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Syrian refugees' experiences while receiving mental health services and psychiatric nursing care: A qualitative study

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Abstract

Aim: This study examined the experiences of Syrian refugees in a community centre in Turkiye as they access mental health services and receive psychiatric nursing care.

Design: A qualitative design was adopted in the study.

Methods: Data were collected from southern Turkiye between November and December 2021. The researchers conducted three semi-structured focus group interviews. Colaizzi's phenomenological method was followed to analyse the qualitative data. A total of 19 Syrian refugees participated in the focus group interviews.

Results: Three key themes related to immigrants' experiences of receiving mental health services and nursing care were identified: barriers to receiving mental health services, coping with negative experiences in Turkiye and satisfaction with mental health services. The participants identified the barriers they experienced while receiving health services as those pertaining to language, discrimination and stigmatization. They also mentioned the methods of coping with these negative experiences in Turkiye. Despite their negative experiences, they expressed satisfaction with the mental health services they received, especially psychiatric nursing care.

Conclusions: This study determined that Syrian refugees face barriers in accessing and receiving mental health services. They stated that mental health professionals in Turkiye approach them with empathy, particularly those in psychiatric nursing. Healthcare professionals may be trained in culturally sensitive care to increase awareness.

Impact: Studies have frequently examined the experiences of nurses providing care to refugees, but few have focused on evaluating nursing care from the perspective of refugees. Syrian refugees have reported various obstacles in accessing and receiving mental healthcare services. Health professionals, especially psychiatric nurses in mental health psychosocial support centres, must facilitate the processes to eliminate these obstacles.

Reporting Method: The consolidated criteria for reporting qualitative research (COREQ) were used.

Patient or Public Contribution: No patient or public involvement.

KEYWORDS
health, immigrant, mental health, nurses, psychiatric nursing, refugees

1 | INTRODUCTION

Migration is as old as human history, with humanity constantly shifting places since its existence. It has never ended in any period of history, and it continues in modern times because of wars, political movements and the search for better working and living opportunities (Bacci, 2018). Therefore, migration has affected almost every country in the world. Recent data from the International Organization for Migration (IOM) indicate that approximately four out of every hundred people are immigrants (IOM, 2021) and that 108.4 million people have moved because of violence, wars, disasters and human rights violations, all of which have increased rapidly worldwide in recent years. Among these individuals, over 35 million reside in Turkiye (UNHCR, 2023).

2 | BACKGROUND

Refugees need the most help among all migrants (IOM, 2021). In addition to abandoning their previous lives, they must establish new settlements and build work and social relationships (Biner & Soykan, 2016). However, they encounter various challenges and stressors during this transition. These obstacles include financial difficulties in their new locations, limited access to necessary health care and other services, the need for psychosocial support and the added burden of stigma and discrimination (Georgiadou et al., 2018). As a result, refugees are more prone to mental disorders (post-traumatic stress disorder, anxiety, depression), infectious diseases (human immunodeficiency virus, tuberculosis, vaccine-preventable infectious diseases) and noncommunicable diseases (orthopaedic disorders, diabetes, cancer, cardiovascular system diseases) than the native citizens of the host countries (Acarturk et al., 2021; Müller et al., 2018). However, refugees continue to face challenges in accessing adequate healthcare and effective treatment (Munz & Melcop, 2018).

Although laws ensure equality and facilitate healthcare access for refugees, these measures are complex and are mainly affected by three factors: individual factors, structural factors and characteristics of health professionals (Beşer & Tektaş-Kerman, 2017). Individual factors encompass various sociodemographic, economic, and cultural characteristics of refugees, including their beliefs, traditions, languages and health habits. Structural factors refer to the quality and adequacy of health services and the relevant legislation to make the system more accessible. Healthcare professionals' characteristics that hinder access to health services include their unfamiliarity with the language of refugees, prejudices, attitudes, cultural differences, beliefs and lack of an understanding of individualized care (Beşer & Tektaş-Kerman, 2017; Doğan et al., 2019; Kiselev, Pfaltz, Haas, et al., 2020; Kiselev, Pfaltz, Schick, et al., 2020). Önal and Keklik (2016) found that refugees in Turkiye encounter negative attitudes from health professionals while using health services and experience communication problems. They attributed these issues to the lack of time spent by health professionals with patients and physicians' failure to convey the necessary information about treatment processes.

