common among participants. In particular, various symptoms related to the head were often mentioned. These included both mental symptoms (forgetfulness) and somatic symptoms (dizziness, poor sleep, and severe headaches).

The few Tigrinya idioms that were used by participants to express emotion *directly* took on different meanings which varied according to how these were expressed, along with the corresponding context. The same idiom was often employed to communicate diverse experiences – from mild distress to severe psychopathology. As S, an Eritrean interpreter working in a mental health clinic in Israel and one of the study's participants, explains:

> *Chincket*, for example, includes everything. People can use *chincket* for depression, for anxiety, also for stress. There is also the word *tsekti* but *chincket* they can also use it for fear, for panic, for worry. So it's really important that we pay attention. Because there are not a lot of words and the patients are used to using this word, *chincket*, for everything. But what makes it different is the tone and body language like (makes noise with mouth). We have gestures that we use, not in all the cases but in a lot, to distinguish between this case and that. So it depends how the patient is expressing this to you, and then you can associate it to what he means if it's depression, anxiety or stress or fear or maybe he is preoccupied with something.

It's important to note, that throughout the adaptation process, the research team emphasized the need to maintain linguistic accuracy, while keeping the translations simple and clear enough to be easily understood by Eritreans from all educational backgrounds. In the first stage of the adaptation process there were several instances where one of the RAs used more formal language

than was used by local people to express the same concept. In these instances the local term was ultimately selected. For example, in Question 7 ("Have you been able to enjoy your day-to-day activities?"), the word "enjoy" –first translated as "Tzane," a formal term – was eventually replaced with "Des," a more common, simpler term.

Structure of responses and scoring system

The instrument's use of severity levels on a Likert scale generated confusion for participants in the pilot. The response options in the English GHQ-12 are "not at all," "no more than usual," "rather more than usual," and "much more than usual." During the pilot test, participants reported that these response categories sounded strange and abstract**.** Every participant who completed the instrument in the pilot had trouble with answering questions posed in this manner. They did not understand why they could not simply provide a "yes or no" answer; in other cases, they wished to expand on their answers with additional information.

Therefore, to ensure understanding of the instrument, the lead researcher decided to prepare it for administration by the study's RAs while retaining its original format (the Likert scale). A similar strategy has been used in other cross-cultural mental health studies (Ali et al., 2016). The GHQ-12 was originally designed for self-administration; however, due to the unforeseen difficulty regarding the Likert scale format as well as participants' varying education and literacy levels, it was decided that, when necessary, the bilingual Eritrean RAs would read the scale items to respondents in their own language and then record their response. When requested, the RAs would also provide short explanations regarding the instructions.

While this decision helped to ensure understanding of the instruments, it is possible that the RAs' sociocultural identities may have influenced participants' responses. There were three incidents, for example, in which participants, all male, received a low score (0-2) after having completed the scale with the assistance of an RA. Although participants rarely received a low score in the GHQ-12, this experience led the research team to pay greater attention to the influence of the RA's presence on participants' responses.

The research team's intuitive suspicion regarding the RAs' potential influence is reinforced by empirical findings derived from the interviews. Participants' narratives revealed that issues pertaining to mental health were rarely shared with others. Participants often made a conscious effort to conceal their emotions, even from close friends and their own family members. This included actively refraining from talking about traumatic events, strong emotions, and symptoms. As expressed by one of the participants: "From a young age we learn to be afraid and we keep it locked inside." (Male, age 35). In light of these findings, it is quite possible that some participants tailored their responses according to their perception of the kinds of feelings they believed would be culturally appropriate for them to share in the presence of the RAs who came from the same refugee community.

Another element related to technical equivalence was the Likert scoring system of the measure, which was also found to be problematic. During the administration of the final scale, several participants expressed confusion and anxiety related to the scoring of the GHQ-12. Although participants signed a consent form explaining the purpose of screening activities prior to enrolment, several perceived the measure as a test in which there was a right or wrong answer. Those who scored either too high or too low to be considered for the study were visibly upset and confused when told that they could not be interviewed. Many of them were offended by their exclusion from the study and requested a chance to retake the psychological measure promising that "they will get the correct score this time." It was only after a lengthy explanation relating to the risks of participation that respondents seemed to comprehend the purpose and implications of the measure and of the screening procedure.

Acceptability

On the demographic questionnaire, the item inquiring about participants' income level raised acceptability concerns in the pretest, due to the context of extreme poverty and lack of services. The RAs reported that the question may have made the participants feel uncomfortable or embarrassed. They explained that participants may also have assumed that a question about income implied that they might receive benefits or services in return for interviewing, possibly leading them to report a lower income in order to become eligible for such services.

Consequently, to avoid offending respondents or engendering false expectations, the question relating to income was excluded.

Lastly, Question 3 ("In the past 30 days have you felt that you are playing a useful part in things?") was found to be a weak item in the pretest. Five out of the ten participants did not understand the question, and requested explanations. Our adaptation team experienced difficulty with translating the phrase "in things" into Tigrinya. While it was decided not to omit the question entirely for fear of compromising the validity of the original instrument, further piloting is needed to determine the best way to phrase this item.

Discussion

Our findings illustrate the possibilities and pitfalls of the CCA approach, by describing how it was used to adapt the GHQ-12 to the particular culture and context of Eritrean refugees residing in Israel. They provide support for the notion that sensitive, appropriate assessment of individuals from refugee backgrounds requires adopting a rigorous, systematic, and contextual approach to instrument adaptation, with an emphasis on integrating idioms of distress while adapting Likert-type questions.

Integrating idioms of distress

The difficulties we encountered in identifying Tigrinya equivalents to the term "depression" resonate with previous studies that have adapted psychological scales for use with Eritrean refugees (Getnet & Alem, 2019; Almedom et al., 2007). These studies ran into similar difficulties when transferring concepts cross-culturally. For example, when administering an adapted "sense of coherence" scale (SOC-13) to measure resilience in Eritrea, Almedom and colleagues (2005) note that many of the participants "questioned the content of the SOC-13 scale during the process of its administration." (p. 96). They had particular difficulty with the SOC-13 assumption that well-being is an individualistic phenomenon. For the participants, by contrast, resilience and well-being was often seen as a collective experience, embedded in their family and community networks. As such, typical responses to the scale included "'How can you ask such a

question?"; "I wouldn't be human if I didn't care about what goes on around me, would I?"; ". . . no, this is not in our culture [i.e., not to care about what goes on around oneself], of course I care and try to do something about it, if I can"; ". . . if I didn't care about what goes on around me, I might as well be dead." (Almedom et al., 2006, p.96).

The lead researcher's final decision to modify the GHQ-12 by inserting idioms of distress into the instrument's item referring to depression was appropriate for the needs of the present study – i.e., the adaptation of a brief mental-health screening instrument for non-specific psychological distress. Although the Tigrinya idioms did not constitute a complete semantic or conceptual equivalent, the decision to include them all in the final adapted instrument ensured that several possible interpretations of the construct were included in the final scale. While there may have been slight deviances from the intended meaning, this strategy retained comprehensibility.

This strategy may, however, be inappropriate for adapting assessment/diagnostic tools to the detection of specific disorders requiring far greater accuracy and sensitivity than screening instruments. The study's findings, along with other studies on Eritrean refugees' mental health (Author's own, 2022), suggest that distress is more commonly expressed through somatic symptoms and local idioms of excessive thinking. These important findings were missed in the survey conducted as part of the CCA process – suggesting that, to elicit idioms of distress, rapid surveys cannot replace in-depth narrative interviews.

