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Syria: coping mechanisms utilised by displaced refugee parents caring for their children in pre-resettlement contexts

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Evidence shows an increased risk of psychological distress and mental health problems in refugee populations. Despite this, refugees often display the ability to continue to function, to recover and live meaningful and productive lives. Parents' mental health and coping style is significant to the mental health and wellbeing of their children. The aim of this study was to explore the coping mechanisms utilised by displaced Syrian refugees who care for children. Twenty-seven mothers and two professional aid workers in refugee camps and humanitarian contexts in Turkey and Syria participated in interviews or focus groups. Data were analysed using thematic analysis. Data were structured into three themes: adaptation to a new norm, such as acceptance, normalisation and gratitude; reaching out for support, such as in aiding problem solving and gaining support; keeping mentally strong using faith to soothe pain and to motivate to parent well. A number of themes associated with Syrian refugee coping during pre-resettlement were identified. These themes may be translated into strategies to improve culturally appropriate psychosocial interventions in such settings.

Keywords: intervention, parenting, refugee camps

Key implications for practice

- Parents in pre-resettlement contexts greatly struggle in caring for their children
- Despite struggles, parents use adaptation to a new norm, reaching out for support and maintaining mental health using faith as coping mechanisms
- More psychologically informed approaches are needed that take into account beliefs, perspectives and values to support families

Introduction: background and context

Worldwide, refugees often live through devastating experiences prior to fleeing their homes, including fearing or being close to death, seeing the death of loved ones and experiencing deprivation or torture (Cardozo, Vergara, Agani, & Gotway, 2000; Kleijn, Hovens, & Rodenburg, 2001). Unsurprisingly, research indicates increased risk of psychological distress and psychopathology amongst refugee populations (Fazel, Wheeler, & Danesh, 2005), and different psychiatric and psychological models have been used to understand this. Many studies focus on posttraumatic stress disorder (PTSD), which may be identified after individuals have experienced or witnessed traumatic events that are usually life threatening or threaten physical integrity. Reviews indicate that PTSD is approximately ten times more likely among refugees than age matched native populations (Johnson & Thompson, 2008). In general, a dose response relationship is found between the number of traumatic experiences and the psychological stress that refugees experience (Steel, Silove, Phan, & Bauman, 2002).

Some studies, however, find much lower levels of symptoms. For example, a study with Cambodian residents living in a refugee camp found that only 15% of the residents suffered from PTSD (Mollica et al., 1993). Another study of Vietnamese refugees resettled in Australia reported an even lower, 3% rate of PTSD in a sample of refugees (Steel et al., 2002). Research with non-clinical communities suggests that refugees may be far more resilient than clinical studies represent (Bonanno, 2004) and that the majority successfully adapt to stressors and trauma (Khawaja, White, Schweitzer, & Greenslade, 2008). Some evidence confirms that, in common with other findings on PTSD, extreme war exposure may lead to immediate trauma responses, but that there is reduction in symptoms during the following 3 months to 1 year (Friedman, Stevens, & Morris, 2008; Thabet & Vostanis, 2000).

Psychological models use the concept of resilience to describe the capacity to return to normal functioning after experiencing severe trauma, in addition to the presence of developmental competences in adverse living conditions (Masten, 2007). Some studies have examined the coping mechanisms utilised by refugees to promote positive adaptation at various stages in the refugee journey to resettlement (Goodman, 2004; Khawaja et al., 2008). A qualitative study with refugees from Sudan revealed that social support, religious beliefs and personal qualities were significant factors in coping (Schweitzer, Greenslade, & Kagee, 2007). Social support drawn from families and communities may act as a protective shield against the impact of traumatic experiences and any current refugee challenges facing those displaced (McMichael & Manderson, 2004). The use of religious practices and beliefs is commonly observed in studies of refugee coping as providing a number of coping strategies such as endurance (Peisker & Tilbury, 2003), and a productive adaptation to life difficulties (Brune, Haasen, Krausz, Yagdiran, Bustos, & Eisenman, 2002). In addition, cognitive processes such as hope and aspirations for the future may increase resilience and aid in overcoming trauma (Goodman, 2004; Beck, Rush, Shaw, & Emery,1979).

Children

Children form one of the largest groups of refugees internationally and research indicates that children who are exposed to war are also at high risk of developing mental health difficulties (Pfefferbaum, 1997; Shaw, 2003; Thabet, Abed, & Vostanis, 2004). A systematic review of child mental health in both ongoing and post war contexts showed an increase in symptoms of PTSD (47% of studies), depression (43% of studies) and anxiety (27% of studies) (Attanayake, McKay, et al., 2009). Other internalising and emotional problems have also been reported, such as: sleep disturbances, social withdrawal, inattention and somatisation (Geltman, Grant-Knight, Ellis, & Landgraf, 2008; Morgos, Worden, & Gupta, 2008).