However, owing to the increasing number of refugees, the workload of healthcare professionals has increased, the quality of service has decreased and language and cultural problems have emerged (Aslan et al., 2018). A previous study reported that nurses need translators to overcome the language barriers they experience with their patients (Eklöf et al., 2015). In addition, they cannot provide individualized care in the same way they do for other patients who speak the same language (Salavati et al., 2019).

Apart from the obstacles in accessing health services, refugees also face discrimination and stigmatization (Kluge et al., 2020; Majumder, 2019). These issues prevent the initiation and continuation of treatment of existing health problems and deprive refugees of the right to use health care (Boydell et al., 2020; Byrow et al., 2019; Hacker et al., 2015). A study conducted in Canada with immigrant service providers by Salami et al. (2018) reported that most immigrant and refugee patients with mental illness feel personally responsible for managing the challenges they face and hide their struggles from their support networks as they experience stigma within their ethnic groups and in their host countries, which leads to discrimination and social exclusion (Salami et al., 2018).

2.1 | Aim

This study examined the experiences of Syrian refugees in a community centre in Turkiye as they access mental health services and receive psychiatric nursing care. Although studies conducted in Turkiye have frequently examined the experiences of caring for refugees from the perspective of nurses, the evaluation of nursing care from the perspective of refugees in the current study is expected to introduce a different perspective to the literature. This research seeks answers to the following fundamental questions:

- What are the experiences of Syrian refugees in Turkiye while accessing mental health services?
- What are the experiences of Syrian refugees in Turkiye while receiving psychiatric nursing care?

3 | MATERIALS AND METHODS

3.1 | Design

This research was designed as a qualitative phenomenological study.

3.2 | Study setting and sample

This study was performed in the Turkish Red Crescent Kahramanmaraş Community Health Center. This centre was selected to reach out to the participants due to the city is near Syria board and has one of the biggest refugee camps in Southeastern Turkiye. The study used purposive sampling (Polit & Beck, 2006). The inclusion criteria for the sample were being Syrian under temporary protection, aged 18 years and older and being followed up at the Turkish Red Crescent Community Health Center between 3 November 2021 and 9 December 2021. All participants were followed up at the Turkish Red Crescent Community Health Center for a year. After obtaining ethical and institutional approval from the Turkish Red Crescent, psychiatric and mental health nurses who had worked in the centre for a year invited individuals who had regularly visited the centre via phone. Refusal to participate in the study and dropping out of the interviews were the exclusion criteria. However, none refused to participate or dropped out of the interviews.

Data were collected through three focus group interviews with 19 participants. The interviews with the participants were conducted at the centre, where social distancing was maintained in adherence to the COVID-19 pandemic guidelines.

3.3 | Data collection and data collection tool

The focus group interview method was used for data collection. During the interviews, translation support was provided by a translator whose native language was Arabic. The translator translated the questions and answers for the participants and the research team. Three interviews were conducted with the participants. In the first interview, information about the research was provided, and informed consent was obtained from individuals who agreed to participate. In the second meeting, focus group interviews were conducted, with each session lasting an hour on average. After the focus group interviews, the participants were again invited to the centre, and a third interview session was conducted. In these interviews, the interpreter read the participants' statements and sought their approval if appropriate. The participants provided feedback, with all of them approving the interviews. A voice recorder was used in the focus group interviews, and separate consent for voice recording was obtained from the participants before the interviews.

The interviews were held in a separate meeting room (without anyone else present except the participants and researchers), where the seats were arranged in a circle so that the participants could see one another. The meeting room was located at the centre and served as a space for group meetings and trainings. Women and men participated in the focus group interviews together without their spouses. In Syria, women and men are typically seated separately. However, the same was not an issue in the study as the participants could sit together given the fact that life in Turkiye is more integrated and women and men participate in other trainings in the Turkish Red Crescent.