Moreover, the research team's difficulties with transferring concepts cross-culturally highlights the general complexities of translating mental health concepts across languages and cultures. Indeed, the idioms of distress included in the adapted GHQ-12 are not semantic equivalents of "depression"; rather, they are distinct idiomatic expressions embedded in larger cultural frames and systems of knowledge which cannot be perfectly captured by translating practices. As Good and Good (1986) note:

> In general, however, the referents of symbols, i.e., their meanings are aspects of a culture or a life world, not objects outside of language through which language obtains meaning. "Heart discomfort" for Iranians is not the equivalent of "heart palpitations" for Americans;

> it does not *mean* the same thing (Good 1977). It is a symbol that condenses a distinctive set of meanings, a culture-specific "semantic network," for Iranians. Complaints of feeling impure in India refer to a semantic domain of profound cultural significance, one that regulates caste, sexuality, and social hierarchy; there simply is no equivalent among Americans (p 36).

To improve our understanding of what is 'at stake' when Eritrean refugees say "*chincket*" – what *they mean* – we need to explore what this term conveys, both to the individual and to the larger Eritrean community in the *local context* (Lewis-Fernández & Kirmayer, 2019). The emphasis on context here is crucial since, as with other idioms of distress (Kaiser et al., 2013), the meaning of "*chincket*" may vary according to education, gender, duration of stay in the asylum country and context of use. In this vein, future research could employ ethnographic methods to explore the complex web of meanings and modes of interpretation related to this idiom, and others.

Adapting Likert-type scales

Regarding the difficulties our study participants experienced with the Likert-type scale, it should be noted that this challenge is not unique to Eritrean refugees. Other scholars working in the cross-cultural mental health field have encountered problems when administrating instruments with Likert-type questions to their non-English-speaking refugee respondents (Baird et al., 2017; Ellis et al., 2019; Flaskerud, 2012). In these contexts, the very process of answering a questionnaire is often unfamiliar. As a result, researchers may end up eliciting responses which represent a misunderstanding of intentions rather than an accurate reflection of respondents' emotional state (Kleinman, 1987). Indeed, the significant methodological difficulties relating to this format have sparked an ongoing debate concerning the cultural validity of Likert-type scales, leading scholars such as Flaskeurd (1988) to ask: *"is the Likert scale format culturally biased?"* (p. 185). To which Flaskeurd further argues that "invalid or meaningless data may be derived from such scales, especially when they are used with culturally diverse participants and those with little formal education" (Flaskerud, 2012, p. 132).

Some of the shortcomings of research with self-report Likert-type scales in refugee populations can be addressed by piloting alternative approaches to quantifying symptom severity, such as the use of locally developed illustrations. For example, in Uganda, Bolton and Tang (2002) used illustrations of a person carrying an increasingly heavy weight to represent severity levels on a local function assessment instrument. Retaining the Likert-type scale and hiring interpreters/RAs to verbally administer the scale, as was done in the present study, is not recommended, however, since it may introduce bias and significantly compromise the validity of the adapted scale.

As demonstrated in the present study, interpreters administering the scale may intentionally or unintentionally alter the responses collected from participants. Our findings regarding participants' tendency to conceal emotions suggests that the outward expression of negative emotions among Eritrean refugees is discouraged. We speculate that this tendency may be more pronounced among Eritrean men. However, our small sample size precluded examination of variation based on gender and other demographic factors, but it is an important element for future research.

Cultural norms and expectations relating to disclosure of distress may have influenced responses provided in the presence of the study's RAs who came from the same refugee community. Participants may have provided what they feel are socially desirable responses, under-reporting mental health symptoms and problems that were viewed as undesirable and over-reporting socially desirable characteristics and behaviors. Despite the possibility of bias, the decision to administer the GHQ-12 with the assistance of the team's RAs increased the study's local validity. However, it may have come at the expense of achieving reliability, comparability and standardization.

More broadly, our finding regarding the measure's scoring system highlights that special care should be taken to ensure that refugee participants fully understand the purpose of screening. Refugees often come from contexts which generally have inexistent, or only nascent, histories of social research**.** As a result, screening procedures intended to assess who is eligible to participate in the final study can be confusing or appear unfair, particularly if participation in a study is perceived as providing some sort of benefit (Seagle et al., 2020). In these contexts, consequently,

researchers should take additional steps to ensure that participants fully understand the scale, its objectives, and items. This may seem self-evident, but it is not routinely done.

Encouraging the disclosure of translation errors

Although not direct findings of the study, the research team encountered some challenges with the adaptation process which deserve noting. In the present study, power disparities between the research team and the refugee participants (arising from differences in social location, race, socio-economic status, and gender) at times precluded the full disclosure of translation errors. Identifying errors in the scale was often interpreted by participants in the focus group and pilot as challenging the authority of the lead (Western) researcher and, as such, avoided. Participants would often prefer to randomly select an answer than admit to the lead researcher that they didn't understand a question on the scale – only later revealing this choice to the Eritrean RAs.

In refugee contexts, consequently, researchers should not assume that participants' completion of the full scale is an indication that they have fully understood all its items or endorsed the translated version of the scale. Although power issues are present in every study, they are exacerbated when the participants are refugees – a population that is often considered particularly vulnerable due to the multiple challenges they face, including trauma, limited political protections, and poverty (Seagle et al., 2020). Building trust with participants and emphasizing that they may comment on mistakes or misunderstandings is essential if researchers are to gather truthful and accurate data reflecting refugees' actual beliefs and feelings. Involving refugees themselves in the adaptation and administration of the scale process (e.g., as RAs or members of expert committees) is one promising strategy that can help build trust and mitigate potential methodological and ethical weaknesses.

Conclusion and Implications for Research and Practice

This paper has aimed to increase the evidence base on the cross-cultural adaptation of psychological scales for refugees populations, by exploring the challenges involved in adapting the GHQ-12 to the culture and context of Eritrean refugees residing in Israel.

Several difficulties emerged pertaining to conceptual non-equivalence, the structure of the measure's responses and scoring system, and acceptability. Overall, the results of the present study contribute to a growing body of evidence suggesting that the assessment of individuals from refugee backgrounds holds its own specific characteristics and challenges, which need to be taken into account to ensure the validity of cross-cultural findings (Davidson et al., 2010).

The difficulties encountered in the CCA process hold several important implications for researchers and practitioners wishing to cross-culturally adapt psychological measures for refugee populations. Correspondingly, several key recommendations are provided bellow:

1. Cross-cultural adaptation is an imperfect process. This study illustrates the inevitable compromises in the adaptation process and the potential bias that each of these compromises introduces. Despite its limitations, CCA appears to significantly improve detection of mental health problems in refugee populations.

2. Cross-cultural adaptation should be preceded by ethnographic work. The research team's failure to capture the full range and nuance of Eritrean refugees' local expressions of distress in the adaptation process emphasizes the necessity of combining CCA with in-depth, and preferably long-term, ethnographic engagement.

3. The assessment of individuals from refugee background holds its own specific characteristics and challenges which need to be considered in the adaptation process. Our findings demonstrate that refugees possess unique cultural systems of knowledge while lacking familiarity with psychological scales. Moreover, they suggest that issues of power and trust are more pronounced when working with refugee populations.

4. Cross-cultural adaptation can be a tedious process, requiring a significant amount of resources and time to complete. In our initial research protocol, the lead researcher did not plan to administer a screening instrument, let alone to undertake a multi-step adaptation process. This delay came as a reminder of the complexity of cross-cultural work. In retrospect, since the purpose of the study was not to compare data across cultures, it might have been simpler and

more effective to have had a clinician conduct a culturally sensitive assessment interview with the help of a highly skilled interpreter.