As with adults, not all children develop war trauma symptoms. Various protective factors have been identified, including: social support (Cairns, & Dawes, 1996), cognitive appraisal and coping strategies (Duraković-Belko, Kulenović, & Dapić, 2003) and family environment (Panter-Brick, Goodman, Tol, & Eggerman, 2011). A child's adjustment to war time stress is reliant not only on their own individual responses and qualities, but very significantly on the availability of support and attachment that they may receive from their parent or primary caregiver (Betancourt, & Khan 2008). A study of Palestinian children found a negative relationship between parental support and posttraumatic stress reactions (Thabet, Ibraheem, Shivram, Winter, & Vostanis, 2009) providing further support that caregiver mental health is an important predictor of child mental health (Dybdahl, 2001). Therefore, understanding and strengthening the ways in which parents cope could be hugely beneficial to such children.

Syria

Syria's ongoing crisis (since 2011) has reached global concern, and the flight and displacement of families presents very significant challenges to parents in coping with caring for and protecting their children. Over 12 million people are in need of humanitarian assistance, including 7.6 million internally displaced (UNHCR, 2015). As the refugee emergency continues, over 4 million Syrians are externally displaced as refugees to neighbouring countries such as Turkey, Lebanon and Jordan. Reflecting statistics worldwide, over half those affected by the conflict are children [World Health Organisation (WHO), 2013]. Researchers have called for more complex and holistic explorations of the refugee experience, away from the direct biomedical frameworks (Hjern & Jeppsson, 2005; Zarowsky, 2004). As the Syrian crisis is relatively recent, with no sign of the rapidly growing number of displaced easing, research is important to better inform holistic interventions and culturally appropriate policy responses (Quosh, Eloul, & Ajlani, 2013). Across Syria and neighbouring countries, hundreds of thousands of recently displaced Syrian refugee parents are struggling to raise their children in very difficult circumstances. Our research has identified significant challenges that parents experience in caring for their children within refugee camps (El-Khani, Ulph, Peters & Calam, 2016), such as dealing with changes in their children's behaviours and emotions, as well emotional struggles that parents themselves experience. Despite these, parents are motivated to better care for their children and seek support. To our knowledge, no exploration of the coping mechanisms used by parents residing in refugee camps in Syria and Turkey has been carried out. In addition, as previous research has identified an association between the levels of caregiver mental health and their children's mental health (Betancourt, McBain, Newnham, & Brennan, 2015; Punamaki & Suleiman, 1990), this study focuses specifically on coping mechanisms that parents use in caring for their children in preresettlement contexts, that is, in transitional displacement conditions and before settlement into more permanent living conditions.

Methodology

Setting

Between 2012 and 2013, two refugee camps were accessed in northern Syria. Two other sites were accessed in southern Turkey, close to the Syria/Turkey border, one a refugee camp and one a building housing refugees who had very recently arrived from Syria. This study was conducted in all four sites.

Study design

Interviews and focus groups were used in a two phase study design. Different participants took part in each phase. During phase one, semi structured interviews were used as their flexible structure would allow participants to feel secure and confident that they were in control of the situation when sharing potentially moving experiences. During phase two, focus groups (FGs) were used in place of interviews for two reasons. Firstly, we rapidly found that experiences were often shared in a collectivist manner naturally by mothers in the camps and they reported not feeling the need to talk in privacy and in seclusion. Groups allowed a space for *'collective testimony'* (Madriz, 1998). Secondly, it was challenging to ensure privacy and that participants were not overheard, or to be alone with the researcher, as the refugee camps and housing were very overcrowded, and therefore, group discussion was easier to achieve. The researcher encouraged open dialogue and facilitated both agreements and disagreements by participants. Opportunistic sampling was used.