All semi-structured focus group interviews were conducted by the same female mental health and psychiatric nurse (R.N.) and the same male translator (B.Sc.) working with refugees at the centre. Both had worked at the centre for a year, and the mental health and psychiatric nurse had received training in therapeutic communication and qualitative studies. During the focus group interviews, the nurse received supervision from senior faculty, who was experienced in psychiatric and mental health nursing and qualitative research. The translator has a bachelor's degree in classroom teaching and is Syrian. The psychiatric and mental health nurse interviewed the translator and took short notes during the interviews. Data collection was completed when the participants started replicating their statements and data saturation was reached. The data were written in Arabic through listening and translation and were then translated into Turkish.

Semi-structured Focus Group Interview Form: A semi-structured interview guide was used to collect the data for this study. Two researchers created the form in line with the literature (Doğan et al., 2019; Kiselev, Pfaltz, Schick, et al., 2020; Önal & Keklik, 2016) and through discussions. The researchers have backgrounds in nursing management and psychiatric and mental health nursing. The form consisted of the following two parts: The first part comprised 17 questions to determine the sociodemographic characteristics of the individuals (e.g. age, sex, educational status, marital status, occupation, income status, social security and place of residence), migration processes, and status related to physical illnesses and mental disorders. The second part comprised 12 focus group interview questions. The questions included the following: 'How would you evaluate the health services offered? How would you evaluate the mental health and nursing services offered to you? Were you treated differently while receiving these services? What did you experience?' Before the focus group interviews, the experienced researchers trained the interviewer and responded to her questions. Individual pilot interviews were then conducted with two individuals, and the form was evaluated. As the individuals stated that they found the questions understandable, no changes were made to the form. These individual pilot interviews were not included in the scope of the study.

3.4 | Data analysis and rigour

In this study, SPSS software (version 26.0) was used to analyse the sociodemographic data with descriptive statistics (mean, percentage and number). The phenomenological interpretation method of Colaizzi (1978) was used to analyse the qualitative data. In the phenomenological approach, data analysis is aimed at revealing experiences and meanings (Colaizzi, 1978; Shosha, 2012). The data analysis was conducted as follows: (1) The interviews were transcribed and read in full text in Turkish. (2) The researchers read the text several times to understand the meanings of the

senses and experiences conveyed in the interviews and to identify important statements directly related to the phenomenon. (3) The expressions were coded using the qualitative study program MAXQDA, and (4) the formulated meanings were grouped into subthemes, themes and categories. (5) Three researchers independently translated the themes, subthemes and expressions into English and checked for inconsistencies. After the data were analysed, the participants were not contacted to confirm the themes and subthemes because the interviews were conducted in Turkish and Arabic while the findings were written in English. Therefore, the last step in Colaizzi's phenomenological interpretation method could not be performed in the study because of language barriers. The participants were asked to read and confirm their respective statements during the third interview to increase the statements' validity and reliability.

The criteria of Guba and Lincoln (1994) were used to read back the participants' statements, obtain consent and obtain counselling from another researcher who was part of the study but did not perform the analysis. This approach was aimed towards increasing the validity between the researchers based on the triangulation method and applying purposeful sample selection methods suitable for the research subject. The researchers who performed the analysis were engaged in psychiatric and mental health nursing (Ph.D.), public health nursing and family counselling (M.Sc.) and women's health and diseases nursing (PhDc). In this respect, data analysis by researchers trained in public health, mental health and women's health nursing allowed for an in-depth understanding of the data.

3.5 | Ethical issues

The data in this study were collected after receiving approval from the Academic Research and Publication Board of Fenerbahce University, numbered 2021–4 and dated 01.09.2021. Institutional permission was obtained from the Turkish Red Crescent Research Center, and verbal and written informed consent was obtained from Syrian nationals under temporary protection who were followed up in this institution and agreed to participate in the study before data were collected through the focus group interviews. The informed consent form was prepared in Turkish and then translated into Arabic by a native translator and separate consent for voice recording was obtained from the participants before the interviews. To protect the participants' rights and ensure that they remained anonymous, their names and genders were removed during data writing.