5. In adaptation studies, researchers should select a broad sample. This will make for a well-rounded tool that includes the perspectives of individuals with the whole range of distress. With respect to this study, our exclusion criteria (those who were suffering from severe mental illness) were put in place to protect participants from potential harm; by the same token, it prevented us from exploring their subjective experiences and thus limited the reliability of the adapted GHQ-12. Futures studies may wish to cross culturally adapt the GHQ-12 for use in more severely distressed patients.

6. Validation is a crucial final step in any adaptation process. The small size of our research team – one investigator and two RAs from the Eritrean community – and our limited resources prevented us from conducting a cross-cultural validation study before administering the instruments. This limitation could have affected the study findings.

7. In Israel and in other countries in which Eritrean asylum seekers and refugees reside, practitioners working in clinical and community settings often have neither the time nor the training to administer complex diagnostic interviews for detecting common mental disorders and psychological distress (Kiat, Youngmann & Lurie, 2017). This lack of diagnostic capacity could be remedied by locally validating our adapted GHQ-12 and integrating it into the assessment of refugee clients. It's important to note that the Tigrinya version of the GHQ-12 was adapted from the original English version. Clinicians wishing to use the Hebrew version of the GHQ-12 would need to repeat the CCA process.

8. Irrespective of how much care and attention is allocated to processes of adaptation, the extent to which mental health concepts can be translated across languages and cultures is still open to debate. Can the emotional worlds of individuals be faithfully translated (Barrett, 2017; Kleinman & Good, 1985)? These and other important epistemological and methodological questions will continue to challenge researchers seeking to conduct cross-cultural measurement. Hopefully, the current study will stimulate further investigation of this important area.

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Discussion

The purpose of this exploratory research project was to gain a better understanding of Eritrean refugees' interpretations of the effects of trauma, torture, loss, and protracted displacement, as well as their subsequent coping strategies. This research gave rise to three complementary manuscripts, each providing a window onto Eritrean refugees' lived experiences of psychological distress and well-being.

Liminality and Coping

In the course of my fieldwork, many refugee participants recounted the indignities of waiting for status, prolonged uncertainty, and the degradations of protracted displacement. In their narratives of illness, participants detailed descriptions of bodily complaints and symptoms – headaches, chest pain and intrusive thoughts – which broadened into more general stories of suffering. One participant described permanent headaches and disturbed sleep, plagued by memories of the repetitive beatings with metal chains and rods he endured in Egypt's Sinai Peninsula. Another told me how he is no longer himself since the year he was incarcerated in the 'Holot' detention centre. Years after his detention, he is still haunted by nightmares of the dark jail cell accompanied by a paralyzing tightness in his chest. And then there was the despair of the mothers who could hardly speak when the conversation turned to their children who were left behind in Eritrea. Interrupted by long stretches of uncontrollable crying, they told me they never imagined that they would be kept apart from their children for over a decade.

These narratives integrated traumatic post-migration memories (oppression, torture, loss) with ongoing extended exile (liminal status, prison, poverty, racism) and their devastating traumatic effects (severe anxiety, demoralization, desperation). Bodily symptoms, past trauma, and the oppressive social context merged. Participants viewed their debilitating mental health symptoms as inherently connected to their state of liminality. Israel, which was supposed to be a country of asylum and protection – a context in which refugee participants were supposed to mend and heal their physical and psychological wounds – was instead experienced as a demeaning environment marked by confinement, poverty, injustice, insecurity, isolation, and endless up-rootedness.

Indeed, conditions of imposed liminality profoundly shaped and affected the mental health of Eritrean refugee participants. This liminality was not simply a juridical status or a spatial/temporal situation, but also an ontological experience that significantly constrained refugees' opportunities and shaped their sense of self, identity, and well-being. My findings thus highlight the negative mental health consequences of living in a state of protracted limbo. They demonstrate how violence is deeply embedded in Israel's migration policies and discourses (public and political), with a profound and long-lasting negative impact on participants' well-being and rights.

Moreover, these results are consistent with previous studies that have established an association between visa insecurity and negative mental health outcomes (Nickerson et al., 2019; Steel et al., 2011; Momartin et al., 2006). Studies have found that refugees with temporary visas have greater incidence of post-traumatic stress disorder (PTSD), depression and suicidal ideation when compared to those with secure visas (Newnham et al. 2019; Nickerson et al. 2019). Temporary status has been frequently associated with an elevation of mental health symptoms, such as anxiety, hopelessness, and the risk of psychiatric disorder (Posselt et al. 2020). The few studies focusing on refugee children and youth found that insecure asylum status was significantly associated with high PTSD scores (Heptinstall et al., 2014). In addition, displacement stressors related to the protracted displacement environment, particularly immigration detention (Zwi et al., 2018), protracted stays at asylum centres (Nielsen et al., 2008) and family separation (Lidell et al., 2022), have been shown to be detrimental to both refugees' mental health (among adults and children).

At the same time, participants did not equate protracted displacement with passive waiting. Rather than simply being passive recipients of professional assistance, refugees often activated their health care by actively coping with their distress and deciding when and whom to consult and engage within the help-seeking process. Coping strategies were rooted and shaped by the Eritrean cultural context – systems of knowledge, values, and cultural perspectives – suggesting that the sociocultural context of coping may be an important factor to consider in efforts to understand and treat refugees' mental health problems.

One of the key findings of the study was participants' engagement in religious and supernatural practices to cope with protracted limbo and adversity, underscoring the prominence of the Eritrean Orthodox church for the refugee community. Spiritual beliefs and practices – praying, listening to Hymns (*Mizmor*), reading the bible, attending church – were employed by participants suffering from psychological distress instead of, or alongside, formal mental health services. They served as important sources of emotional and cognitive support, helping participants to nourish hope and create meaning amidst ongoing traumatic stressors. Spiritual beliefs and practices served as a first-line and, at times, sole treatment for problems associated with psychological distress. Traditional treatments, including treatment with *Maychelot* (holy water) and treatment in the case of Buda possession, were also important sources of healing and care. The positive impacts of faith-based coping are consistent with recent studies with Eritrean asylum seekers that point to the salience of spirituality in the daily lives and wellbeing of Eritreans (Abraham et al., 2022; Melamed et al., 2019).

The integration of spiritual beliefs and practices into the therapeutic process therefore appears to be an important and culturally appropriate approach which may relate to the inner world of many Eritrean refugees. This notion is in line with a growing body of literature that highlights the important role of religious and spiritual coping in the trauma-recovery process (Bryant-Davis & Wong, 2013; Chen & Koenig, 2006; Schaefer, Blazer, & Koenig, 2008). It is further supported by the finding that religious practices were viewed as more accessible and less stigmatizing than formal mental health services. Since Eritrean religious and supernatural practices, such as treatment with *Maycholot* or going to church, are used for various diseases as well as maintenance of general health and wellbeing, they do not carry the stigma that formal mental health services often do (Habtom, 2015). It is noteworthy that the phenomenon of sending individuals with severe mental illness for local treatment in Eritrea has not been reported in other studies, calling for additional research to understand its beneficial and harmful outcomes.