Procedure

Research information sheets were distributed to parents at all four sites, and it was

made clear that families were under no pressure to take part. The inclusion criteria stated that participants must be parents or primary carers to children aged 3–11. During phase one, interested parents provided written consent and were interviewed the next day as research ethics stipulated. However, the one-day wait, following consent, proved challenging. The reality of refugee camps and temporary housing was that frequently families did not have a fixed structure to their day. Gaining access to the camp the following day and locating the same families was additionally very challenging. Therefore, during phase two, an ethics amendment allowed immediate consent and participation (El-Khani, Ulph, Redmond, & Calam, 2013). Information sheets for recruitment of professional aid workers were also distributed at the same four locations. Those who were interested contacted researcher AE who conducted the field research, and a date was arranged in which written consent was taken and an interview conducted. During consent, participants were again reminded that they were under no pressure to take part and could withdraw at any time. Interviews with professionals were conducted in an aid agency office. AE's primary role during the two phase research, were research activities related to recruitment and interviewing of families for this study, although she was also involved in other humanitarian activities in recruitment sites prior to the study commencing and after completion.

Measures

The interview schedule was designed by the main researcher (AE) together with a child and family psychologist (RC) and a qualitative expert (FU). It covered three areas: changes and challenges in the parenting experience (El-Khani et al., 2016); what coping mechanisms parents were using; and what, if any, challenges parents wanted support to address. It was originally piloted using one-to-one interviews with two mothers, via Skype, who were residing in Gaza and had experienced the 2009 Israeli attacks. Following the pilot stage, the interview schedule was altered with more direct questions and prompts, as well as the addition of more Arabic terms for the word *'parenting'*. Interviews and focus groups (FGs) were conducted in Arabic by AE.

Ethical approval

Ethical approval was granted by The University of Manchester research ethics committee.

Data analysis

Data were analysed using thematic analysis (TA) (Braun, & Clarke, 2006), where dominant themes were identified through close examination of the data. First, open coding was carried out and an initial coding schedule was devised in order to define each emerging theme. The coding manual was then revised throughout the coding of the remaining transcripts. The original codes were frequently combined or divided into further codes, depending on the emergent findings. Themes were continually compared with newly coded interview transcripts to ensure that these were readily applicable to the data by using the research team's familiarity with the text and coding manual to frequently assess and reassess how codes were being applied to the raw data. The coding manual was discussed within the research team and final amendments were made. The team developed a revised code set that included the new and combined codes. NVivo9 software was used to facilitate analysis. Regular coding meetings were held to review the framework with FU. Analysis ceased when the research team judged thematic saturation was reached.

Results

Twenty-nine participants took part in this study (N = 29) comprising eight interviews

and four FGs (19 mothers, range 5–6 per group) with mothers, and two interviews with professional aid workers (a local camp doctor and an on-the-ground nongovernmental organisation (NGO) director). Participants ranged in age from 22 to 45 years and cared for between 1 and 7 children. While some families had only recently arrived from Syria, others had been in the camps for up to eight months. Four were war widows, and two did not know if their husbands were alive. All participants were of the Muslim faith.

It was evident that participants had coped with or were coping with previous traumatic events, present difficulties and future uncertainties. Narratives were explored and three coping themes emerged: 1) adaptation to a new norm; 2), reaching out for support; and 3) maintaining mental health using faith. Each is described and illustrated with quotes provided (identified according to interview (I) or FG number). Pseudonym initials are used for FG members when reporting data from more than one mother.

Theme 1: adaptation to a new norm

Accepting changes in their children

Parents struggled to cope with the physical, emotional and behavioural changes they saw in their children. They were worried, saddened and stressed by not knowing how to help them. One coping strategy parents used was to accept changes in their child.

> *'Now these things [that the children experienced and saw] kill even an adult, how then do we expect kids to not be affected?' 1(3)*

Parents often suggested reasons why their children were acting in new and challenging ways.

> *'I don't blame them, they are mostly sad . . . Their trust in life was broken, my husband says it's not our fault, we didn't do anything wrong. They used to have a good life and now it was dragged away from them and they don't trust anything good happening (cries).' 1(7)*

Parents described great uncertainty for their future and felt that their situation was out of their control. They were coping by resigning themselves to accept that there was not much they could do to change the situation for themselves and their children.

> *'Really, the big difference is now it is wasted, no one listens or cares. Even me, really I stopped exhausting myself, I asked myself last week why are you doing this to yourself? They are older now, they are small men, stop hurting yourself by worrying and being stressed about them as really it's not in my hand. I started to leave them to do what they want more.' 1(5)*

This psychological acceptance refers to a willingness to experience thoughts and feelings which are worrying and frightening, without allowing them to determine actions. Mothers' parenting strategies changed once they allowed themselves to accept their situation, leading them to experience some relief.