4 | FINDINGS

Nineteen individuals participated in the study. A total of 602 codes were created from the interview data. Afterwards, three main themes were created from these codes: 'barriers to receiving mental health services', 'coping with negative experiences in Turkiye' and 'satisfaction with mental health services'.

4.1 | Characteristics of the sample

The average age of the individuals was 36.21 years (8.23), and the majority (63.2%) were women. In addition, 78.9% of the participants were married, 63.2% were secondary school graduates, 78.9% were not working, 57.9% described their income status as low, none had social security, and 73.7% lived in metropolitan areas or cities. Syrians who started immigrating to Turkiye in 2010 had lived in Turkiye for an average of 8.52 years (1.67); 78.9% of these individuals came to the country with their spouses and children, and 63.2% still lived with them (Table 1).

More than half of the participants did not have a physical illness, and only 1.5 (0.9) were hospitalized due to physical illness. However, almost all of them had mental disorders, the most common of which was anxiety. On average, the participants were diagnosed with mental disorders 3.78 (2.55) years prior, and an average of 1.05 (0.22) had been hospitalized. In addition, approximately one third of the participants had attempted suicide (Table 2).

4.2 | Thematic analysis

The analysis identified three key themes related to the immigrants' experiences while receiving mental health services and psychiatric nursing care. For the first theme, 'barriers to receiving mental health

TABLE 1 Participants' sociodemographic characteristics.

Variables	(*n*) Number	% (percentage)
Sex		
Female	12	63.2
Male	7	36.8
Marital status		
Married	15	78.9
Single	4	21.1
Education		
Literate	2	10.5
Primary school	3	15.8
Secondary school	12	63.2
High school	2	10.5
Income status		
High	11	57.9
Low	8	42.1
People he/she migrated with		
Husband/wife and children	15	78.9
Alone	2	10.5
Mother and father	2	10.5

TABLE 2 Participants' physical and mental illnesses story.

Variables	(*n*) Number	% (percentage)
Physical illness		
None	10	52.6
Heart and vascular disease	3	15.8
Respiratory system disease	2	10.5
Muscle and skeletal system disease	2	10.5
Neurologic disease	1	5.3
Organ loses	1	5.3
Mental illness		
Anxiety disorder	11	57.9
Schizophrenia and other psychotic disorders	5	26.3
Mood disorder	1	5.3
Consultancy service	2	10.5
Suicide intervention		
Yes	6	31.6
No	13	68.4

TABLE 3 Themes and subthemes of the participants.

Themes	Subthemes
Theme 1: Barriers to receiving mental health services	• Language barrier • Discrimination and stigmatization • Inability to access hospital services • Obstacles experienced during service procurement
Theme 2: Coping with negative experiences in Turkiye	• Problem-focused strategy • Emotion-focused strategy
Theme 3: Satisfaction with mental health services	• Caring healthcare professionals • Free health care • Safety • Psychiatric nursing care

services', the participants explained the problems they experienced while receiving mental health services. For the second theme, 'coping with negative experiences in Turkiye', the participants talked about their methods for coping with these negative experiences. The third theme, 'satisfaction with mental health services', was formed by the positive attitudes and behaviours experienced by the participants during the service procurement process regardless of their negative experiences. Thematic details and subthemes are described below (Table 3).

4.3 | Theme 1: Barriers to receiving mental health services

The obstacles faced by individuals while receiving health services were examined. In the subtheme 'language barrier', the participants identified language difference, lack of translators and incorrect or incomplete translations as the critical challenges in their use of mental health services. In the subtheme 'discrimination and stigmatization', the participants mentioned that they were exposed to negative behaviours by health professionals owing to their race and that people were labelled in their social circles because they received mental health services. Meanwhile, inadequate appointments, difficulty in transportation, economic problems and systemic problems were examined under the subtheme of 'inability to access hospital services'. The obstacles experienced by many participants during their meetings with health professionals were explained in the subtheme of 'obstacles experienced during service procurement'.