Explanatory models and idioms of distress

The ways in which participants made sense of or interpreted their trauma-related experiences and symptoms profoundly influenced their coping strategies and their motivation to seek out

assistance or treatment. These understandings both differed and coincided with the biomedical or biopsychosocial models of illness commonly privileged by western-educated clinicians. Similar to the biopsychosocial model, Eritreans often understood their symptoms to be the results of pre-migration experiences of war-related violence and loss. Given the wide and established literature on the direct effect of exposure to violent conflict and torture on mental health – and PTSD in particular – this finding is not surprising (Steel et al., 2009; Miller & Rasmussen, 2017). A finding that is surprising, however, is the prominence of ongoing displacement stressors related to the protracted displacement environment in participants' explanatory models. Out of these, the most prominent stressor was participants' liminal status, which contributed to a chronic sense of uncertainty and anxiety for the future. This finding draws attention to the significant influence of liminal status on refugees' levels of distress as well as the importance of further examining the concept of liminality in relation to refugees' mental health and wellbeing.

Participants also attributed their symptoms to causes that did not readily align with Western models. These causes, which appear to be firmly rooted in Eritrean culture and local context, include supernatural causes such as possession by demonic entities (*Diablos)* or evil eye (*Buda/Tabib),* or viewing their distress as a result of 'thinking too much' – an idiom used by Eritreans to describe the dangers of excessive worry and intrusive rumination. To my knowledge, no prior studies have focused primarily on Eritrean refugees' explanatory models. Nonetheless, my results largely concord with findings of the small body of literature in Eritrea which explored perceived causes of mental illness (Amahzion, 2021; Adgoy & Habtemariam, 2018) as well as with studies on casual attributions which included Eritrean refugees in their samples (Grupp et al., 2018). These findings suggest that cultural attributions/explanatory models may play a key role in the preference and acceptance of certain types of mental health treatment and may affect refugee patients' adherence to treatment.

At the same time, supernatural explanations were reserved for *others* and were not used by participants to explain their *own* distress. One possible interpretation of this finding is that possession or evil eye were associated with behaviors such as hallucinations and impaired reality testing, which could conceivably be indicative of a psychotic illness (Asher et al., 2021). Since my sample did not include individuals suffering from severe mental illness, participants spoke of

neighbors and relatives rather than of themselves. It is difficult, however, to directly map the participants' classification onto psychiatric taxonomy, particularly since identifying cultural syndromes was not the focus of this study.

It has been rightfully noted that explanatory models (EMs) may change across time and circumstances (Williams & Healy, 2001). The study's findings relating to the multiplicity of EMs may be an indication that Eritreans' EMs are continuously being redefined and reconstructed during the forced migration process. While in Eritrea supernatural explanations remain extremely popular (Amahazion, 2021), my findings suggest that among the community in Israel they are slowly giving away to biopsychosocial explanations. Relatedly, nearly 50 percent of participants reported accessing formal health and psycho-social services, suggesting an increased acceptance of Western mental health care. The diminishing of supernatural explanations for mental illness and the acceptance of Western models of care may be explained by participants' young age at departure coupled with their exposure to Western ideas of mental health together with their growing distance from Eritrea. At the same time, Eritrean understandings of healing, including notions of spirits and treatment, continue to be important in exile – pointing to both the persistence and the transformation of traditional conceptions of mental distress.

This 'continuity and change' in EMs has been observed in other studies on war-affected refugees residing in other high-income countries (Aarethun et al., 2021; Molsa et al., 2010). Taken together, these findings point to the importance of accounting for the ways in which Western models of health interact with local ideas of health and wellness. Longitudinal studies are needed to study the dynamic changes of explanatory models over time and their potential influence on attitudes and actual behaviors with regard to seeking professional help, especially in the context of forced migration and resettlement.

Although Eritrean refugees have been residing in Israel for over a decade, concepts of depression and PTSD were foreign to the participants. Findings from in-depth interviews reveal that in both their day-to-day and their clinical encounters, Eritrean refugees seldom used western vocabulary to describe their psychological distress. Instead, distress was more commonly expressed through somatic symptoms (dizziness, poor sleep, and severe headaches) and local idioms of excessive

thinking ("*Bzuh mhasab" (thinking a lot)* and *"Ab aemroy selam ysen" (I don't feel peace in my head)*.

The tendency to express distress indirectly may be explained by the fear of stigma associated with mental illness, which has led Eritreans to find alternative ways of expressing their distress as a means of legitimizing a clinical visit and avoiding stigmatization (Keys et al., 2012). For example, instead of using the word *'chincket'*, one of the few words that Eritreans use to express psychological distress directly, a patient may share that he is suffering from *'hamam resi'*, an idiom which literally means headache but may also be used to communicate psychological distress and may mean: 'I have a problem in my head', 'I am suffering from psychological distress and need help.' In this case, a physical interpretation alone will not suffice and may cover up the psycho-social suffering that the patient is trying to convey.

Moreover, it is important to note that even the few idioms that were employed by participants to express distress *directly* have been found to hold multiple meanings, and are not synonymous to any specific psychiatric construct. This finding is in line with a large body of scholarship that has examined idioms of distress within war-affected populations (Hinton & Lewis-Fernández, 2010; Lewis-Fernández & Kirmayer, 2019; Rasmussen et al., 2011; Miller et al., 2009). These studies have found complex local categories which, while having some overlap with Western psychiatric constructs, were not fully synonymous terms. Findings of my study provide preliminary evidence regarding the psychosocial dimensions of local idioms of distress and call for further exploration. To improve our understanding of what is 'at stake' when Eritrean refugees say local idioms such as *'hamam resi'* or "*chincket*" – what *they mean* – we need to explore what these terms convey, both to the individual and to the larger Eritrean community in the *local context* (Lewis-Fernández & Kirmayer, 2019). The emphasis on context here is crucial since, as with other idioms of distress (Kaiser et al., 2015), the meaning of local Eritrean idioms may vary according to education, gender, duration of stay in the asylum country and context of use. In this vein, future research could employ ethnographic methods to explore the complex web of meanings and modes of interpretation related to these idioms, and others.

Silence and Social Support

An important finding has been the salience of suppression, concealment, and silence as coping strategies. Many participants reported attempting to suppress their thoughts and emotions in order to manage their distress. For many participants, any form of speech, even internal speech, was viewed as a threat to their ability to continue functioning in a highly stressful environment. Others avoided sharing their distress or seeking help from informal and formal sources for fear of eliciting disapproval or being perceived negatively by family and community members. For these participants, silence enabled the avoidance of stigma, community gossip, and public shaming which was often perceived to be more debilitating than symptoms themselves. This is consistent with previous research, whereby mental health stigma associated with symptoms of mental illness have been shown to be a key barrier to help-seeking among refugee populations (Byrow et al., 2020).

Taken together, my results suggest that for populations who have experienced extreme trauma and who continue to struggle for survival in situations of protracted displacement, suppression and silence can be adaptive coping strategies. The adaptive possibilities of silence are consistent with previous literature with non-western war-affected groups. Researchers have noted that for populations affected by war and displacement, the use of concealment strategies, silence, and forgetting are often regarded as a culturally appropriate means of dealing with trauma and distress. For example, Eastmond and Selimovic (2012) have noted the importance of silence and 'forgetting' in facilitating coexistence in post-war Bosnia and Herzegovina. Silence, they note, was a pragmatic and, at times, successful strategy for coexistence and a form of collective healing: "A consensual and tacitly agreed upon means of avoiding the personally painful and the socially disruptive" (Eastmond and Selimovic, 2012, p.66). In a similar vein, Goodman (2004) shows the ways in which suppression of traumatic memories and their associated feelings contributed to Sudanese youths' perseverance and, ultimately, survival, in spite of tremendous trauma and struggle.