Parents acceptance and normalisation of changes they saw within their children, in light of what they had experienced, was not a passive process. These changes were fuelled by sympathy towards their children at what they had experienced which, in turn, facilitated a change in perception. Parents often described modifying their own behaviour with the acceptance of changes in their children. One mother said:

> *S: 'We are much more understanding.'*
> *I: 'How?'*
> *S: 'They cry a lot, they move slowly, they seem down. Usually I would get frustrated about this, but now I know I shouldn't get too angry as it's not their fault they have been through pain, a lot of pain.' FG(4)*

This change in perception often expressed itself in adaptation of how they parented. They reported pushing themselves, even when they themselves were emotionally

exhausted, to be more understanding and patient.

M: 'It's hard for them and we have to be patient.' FG (1)

With so much physical, environmental stress from their refugee camp life, in addition to emotional stresses, it was a significant challenge for mothers to remain patient with their children.

FG (4) It's all about trying to be patient, but this is very hard. They hurt our hearts, we feel sorry for the children. We try our best to be patient. But it isn't easy.

The most pertinent effect parents reported of this change in their perception and the understanding some had tried to embrace, was in their disciplining of their children. Participants reported being more forgiving and lenient. They often compared how different their parenting experience was now, but also how they had to accept this was the right way to care for their children currently.

A: 'We push slightly and then leave them slightly, we don't want to put too much pressure on them.'
I: 'What do you mean you push slightly and leave slightly?'
A: 'Like I might not let them out in the morning, then later on I'll say ok go now as I feel sorry for them.' FG (2)

Normalisation Participants discussed how they would often consciously make an effort to change their view of their situation in order to help them deal with challenges within their families. In accepting their situation, they allowed themselves to normalise both their situation and changes seen in their children. This was not easy for mothers; often what they had to accept as normal was both emotionally and practically overwhelming. One mother had fled to Turkey with her children once her husband had been captured by armed forces in Syria, did not know if he had been killed and was told that he was probably dead. She spoke of pushing herself to normalise her new situation, being a single mother to four young children and working in a camp bakery to support her family, she said:

'You have to make new things 'normal' for your family.' FG (4)

Social comparison emerged as a salient coping strategy utilised by participants to aid them in achieving this. Parents discussed problems they were having with their children with other parents in the camps. Knowing that those around them were experiencing similar feelings and struggles helped them to normalise their situation and feel more at ease.

K: 'When I tell you and you tell me, we will feel like we are all the same. Not that I am the one who should be feeling sorry for herself.' FG (4)

Gratitude Gratitude commonly arose from the social comparisons parents made, and they reported often thinking of others as less fortunate than themselves. Many of the participants often expressed their appreciation for the positive things that they still did have, such as their health, their children and their family.

'All praise be to God, we have each other, we have our health, we are managing.' 1 (3)

Parents compared the condition their children were in physically and emotionally to others who they perceived as more tragically affected by the conflict. They reported that this allowed them to feel as if they were in a fortunate position and to focus on the positive aspects of their situation, despite all they had been through and were still experiencing.

'We are lucky, so many are worse than us. We are all together, most that are here are alone without their husband or missing their children.' 1(6)

Mothers reported that thinking of others less fortunate than them reframed their view of their situation, providing a more positive outlook. This allowed them to normalise and feel better about their situation, as well as minimising the hardships they were experiencing.

'We made it here and we are not hurt, others are much worse.' 1(7)

Theme 2: reaching out for support

Problem solving Participants stated that social support provided them with not only the chance to normalise their experiences and feelings, but also to reach out and find solutions for new problems they were facing. They spent time together, often in between daily tasks, discussing their difficulties both with their children, as well as other aspects of their lives and how they could improve their situation.

'We stand with each other, she will tell me an idea and she will tell another one and I'll think of what to do.' 1(3)

One mother reported that, traditionally pre conflict, Syrian women would rely on the female elders in their family (such as mothers and grandmothers) for parenting advice, but that they felt this traditional support network was no longer effective to meet their new needs. One mother highlighted the great significance of new neighbours and friends said:

A: 'They [our parents] raised them [their children] in easier circumstances, not like now. They won't benefit us as much as talking to a friend or neighbour who may have been here a few months more than ourselves.' FG(2)

Though participants did not necessarily have their more senior female relatives close by to them in the camps, this mother highlighted the great significance they placed on their new neighbours and friends.

However, there were limits to the value parents placed on this sort of support, with some parents reporting not listening to the advice of other parents around them in the camps, feeling it was not useful. They said that their past traumas and current difficulties needed to be addressed by more professional help. While they participated in giving and accepting advice, this was often not sufficient for them. One participant said:

'We're relying on each other but we aren't getting anything from each other, as we are all the same.' 1(3)

This mother had been living in a refugee camp for over 6 months, unaware of whether her husband was alive or had been killed in Syria. Her four children, all under the age of 10, were displaying severe trauma symptoms. She indicated that though she felt that she needed more professional help for herself and children, she still accepted support from others as this was the only support she could access.

Bringing in support In addition to receiving advice, mothers actively sought comfort and help from each other. Participants conveyed being very reliant on other adults in the camps and were highly effective at seeking out available sources of assistance. By drawing out support from those around them, mothers found their situation less weighty and frightening. The opportunity of being listened to appeared very significant to these participants and drove the process of reflection.

M: 'Generally all we have is each other, we advise each other and we complain and let all our problems out to each other.' FG(2)

Though reaching out for support did not necessarily change their situation, being listened to was still regarded as highly important. Mothers cherished their new friendships and often bonded with women much older or younger than themselves. One mother described a significant reciprocal process of emotional support:

'If I get sad, you will lift my spirits and I will lift yours.' FG (2)

By reaching out they were able not only to acquire support for themselves but also build a bond with another parent. Participants described that these new relationships they had formed may not have assisted them physically or eased their difficulties, but they did provide empathy and shared experiences, all of which these participants deemed to be very important.

Theme 3: keeping mentally strong using faith

Faith to soothe pain One of the most commonly reported ways parents were dealing with their stressors was religious coping. Parents readily described their need to remain mentally strong for themselves and their children. They were aware how mentally challenging their struggles were and spoke comfortably about how they tried to keep strong. A commonly identified coping strategy was the use of religion. Parents proudly reported that religion and its associated practices positively influenced their wellbeing on an individual level, and as a parent. With the acceptance of their situation and its accompanying difficulties for them and their children, participants surrendered their sense of control and responsibility to God, noting a sense of relief. One mother said:

S: 'I Just sit and read the Quran (holy book), that always soothes me.' FG (2)

They described that by praying they were provided with comfort, believing that God would listen and answer their prayers. Parents reported using faith to cope with moments or times when they felt especially overwhelmed by challenges with their children, or were upset or stressed.

SF: 'I spend longer in prostration now when I pray and feel so much closer to God, as if God can feel me and hear my prayers.' FG (2)

These activities were important facets of participants coping strategies. God played a variety of roles for participants, including providing a sense of meaning, control and understanding. They had an immense trust in God, which was contrasted with their distrust of other forms of support, as one mother said:

SF: 'What else is going to help us but almighty God?' FG (2)

Participants' religious practices also provided them with an opportunity to be reminded of their trust in God. They reported that their holy book, the Quran, was a source of guidance on how to react and cope during their difficulties.

'I find myself reading the Quran (holy book) and it calms us all and gives us hope that Allah will not leave us, we will have our relief, if not now in the next life.' 1 (3)

Faith as motivator to parent well Participants' faith also had a direct effect on their parenting. They used their Islamic faith as a positive motivator to better their situation and the way they cared for their children. They reported a sense of hope and motivation for their situation generally, and their children particularly. They described that the trust they placed in God was not a passive trust but one that,

according to their faith, provided them with the encouragement to strive to improve all aspects of their situation, including how they cared for their children.

> *K: 'God will protect us, but HE has told us to do all we can to look after ourselves. We do our part and put our trust in God. Fear of what is around us is always what makes us sensible. Not to go out alone, make sure children are with us at all times.' FG (4)*

Parents reported their faith as guiding them to view their children as trusts from God, to be cherished and cared for. They found comfort in this and often spoke about this topic with softened voices. They believed that they will be questioned by God on whether they did their best towards their children.

> *A: 'These are our kids, what do we have that is more precious? Just God protect them and us, these are our trusts from God.' FG (4)*

This religious belief was noted by a camp doctor as motivating parents to try their best with their children.

> *I (doctor): 'Because the parents are strong, yes, they are going through hard times and the children are getting out of control, but the parents are doing their best. They feel the responsibility in front of God. These are their kids! Each person is doing their best, whatever that best is and how useful it actually is and how good for the child it is, is a different story.'*

Parents spoke of praying and making supplications to God for both guidance and strength to do the right thing for their children.

> *'I pray to Allah to make me do the right thing to help them [our children] now.' 1 (2)*

Being hopeful for the future Participants' trust in God extended to the belief that they would be rewarded for the hardships they had experienced and were still facing, which they perceived as allowing them to cope with their difficult circumstances. Participants often stressed the importance of this belief to them as a coping strategy. They reported talking with their partners and children about this trust in God.