In the mental health literature, silence is often understood as a form of denial or avoidance, and as such an inherently maladaptive coping strategy that promotes poor long-term psychological

outcomes (Waugh et al., 2020). My study, on the other hand, demonstrates that silence may not always be maladaptive. My findings highlight the possibilities of silence in a highly stressful and demeaning environment marked by confinement, poverty, injustice, insecurity, isolation, and up-rootedness. In such environments, silence can be a culturally appropriate coping mechanism that enables refugees to moderate or regulate their distress while maintaining positive psychological functioning. This strategy, in turn, positively influences their capacity to negotiate the many challenges of life in protracted displacement. As Eastmond and Selimovic (2012) note: "…*there are other ways of* conceptualizing the paths to closure, healing and justice that rely more on evocation than on speech, more on forgetting than on memory."

Past researchers have similarly pointed to the discouragement of outward expression of negative emotions among Eritrean refugees (Mouton et al., 2019). Yet, they have offered an alternative explanation. They attributed Eritrean refugees' tendency to avoid expressing and sharing negative impacts or thoughts to a "learnt lack of emotionality in response to terror", explaining that due to the climate of fear in Eritrea, most Eritreans have internalized a form of self-censorship (Mouton et al., 2019, p. 416). Eritreans, they explain, have learned that expressing negative emotion (fear, anger, sadness) may be dangerous, since it can interpreted as a criticism of the government. While I find this explanation plausible, I found no evidence for it in my research.

At the same time, for many participants in my study, attempts at 'forgetting' and 'silencing' were, in the long-term, largely unsuccessful. Many participants reported being unable to suppress their thoughts and emotions over time. A possible explanation for the lack of success may be related to the context of protracted displacement, which renders refugees' attempts to suppress or even recover from trauma and torture-related psychopathology futile. One of the basic tenets of trauma-recovery is the establishment of safety and security. Judith Herman (2015), writing in her widely cited book *'Trauma and Recovery'* which has been revered as the seminal text on understanding and treating survivors of trauma, notes that establishing safety is the first and most important stage in the trauma rehabilitation process. According to Herman (2015) "this task takes precedence over all other, for no other therapeutic work can possibly succeed if safety has not been adequately secured" (p. 159).

For participants, however, establishing spaces and contexts that were both physically and psychologically safe was close to impossible. Participants were continuously exposed to powerful forms of structural violence, including suppressive laws and policies, and accompanying social and political stressors such as discrimination, detention, uncertainty regarding temporary status, and a lack of access to basic resources, all of which precluded a sense of safety and belonging. These forms of structural violence were experienced alongside significant mental health symptoms. While participants' efforts to silence their thoughts and emotions may have been regarded as a means to protect their overall health and well-being, the cumulative burdens of displacement stressors and structural violence appear to have nonetheless limited their ability to entirely suppress or process traumatic memories while coping with the daily challenges of protracted displacement.

A sizable literature has shown that social support can often moderate the relationship between trauma exposure and posttraumatic stress (Sippel et.,2015); despite some limitations, these networks were important coping resources for many participants. Indeed, the findings of the study demonstrate that refugees are often aware of their needs and often organize among themselves, whether through faith-based organizations or informal networks, to support vulnerable members of the community. Yet, extended family separation meant that participants lacked the support of nuclear and extended families and other traditional networks. This presented a profound challenge to individual mental health, particularly since Eritrean culture holds strong collectivist values, and individuals often value family connection and interdependence (Melamed et al., 2019). Indeed, previous studies have demonstrated that in collectivist cultures, family unity and cohesion represent an important indicator of individual mental health (Landau et al.,2008). When refugee families are stripped from their natural contexts and resources, they are more vulnerable to psychological distress (Mak & Wieling, 2022). Study findings support this notion, suggesting that extended family separation associated with protracted displacement may reduce refugees' ability to cope with past trauma and ongoing risks resulting in maintenance or escalation of psychological distress.

Even in intact or newly founded families, relationships were often undermined by the cumulative effects of past trauma and ongoing stressors, resulting in conflict and, for many women in my

sample, intimate partner violence. Moreover, the tendency to conceal emotions and the lack of trust in others meant that the forms of social support that participants sought out and/or received, were mainly *instrumental* rather than *emotional* forms of support, which, at times, left participants struggling with feelings of isolation and loneliness.

Taken together, my findings indicate that the adversities and trauma experienced pre-migration combined with the protracted and precarious displacement environment – characterized by structural violence, chronic stress, anxiety, trauma, uncertainty, and above all a lack of safety – create an increased risk for deteriorating mental health and the development of mental disorders and psychiatric symptoms. This conclusion is consistent with a growing literature on the mental health implications of precarious legal status, which has similarly revealed the ways which unequal social structures such as liminal status, displacement, and exclusion cause "existential and health-related ruptures in people's lives and bodies" (Mattes & Lang, 2021, p. 2; El-Shaarawi, 2015; O'Reilly, 2018).

Pathways by which protracted displacement may increase susceptibility to mental health problems

To summarize, I draw on the evidence presented in my study to suggest three core explanations for *why* liminality and protracted displacement place such a significant burden on refugees' mental health. One pathway by which the protracted displacement environment may increase refugees' susceptibility to mental health problems is through the depletion of refugees' coping and protective resources. This depletion, in turn, has the potential to adversely affect both their capacity to heal from past traumas, as well as their ability to negotiate the many challenges of life in protracted displacement. This pattern is in line with previous studies with war-affected populations, which have similarly found that traumatic events not only *directly* influence stress-related outcomes, but also influence them *indirectly* by undermining refugees' ability to cope with challenges in displacement (Miller & Rasmussen, 2017). For example, in their study with Somali refugees, Matheson and colleagues (2008) found that "refugees were at risk for stress-related dysfunction long after migrating, and the diminished capacity to cope with acculturation challenges was particularly important in this regard" (p. 291).

Another pathway by which the protracted displacement environment may increase refugees' susceptibility to mental health problems is through the heightened and continued perception of insecurity and impermanence. Worrying about a future over which they had very little control was a dominant concern for all participants in this study. Due to participants' liminal status and Israel's unpredictable immigration policies, participants lived in fear about what would happen in the distant future (*Where will I live 20 years from now? When will I next see my family?*), but also about the very near future, even the next day (*Will the immigration police come to detain or deport me tomorrow?*). This chronic sense of anxiety about the future affected participants' psychological health and daily functioning.

The third pathway involves refugee exposure to trauma and risk. My findings demonstrate that liminality is not only a risk factor in itself, but also exposes refugees to additional risks such as detention, occupational hazards, labour exploitation, extortion, racism, violence and poverty. For many of my participants, these risks became interconnected, compounding and intensifying the impact of past trauma, ultimately exacerbating mental health symptoms. This is consistent with previous studies which have found that refugees who hold temporary protection visas face greater living difficulties, as compared to those with permanent protection visas (Li et al., 2016). Moreover, the impact of exposure to risks may be cumulative. An increased length of displacement is associated with poorer mental health outcomes, suggesting that with the passage of time, the mental health of refugees with precarious status may deteriorate due to the extremely stressful post-migration environment in which they live (Ryan et al., 2009).