> *'I tell them [the children] Allah will give us relief, we will have our reward, if not now in the next life.' 1 (2)*

Their religious beliefs allowed them to imagine and actively focus on the future, which they envision as a better place to raise their children. They frequently described their aspirations for the future as centring on their parenting motivations in order to give their children a better and safer life. They drew strength in viewing their time in the camps as a short period that they would be leaving soon for a much brighter future. Another major desire for all participants was to go back to Syria and rebuild their previous lives.

> *'But we are ok, thank God, we love each other and we tell each other that we will be able to raise our children in a free Syria. God willing it will all change.' 1 (3)*

The influence of participants' religious faith was evident when reflecting on their hopes for the future. Their faith guided them to feel optimistic, and paramount to this was their trust in God to fulfil their dreams.

> *'When the regime [government] falls will be the best day, we are waiting for that, Allah will reward us soon.' 1 (6)*

Another participant echoes feeling of hope for the future:

> *MU: 'When we go back, God willing, we will be able to restore how we used to be. I know it. I*

pray this is just a short period that will pass.' FG(4)

Participants believed God had a plan for them and that by believing in Him and being hopeful their situation would improve. This component of parental coping highlighted participants' strength, resilience and determination.

Discussion

To our knowledge, this is the first study to explore coping strategies in Syrian parents living in refugee camps and refugee housing and aimed to identify strategies used to cope in pre-resettlement contexts. Parent management of challenges and uncertainties in refugee contexts affects both their own mental health and that of their children (Garbarino & Kostelny, 1996; Smith, Perrin, Yule, & Rabe-Hesketh, 2001), therefore identifying and understanding these coping strategies is important so that interventions can be developed or adapted to support parents in better managing the challenges they face in caring for their children in these contexts.

The three themes of: 1) adaptation to a new norm; 2) reaching out for support; and 3) maintaining mental health using faith, offered a unique insight into better understanding the coping mechanisms parents used to remain resilient and to care for their children. These themes and actions are consistent with characteristics that have been identified as buffers to the development of psychological disturbance (Goodman, 2004; Khawaja et al., 2008; Schweitzer et al., 2007). Faith appeared as a clear common element between them, often facilitating other coping strategies. For this reason, discussions about the influence of faith will be made for all three themes.

The first theme involved the psychological mechanism parents engaged in to cognitively reframe their situation. Parents had been through highly challenging and traumatic circumstances prior to reaching the camps. They were very open about the emotional difficulties they faced in trying to accept the new reality of their lives. Several mothers were now widows, two had lost children, most had witnessed extreme violence or torture and now they were faced with the difficulties and uncertainty of refugee camp life. Parents described how they had started to accept their situation, including changes in themselves, their children, and their environment. They described different psychological ways they reacted before feeling acceptance of their situation, initially feeling overwhelmed, angry and confused as to how to deal with the changes they were facing, to a more positive and hopeful acceptance that they must adapt to meet their new difficulties. This progression towards acceptance is significant as PTSD symptom severity has been associated with lower acceptance of emotional experiences (Tull, Barrett, McMillan, & Roemer, 2007). An important finding was that as parents started to accept the changes they saw in their children they began to adapt their parenting techniques to meet their new needs. They described putting a lot of thought into these changes, which resulted in a conscious decision to become more sympathetic and patient with them. Park and colleagues (1996) argue that *'acceptance coping'* is one of the most relevant coping strategies in relation to trauma recovery. Likewise, Zoellner and Maercker (2006) suggest that the ability to accept situations that cannot be altered is crucial for post traumatic growth. Of course, parents also often react to stress poorly and may use maladaptive parenting techniques such as hitting and shouting (El-Khani et al., 2016). Another cognitive reframing tool was to normalise their situation. They did this by both minimalizing the severity of what they had experienced and were still experiencing, and resigning themselves to whatever the future held. This is consistent with previous studies in which refugees described resigning themselves (Başoğlu et al., 1997; Khawaja et al., 2008), feeling some things were not in their control to change. Normalisation was

greatly aided by social comparisons between themselves and other mothers who were worse off. Downwards comparisons can make people feel less distressed about themselves (Todd & Worell, 2000). Participants in this study compared their children with those of others, who were severely injured or had troubling emotional and behavioural difficulties. They recounted stories to each other of such families and children and were quick to follow with prayers and thanks to God for not being in such a position.