Conclusion and Implications

The goal of this exploratory dissertation study was to examine and understand the on-the-ground, lived experiences of psychological distress and well-being, from the perspectives of Eritrean refugee adults living in Israel. In the course of my fieldwork, I identified several unique culturally embedded coping strategies, as well as distinctive idioms of distress and explanatory models of mental health. These results contribute to knowledge and theory regarding the cultural dimensions of trauma and coping amongst Eritrean refugees. They also provide a first step towards better understanding the complex manner in which liminality and protracted

displacement plays out in refugees day-to-day lives — how they are lived, and how they may eventually become embodied biologically as negative health outcomes.

Much-needed attention has been focused on the mental health needs of refugees as they seek shelter in host countries. In the well-intentioned effort to provide assistance, I urge mental health practitioners and researchers to refrain from employing Western-based screening and intervention methods that rely on mental health constructs that do not reflect refugees' local cultural setting. On the basis of the study findings, I recommend that social workers and other mental health practitioners address refugees' cultural and linguistic realities in mental health interventions and assessment measures, and by doing so not only improve the effectiveness of interventions and services but also ensure refugees' right to enjoy the highest attainable standard of health.

Cultural adaptation (CA) presents one promising avenue to achieving this goal (Fennig, 2021). It can not only improve the accuracy and sensitivity of psychological scales, as has been demonstrated in this study, but has also been found to improve the effectiveness and appropriateness of interventions (Griner and Smith, 2006; Benish et al., 2011; Chowdhary et al., 2014). The basic assumption underlying CA is that by explicitly integrating culture and context into interventions and services, researchers and practitioners can improve their reach, acceptability, effectiveness and sustainability while retaining the scientific integrity of established evidence-based interventions (EBIs) (Cabassa and Baumann, 2013).

One possible form of cultural adaptation is modifying the explanatory model (EM) of illness to be congruent with the client's cultural beliefs about mental health, in general, and the client's psychological distress, specifically (Benish et al., 2011). Using this approach, practitioners can perform a 'mini ethnography' to explore clients' views (Kleinman and Benson, 2006). Several clinical interview techniques have been developed to help practitioners elicit individuals' EMs. One of the notable techniques is "Cultural Formulation", which guides the practitioner in developing a culturally embedded biographical narrative with the client (Hinton et al., 2016). These types of techniques can help the practitioner bridge the cultural divide between their own EM and that of their refugee clients (Kleinman and Benson, 2006). Adaptations may involve

using the client's language and metaphors, adapting the intervention goals so they target the symptoms and consequences most distressing to the client, as well as including local illness categories as outcome measures (Hinton and Jalal, 2014).

When we think of refugee mental health care, we tend to envisage psychologists and other health professionals delivering a variety of specialized treatments such as cognitive behavioral therapy (CBT); pharmacotherapy; and individualized therapy (Murray et al., 2020). This is certainly a crucial element, but it risks obscuring the abundance of therapeutic activity that transpires between refugees and their family, community and place of worship in what Kleinman (1980) terms the "popular sector of health care" (p. 50). As has been demonstrated in my study, refugees are acutely aware of their needs, and they often work together to support vulnerable members of their community. Attention to these existing social networks and spaces that are not traditionally considered therapeutic can help revive a sense of connectedness, promote self-help activities, and overcome some of the major barriers that currently impede refugees from receiving care.

Importantly, the findings of my study call for a reform in Israel's immigration system to bring an end to the country's unfair and ineffective refugee status determination processes and to provide an accessible pathway to citizenship for refugees' living in the country, recognizing their dignity and rights as human beings. I caution against remaining complicit in the face of the country's ongoing structural violence and injustice. Social workers in Israel must organize amongst themselves and take an active stance against restrictive immigration policies as has been done in the United Kingdom (Social Work Without Borders, 2022), Greece (Teloni and Adam, 2016) and Australia (Briskman, 2019).

Emerging evidence suggests that the provision of better social and economic securities through legal status regularization represents a key step towards better mental health and wellbeing. For example, Nickerson and colleagues (2011) found that the conversion of refugees' visa status from temporary to permanent was associated with a significant decrease in refugees' negative psychological symptoms. In this sense, my findings suggest that for refugees impacted by trauma, liminality and protracted displacement, regaining permanence both in the legal and ontological sense may be as important as concerns about the resolution of past traumas, or even

more so. Embedded into regularization programs, complementary policies should aim to tackle precarious working conditions and salaries, ensure access to education and language programs, develop avenues for family reunification, and provide protection against racism, abuse and discrimination. Moreover, ensuring timely and effective access to health services, including mental health services, to treat past and ongoing trauma is a priority.

Study Limitations

It is important to recognize several potential limitations of this study. A first limitation concerns my rather small sample size which precluded meaningful examination of variation among Eritrean refugees. I am aware that intersecting characteristics such as gender, education, age, and other demographic factors affect the impact of war and protracted displacement on individuals. Insufficient attention to these intersecting characteristics may have limited my results. A second limitation relates to my decision to exclude individuals suffering severe mental illness from participating in the study. While this exclusion criteria was put in place to protect participants from potential harm, it prevented me from including their subjective experiences in the study and, as such, limited my results. Third, while a qualitative research approach was chosen because of its ability to elicit respondents' local 'emic' perspective, it is not best suited to measure associations between coping and other outcome variables, nor to conduct meaningful comparisons with other populations with or without war-affected backgrounds. Finally, my social and cultural position, as well as those of my RAs who assisted me in conducting the interviews, may have had an influence on participants' responses. It is possible that participants tailored their responses according to their perception of the kinds of feelings it would be culturally appropriate for them to share with the interviewers.

Despite these limitations, the present study has provided rich insights into the *meanings* that Eritrean refugees impart to their mental health problems and how they *manage* their distress. In terms of future research, it would be useful to extend the current findings by examining further how refugees and other war-affected populations living in protracted displacement cope and heal from extreme trauma, as well as the local shaping and presentation of psychological distress and well-being among these populations. Given that the present study did not sufficiently

unpack the gendered realities of life in protracted displacement, it would be particularly important to examine this important area of study, especially given female participants' comments on IPV. Moreover, an important finding of my study was participants' frustration, worry, and fear of having no sense of identity or belonging in the legal sense. This persistent worry and anxiety extended to their children, that, although often born and raised in Israel, shared their parents' precarious status. This preliminary data suggest that there is an urgent need to examine the impact of protracted displacement on children, particularly from the perspectives of children themselves. Lastly, a deeper analysis and exploration of power relations, particularly as they relate to race, is essential. I hope that the current research will stimulate further investigation of this important area.

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Appendix A
Interview Guide - English

INTRODUCTION

I would like to understand the problems you face. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

Cultural definition of the problem

1) Please think about the problems that trouble you most. How would you describe these problems?
    a) IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?
    b) Do you have another term or expression in your mother tongue (Tigrinya) that describes your problem?
2) Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?
3) What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

Causes

4) Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
    a) Prompt further if required: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes

5) What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

Stressors and Supports

6) Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?
7) Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with visa and status, money, or family problems?

Role of Cultural Identity

Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.

8) For you, what are the most important aspects of your background or identity?
9) . Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
10) Are there any aspects of your background or identity that are causing other concerns or difficulties for you?

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

Self-Coping

11) Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]? Has that way of coping with it been helpful? If so, how?
12) Can you tell me more about how you tried to cope with the [PROBLEM] or with similar problems in the past? Was that way of coping with it helpful? If so, how?

13) Have you sought help for your [PROBLEM] on the internet, by reading books, by viewing television shows, or by listening to audiotapes, videos or other sources? If so, which of these? What did you learn? Was it helpful?
14) Do you engage by yourself in practices related to a spiritual, religious or moral tradition to help you cope with your [PROBLEM]? For example, prayer, meditation, or other practices that you carry out by yourself?
15) Have you sought help for your [PROBLEM] from natural remedies or medications that you take without a doctor's prescription? If so, which natural remedies or medications? Were they helpful?

Past Help Seeking

16) .Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
    a) PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED: What types of help or treatment were most useful? Not useful?

Barriers + Migration and Status

17) Has anything prevented you from getting the help you need?
    a) PROBE AS NEEDED: For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?
18) Is there anything about your migration experience or current status in this country that has made a difference to your [PROBLEM]?
19) Is there anything about your migration experience or current status that might make it easier or harder to get help for your [PROBLEM]?)

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

Social Network

20) Have you told a family member about your [PROBLEM]? Have family members helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful?
21) Have you told a friend or co-worker about your [PROBLEM]? Have friends or co-workers helped you cope with the [PROBLEM]? If so, how? What did they suggest you do to cope with the [PROBLEM]? Was it helpful?
22) Are you involved in activities that involve other people related to a spiritual, religious or moral tradition? For example, do you go to worship or religious gatherings, speak with other people in your religious group or speak with the religious or spiritual leader?
23) Have any of these been helpful in coping with [PROBLEM]? In what way?
24) Have you ever tried to get help for your [PROBLEM] from your general doctor? If so, who and when? What treatment did they give? Was it helpful?
25) Have you ever tried to get help for your [PROBLEM] from a mental health clinician, such as a counselor, psychologist, social worker, psychiatrist, or other professional? If so, who and when? What treatment did they give? Was it helpful?
26) 11. Have you sought help from any other kind of helper to cope with your [PROBLEM] other than going to the doctor, for example, a chiropractor, acupuncturist, homeopath, or other kind of healer? What kind of treatment did they recommend to resolve the problem? Was it helpful?

Future expectations

27) What hopes and plans do you have for you and your family in the coming years?

Appendix B

Interview Guide - Tigrinya

መምርሒታት ቃለ-መሕተት - ቃለ መሕተት ብዕምቆት

መእተዊ

ብዛዕባ ዝገጥምኻ ጸገማት ክርዳእ ደልየ ኣለኹ። ብዛዕባ ተሞክሮኻን ሓሳባትካን ክፈልጥ ደልየ ኣለኹ። ከመይ ይኸይድ ከም ዘሎን ብኽመይ ትገጥሞ ከም ዘለኻን ገለ ሕቶታት ክሓተካ እየ። ብኽብረትካ ቅኑዕን ሬጋን ዝበሃል መልሲ ከም ዘየለ ዘክር።

ባህላዊ መግለጺ ናይቲ ጸገም

ባህላዊ መግለጺ ናይቲ ጸገም

1) ብኽብረትካ ብብዝሒ ዘሸግረካ ጸገም ሕሰብ። እዞም ጸገማት ብኽመይ ክትገልጾም ምደለኻ?

   a) መብዛሕቲኡ እዋን ሰባት ንጸገማቶም ብናይ ውልቆም መንገዲ ይርድእዎም እዮም፡ ብኻልእ ናይ ሓካይም ዝተፈልየ ወይ ዝተመሳሰለ መግለጺ ክኸውን ይኽእል?

   b) ብናይ ቋንቋ ኣዴኻ ንጸገምካ ዝገልጽ ካልእ መግለጺ ኣለካ ድዩ?

2) ሓደ ሓደ ግዜ ሰባት ጸገማቶም ንስድራቤቶም፡ ኣዕሩኽቶም፡ ወይ ካልኦት ኣካል ሕብረተሰብ ናይ ምግላጽ ዝተፈለየ መንገዲ ኣለዎም።

3) ብዛዕባ ጸገማትካ ብብዝሒ ዘሸግረካ እንታይ እዩ?

ባእላዊ ርድኢት ናይ ሳዕቤን፡ ኣቃማምጣን ሳዕቤን ናይ ደገፍን

4) እዚ ንዓኻ የጋጥመካ ኣሎ ኢልካ ትሓሳብ? ሳዕቤናት ናይ ጸገማትካ እንታይ እዮም ኢልካ ትሓስብ?

   a) ገለ ሰባት ጸገማቶም ውጽኢት ናይ ኣብ ሂወቶም ሕማቕ ዘጋጠሞም ነገራት፡ ጸገማት ምስ ካልኦት፡ ኣካላዊ ሕማም፡ መንፈሳዊ ምኽንያት ወይ ካልእ ሳዕኔናትን።

5) ኣብ ስድራቤትካ፡ ኣዕሩኽትኻ ወይ ካልኦት ኣብ ሕብረተሰብካ ሳዕቤን እንታይ እዩ ኢሎም ይሓስቡ?

ጸቕጥትን ደገፍትን

6) ዝኾነ ዓይነት ደገፋት ንጸገማትካ ዘቃልሉ፡ ከም ደገፍ ካብ ስድራቤት፡ ኣዕሩኽ ወይ ካልኦት ኣለሙ ዶ?

7) ዝኾነ ዓይነት ጸቕጥታት ንጸገማትካ ዘጋድዱ፡ ከም ሽግራት ናይ ቪዛን መንበርን፡ ገንዘብ፡ ወይ ጸገም ስድራት?

ተራ ናይ ባህላዊ መንነት

ገለ ግዜ፡ጠመተ ናይ ናይ ሰባት ኣብ ድሕረባይታ ወይ ከኣ መንነት ንጸገማቶም ዝበለጸ ወይ ዝበኣሰ ክገብሮ ይኽእል ኢዩ።እዚ ድሕረ ባይታ ወይ ከኣ መንነት ማለት ከኣ፡ከም ኣብነት እቲ እትውከሎ ማሕበረሰብካ፡እትዛረቦ ቋንቋኻ፡መበቆልካን መቦቆል በተሰብካን፡ድሕረባይታ ዓሌትካን ብሄርካን፡ጾታኻ ከምኡ ውን እምነትካ ወይ ሃይማኖትካ።

8) ንዓኻ፡እቲ ንዓኻ ዝያዳ ኣገዳሲ ዝኾነ ቆላሕታ ድሕረባይታኻ ወይ መንነትካ እንታይ ኢዩ?

9) .ካብቶም ቆላሕታ ድሕረባይታኻ ወይ መንነትካ ኣብ ልዕሊ ጸገምካ ዝኾነ ለውጢ ወይ ፍልልይ የምጽኡልካ’ዶ?

10) ካብቶም ቆላሕታ ድሕረባይታኻ ወይ መንነትካ ኣብ ልዕሌኻ ካልእ ኣጸጋሚ ጉድያት ኣብ ምምጻእ ጠንቂ ይኾኑኻ’ዶ?

ገዛእ ርእስኻ ንምብዳህን ሕሉፍ ሓገዝ ንምድላይን ዝጸልዉ ባህላዊ ረቓሒታት

ገዛእ ርእስኻ ምብዳእ

11) ገለ ግዜ ሰባት ንጸገማት ዝብድህሉ ዝተፈላለየ መንገድታት ይጥቀሙ።ብዛዕባ ጸገማትካ ኣብ ምብዳህ ንስኻ’ከ እንታይ ገርካ?እቲ ዝወሰድካዮ ናይ ብድሆ መንገዲ’ኸ ሓጋዚ ዶ ነይሩ? እንተኾይኑ’ኸ ብኸመይ?