Parents expressed feeling gratitude to God and reported seeing his blessings in their children. They spent time valuing and reflecting that their children were alive, in relatively acceptable health and that they were together. They understood that others may not be able to express such gratitude in their circumstances, but did not convey signs that they were struggling to be grateful, rather it seemed to aid hopeful emotions and thoughts for their future. Expressing gratitude has been shown to increase life satisfaction (Boehm, Lyubomirsky, & Sheldon, 2011), to reduce negative affect (Emmons & McCullough, 2003), and increase positive emotional style (Danner, Snowdon, & Friesen, 2001).

The second coping strategy identified, also previously shown to be important in dealing with stress and trauma, is that of the use of social dimensions (Folkman & Moskowitz, 2004; Gorst-Unsworth & Goldenberg, 1998). Social coping involves using available external social support networks to access support. With this, mothers in this study were able to enjoy both social and material support. Feelings of belonging were increased and also practical help became available, such as support with childcare or chores. This was similar to other findings showing that by accessing such networks, refugee mothers tended to feel less sadness, depression and anxiety and an enhanced belonging to their new community (McMichael & Manderson, 2004).

Social support also allowed mothers to access help and engage with others in an active and problem solving way, rather than responding passively to events. In a meta-analysis investigating relationships between coping styles and health outcomes, problem focused strategies were more positively associated with better mental health outcomes (Penley, Tomaka, & Wiebe, 2002). Problem solving was highly important to participants in this study, as they described facing many new, confusing and challenging problems with their children. The connections they made with each other allowed them the space and time to discuss, normalise and think through how best to meet their new challenges.

Social coping also involves individual factors, such as social support seeking or the ability to bring in support, as we found prominent in our sample of mothers. Often within war settings, individuals lose significant social networks which may leave them feeling low, depressed and more likely to develop PTSD (Ozer, Best, Lipsey, & Weiss, 2003). In the present study, participants were actively seeking to bolster social networks with new neighbours or other mothers further away in camps. They also made efforts to seek support from teachers and camp workers for advice, though these were often futile. Being able to utilise social support is a very adaptive and important coping mechanism as it is widely viewed as a protective factor against the development of psychopathology following trauma (Brewin, Andrews, & Valentine, 2000). However, mothers often wanted more external support. One described engaging in social activities, conversations and asking advice from other mothers, but only because this was the only support available. She felt that if other, more professional, help was available she would not rely so much on social support from other mothers.

The third coping strategy was the strength and comfort found in their faith. Finding strength in religion was based on the positive

appraisals mothers made of their circumstances: participants believed they were still alive because God had protected them and their children, and would continue to protect them. A meta-analysis of 49 studies examining relationships between religious coping and psychological adjustment to stress (Ano & Vasconceeles, 2005) indicated that positive and negative forms of religious coping are related to positive and negative adjustment, respectively. That religious coping primarily involves thoughts of placing one's trust in God and should not be misunderstood as helplessness, rather as a passive form of empowerment for individuals (Mattis, 2002). Consistent with previous finding with refugees (Brune et al., 2002; Khawaja et al., 2008), participants maintained religious practices to alleviate their stress and felt better doing so. They engaged in their faith by surrendering themselves to God, undertaking religious activities and asking God for strength and patience.

All participants were of the Muslim faith, in which believers are encouraged to follow the teachings of the Quran, the holy book. As parents described, children have an elevated position in Islam (the Muslim faith), and the Quran states that parents will be judged by God on how much effort they placed in caring for their children. Parents described this as a motivator to make an effort to spend time with their children and be more patient even when they felt overwhelmed with their own emotions. A camp doctor supported this view, describing parents as doing their best with their children as God had instructed them to.

Consistent with previous findings (Brune et al., 2002), refugees described their belief that their fate was in the hands of God and that, by maintaining their faith in him, their situation would improve. Focusing on the future and having wishes and aspirations for what one will go on to achieve has been reported to help refugees endure severe circumstance (Peisker & Tilbury, 2003). When explored further, participant goals were almost all to do with having a better future for their children in which they would be safe and have an education. Similar to other findings, participants in this study adopted a positive cognitive style of focusing on the future (Goodman, 2004). This allowed them along with their families collectively to create dreams and wishes and maintain a sense of purpose in life. This collaborative religious coping, in which individuals involve their families and those around them, has been found to be a much more positive coping strategy than more individual self-directed and self-reliant coping (Salama et al., 2013).