12) ብዛዕባ ዘጋጥመካ ጸገማት ወይ ውን ካልእ ኣብ ዝሓለፈ ዘጋጠመካ ተመሳሳሊ ጸገማት ብኸመይ ከም እትብደሆም ወይ እትገጥሞም ዶ ምነገርካኒ?ነቲ ጸገም ክትፈትሕ ኢልካ ዝገበርካዮ ነገራት’ከ ሓጋዚ ዶ ነይሩ? እንተኾይኑ ከ ብኸመይ?

13) ንጸገማትካ መፍትሒ ንምርካብ ክሕግዘካ ኣብ ኢንተርነት ደሊኻ ፡መጽሓፍ ኣንቢብካ፡ወይ ተለቪጅን ምርኣይ ወይ ውን ኣብ ተፕ ብድምጺ ብምስማዕ፡ወይ ውን ካልእ ቪድዮ ምርኣይ ወይ ውን ካልእ ምንጭታት ሽግራትካ ንምፍታሕ ትፍትሽ’ዶ?እወ እንተኾይኑ ከኣ ካብዞም ዝጠቐስናዮም ኣየናይ?እንታይ ተማሂርካ?ሓጋዚ’ዶ ነይሩ?

14) ሽግራትካ ንምብዳህ ኣብ መንፈሳዊ ንጥፈታት፡ሃይማኖታዊ ወይ ውን ኣብ ናይ ሞራል ባህልን ልምድን ትሳተፍ’ዶ?ንኣብነት ጸሎት፡ኣስተንትኖ፡ወይ ውን ካልእ ባዕልኻ እተዘውትሮም ንጥፈታት ኣለዉኻ’ዶ?

15) ሽግራትካ ንምግጣም ወይ ንምብዳህ ብዘይ ናይ ሓካይም መሰነይታ ወረቐት/ፕሪስክሪፕሽን ዝኾነ ይኹን ተፈጥሮኣዊ ኣፋውስ ወይ መድሃኒት ንምጥቃም

ደሊኻ ትፈልጥ ዶ?እወ እንኾይኑ ኣየኖት ተፈጥሮኣዊ ኣፋውሳት ወይ መድሃኒታት?ሓገዝቲ'ዶ ነይሮም?

ሕሉፍ ሓገዝ ምድላይ

16) ሳሕቲ :ደቂ ሰባት ካብ ዝተፈላለየ ምንጭታት ሓገዝ ይደልዩ፡ካብ ዝተፈላለዩ ዶክተረት፡ ሓገዝቲ፡ወይ ፈወስቲ።ኣብ ዝሓለፈ ጸገማትካ ንምብዳህ እንታይ ዓይነት ፍወሳ፡ምኽሪ ወይ ውን ክንክን ኢኻ ደሊኻ ነርካ?

a) ምናልባሽ እቲ ዝተቐበልካዮ ሓገዝ ጠቓሚ እንተዘይኮይኑ ጥቀሶ፡እንታይ ዓይነት ሓገዝ ወይ ክንክን ኢዩ ዝያዳ ሓጊዙካ?ሓጋዚ ዘይኮነ'ኸ?

ዕንቅፋታት+ስደትን ኩነታትን

17) እትደልዮ ሓገዝ ንኸይትረክብ ዝገትኣካ ዝኾነ ነገር ኣሎ ዶ?

ኣድላዩ ኢዩ፡ከም ኣብነት ገንዘብ፡ስራሕ፡ናይ ስድራቤት ኪዳን፡ተነጽሎ ፡ዓሌታውነት፡ወይ ከኣ ብቋንቋኻ ሕጽረት ኣገልግሎት ብምህላዉ ወይ ውን ድሕረባይታኻ?

18) ኣብ'ዚ ሃገር እዚ ከም ስደተኛ ብምኺንካ ዝተመኮርካዮ ወይ ውን ኩነታት ስደትካ ነቲ ዘለካ ጸገማት ዝጸሉ ነገራት ኣለዎ'ዶ?

19) ከም ስደተኛ ኾንካ ካብ ስደት ዝተመኮርካዮ ወይ ውን ዘለኻዮ እዋናዊ ኩነታት ስደትካ ንሸግርካ ሓገዝ ንምርካብ ኣቃሊሉልካ ወይ ኣጸንኪሩልካ'ዶ ይፈልጥ።

ንህሉው ሓገዝ ንምድላይ ዝጸልዉ ባህላዊ ረቋሒታት

ማሕበራዊ መራኸቢ

20) ንቤተሰብካ ብዛዕባ ጸገማትካ ኣዕሊልካዮም ትፈልጥ'ዶ?ቤተሰብካ ኸ ጸገማትካ ኣብ ምብዳህ ሓጊዞሙኻ'ዶ?እንተኾይኑ'ከ ብኸመይ?ንጸገማትካ ንኽትብድህ'ከ እንታይ መኺሮሙኻ?ሓጋዚ ዶ ነይሩ?

21) ንዓርክኻ ወይ መሳርሕትኻ ብዛዕባ ጸገምካ ተዛሪብካዮ ትፈልጥ'ዶ?ኣዕሩኽትኻ ወይ መሳርሕትኻ ሽግራትካ ንምብዳህ ሓጊዞምኻ'ዶ?እንተኾይኑ'ከ ብኸመይ?ጸገማትካ ንምብዳህ እንታይ መኺሮሙኻ?ሓጋዚ'ዶ ነይሩ?

22) ኣብ መንፈሳዊ ንጥፈታት፡ሃይማኖታዊ ንጥፈታት፡ወይ ውን ሞራላዊ ባህልታት ምስ ካልኦት ሰባት ዘጠቓለለ ንጥፈታት ትሳተፍ'ዶ?ምስ ሃይማኖታውያን ጉጅለታት ትዘራረብ ዶ ወይ ምስ መንፈሳውያን መራሕቲ ትዘራረብ'ዶ?

23) ገለ ካብዚኦም ጸገማትካ ኣብ ምብዳህ ዝሓገዙኻ ኣለዉ'ዶ?ብምንታይ ዓይነት መንገዲ?

24)ንጸጋማትካ ሓገዝ ክትረክብ ካብ ሓፈሻዊ ሓኪምካ ሓገዝ ሓቲትካ ትፈልጥ'ዶ?እንተኾይኑ'ከመንን መዓስን?እንታይ ዓይነት ክንክን ገይሮም?ሓጋዚ'ዶ ነይሩ?

25) ንጸገማትካ ካብ ናይ ስነልቦና ሕክምና ማእከል ከም ኣማኻሪ፡ስነ-ኣእምሮ፡ማሕበራዊ ጉዳይ ሰራሕተኛ፡ወይ ካልእ ሰብ ሞያ ሓገዝ ሓቲትካ’ዶ ትፈልጥ?እንተኾይኑ ከኣ መንን መዓስን?እንታይ ዓይነት ክንክን ሂቦሙኻ?ሓጋዚ’ዶ ነይሩ?

26) ናብ ዶክተር ካብ ምኻድ፡ንኣብነት ቺይፕራክተር ፡ አኩፓንቸር ፡ ሆሚዮፓትስ ወይ ካልእ ዓይነት ፈዋሲ ካብ ዝኣመሰሉ ካልኦት ዓይነት ደገፍቲ ጸገማትካ ንምብዳህ ሓገዝ ትሓትት’ዶ ?እንታይ ዓይነት ደገፍ ሂቦሙኻ?ሓጋዚ’ዶ ነይሩ።

ትጽቢታት መጻኢ።

27) ንዓኻ ይኹን ንቤተሰብካ ንመጻኢ እንታይ ዓይነት ተስፋታትን መደባትን ኣለካ?

Figure 1

Cross cultural adaptation process for the adapted GHQ-12