As mentioned previously, this study had not sought to explore connections between different strategies, but exploration revealed faith as a clear common element between them. Faith, as a combination of both beliefs and the physical practices parents undertook, had a significant effect on their lives which seemed to facilitate their other coping strategies. Thus, though other coping strategies were utilised independently of faith, it was common on deeper examination to find these based on religious beliefs. For example, acceptance as a psychological mechanism was based on participants' belief that God had a plan for them that they must accept. This helps to differentiate between acceptance as an intentional strategy of change, rather than as a detachment or result of hopelessness. Social support was also embedded in faith, as participants' religious beliefs greatly encouraged social cohesion and reciprocal social support, thus by engaging in social support they believed they would be rewarded by God.

Faith gave parents feelings of independence that they did not have to rely on other people or organisations. They had felt let down by others, but believed God would always be there for them. Having a religious background and growing up in religious societies, they perceived religious coping as a compelling and available resource (Pargament, 1997), which was principal to them and

connected with their other coping strategies. Previous research has highlighted that NGOs do not have a clear set of interventions to address the spiritual needs of populations affected by emergencies, in conjunction with their mental health and psychosocial support needs (Onyango, et al., 2011). This study further supports the notion that faith can be an important resource for coping and aid in facilitating other coping strategies and should be incorporated into psychosocial programmes (Schafer, 2010). It is only in recent years that there has been a renewed interest in how faith can be a positive agent of change in humanitarian support (Kidwai, Moore, & FitzGibbon, 2014), and this study allows for this examination of the positive way that faith can aid in coping.

Strengths and limitations

The lead researcher was of Syrian origin, which provided a number of advantages including conducting the research in Arabic using the Syrian dialect, having a good understanding of participants' culture and traditions and being sensitive to their beliefs. Despite both physical and time restraints in accessing camps and meeting with families, much effort was put into carrying out repeat visits and spending time with families outside the research process to understand their day-to-day experiences of living in refugee settings. Qualitative methodology allowed in-depth exploration of mothers' views, and both interviews and focus groups were utilised to enhance rigour, relevance and validity of results. In addition, the sample size was similar to that used by other studies with participants in pre-resettlement context (Khawaja et al., 2008; Pavlish, 2007) and there was variation in factors including mothers' age, marital status, number of children and length of displacement.

The study has several limitations, as expected when conducting research in conditions such as refugee camps (El-Khani et al., 2013). Several participants expressed unease initially about being audio taped, an important tool in qualitative narrative research. Participant confidentiality was explained and all expressed reassurance that they were happy to be audio taped. Nevertheless, we cannot be certain that parents did not withhold information from the researcher due to the taping.

Another limitation is the absence of fathers in the sample. This is a common limitation in parenting research, but was far more challenging in the refugee camp setting this research was conducted. Fathers, when present, were often separated from their families during the day time as they searched for resources for their families and work. The areas that were mainly male dominated were deemed unsafe for the female researcher to enter. Involving male researchers could aid the recruitment of fathers into such studies, as insight into fathers coping mechanisms, experiences and thoughts are crucial for more generalisable results.

Opportunity sampling was necessary in this context, which may have led to the researcher not having great contact with mothers who were withdrawn or isolated themselves. It may not be possible to make generalisations based on this sample, as the contextual nature of narrations are that they reflect an understanding of a certain time, place and circumstances (Pavlish, 2007). However, given that the identified coping strategies reflect those in previous research within other pre-resettlement contexts (Khawaja et al., 2008; Pavlish, 2007), it seems that the results may be applicable should this study be repeated with a larger sample. Finally, no measures of participant's trauma levels and experiences were used, so we cannot differentiate between the coping strategies used by those more traumatised than others.

Conclusion

The current study has identified three coping mechanisms utilised by Syrian refugees living in refugee pre-resettlement camps and buildings. These include adaptation to a new norm, reaching out for support and maintaining mental health using faith. This has significant clinical implications, as to date, the focus of research concerning the relatively recent crisis in Syria has focused on the devastating humanitarian and mental health effects on Syrians, and much less is known about coping strategies. We echo the call by Kline and Mone (2003) for a move towards more psychologically informed approaches that take account the beliefs, perspectives and values of individual people. Research highlights that different cultures and populations experience and deal with stressors in different ways. Therefore, this study is important when planning suitable interventions for Syrian refugees in pre-resettlement contexts. This study specifically focused on parental coping strategies. An exploration of individual coping strategies versus parental coping strategies could be valuable to differentiate between whether behaviours parents display, such as allowing their children to go out and play even when they do not want them to, are deliberate parenting strategies or whether they are reactions to camp stressors or emotional problems the parents may be experiencing. Further research involving both parents and children could be valuable in better understanding family mechanisms involved in coping and how best to encourage adaptive strategies and discourage those that are maladaptive for post trauma recovery.

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