4.3.1 | Language barrier

The language barrier negatively influenced the immigrants' experiences in receiving mental health services and nursing care. Specifically, the participants described how they had been challenged as result of them not being able to understand Turkish and express their problems in a hospital environment. For example, almost all participants identified the absence of Arabic-speaking personnel who they could approach during hospital visits or when booking their appointments. They also emphasized how they could not communicate in Turkish or had difficulty making an appointment because they knew little Turkish.

The participants stated that some healthcare settings had Arabic translators but that more translators were needed. With this barrier, they could not effectively explain themselves, express their emotions or talk about their illness to their physicians because of the limited time and incorrect or incomplete translations. They also stated that the language barrier between them and health professionals and the incorrect or incomplete translations by translators caused them to be misdiagnosed and unable to follow up on the treatment processes.

It is challenging to be an interpreter in a state hospital, and it is also challenging to find an interpreter—the state hospital has very bad mental health department. The person who wants to be treated will have many difficulties because an interpreter is needed, and the interpreter does not always understand. For example, we describe our situation to the interpreter, the interpreter talks to the doctor, the doctor speaks to the interpreter using 50 words, and the interpreter then speaks three words. I had much trouble because of this and they did not know about my disease. (Participant 4).

4.3.2 | Discrimination and stigmatization

Most participants experienced discrimination and stigmatization while trying to receive mental health services. Although some individuals claimed that they did not encounter any racism, the

majority of the participants stated that less time was allocated to them because of their race, their waiting times were longer, meetings were kept short, citizens of the country were given priority, and the attention shown to citizens was not applied to them. Some individuals also stated that they avoided getting health services because of these negative experiences. Furthermore, the participants stated that they felt worthless because they were excluded due to their race.

When we went to the hospital to discuss health care, the doctor constantly told the translator to leave the Syrians for last. Maybe a few people have experienced this. I made the appointment at 9 AM, but I waited until 11 AM. So, am I wrong? The doctor does this all the time. I have to stay there for 2 h because Syrians are seen last. I do not want to talk about racism, but some doctors take Turks before they take us. Some patients speak 100% Turkish, and when the doctor finds out that they are Syrian, he immediately starts saying, 'Go find an interpreter!' (Participant 16).

Many participants stated that they did not need psychiatric support in their own country, mental problems started to emerge after their forced migration, some of them were not aware of the existence of such mental health services for a long time, and some knew about the services but had hesitations about availing them. They attributed their hesitation to the fact that people around them called them 'crazy'. One of the participants highlighted that this situation affected their initiation of psychiatric treatment; because of labelling, they refused to see a psychiatrist and thus preferred to suffer from mental disorders.

We found out when we got here. We learned here because a psychologist, psychiatrist, and someone were listening to us; we did not know these before. Most of us do not go to a psychiatrist so that they do not call us crazy. I would rather sit at home and suffer just so they do not call me crazy. I do not go to a psychiatrist, so they do not call me crazy. (Participant 9).

4.3.3 | Inability to access hospital services

Most participants stated that they had problems accessing hospital services because of issues related to transportation, official regulations, temporary protection identity cards, economic situations and appointments. Additionally, the individuals stated that they encountered bureaucratic difficulties when they wanted to receive mental health services in other cities. Some individuals indicated that they had to change cities because of the limited mental health services they could receive in the towns they were registered in and that they had to secure a 'road permit' every time they changed cities. One participant explained an experience as follows:

When I came to Turkiye, my psychological condition deteriorated. Especially when I came here, I had an identity problem. First, I went to another city, and then I had to move here, but I cannot get any service here because my ID belongs to the town where I first lived. A while ago, I got a road permit to get psychological support from a hospital. When I went to the hospital, they did not talk to me at all; they just asked me about my illness, gave me medicine and sent me home. I needed a road permit to go to the hospital, I went to the control for the first time, but I could not go again because I could not get a road permit for the second time. I currently reside here, but I cannot go to any institution or hospital without a road permit. I could not complete my treatment because I could not get a road permit from the city of Iskenderun. (Participant 10).

Some individuals described their income levels as low and stated that they experienced economic difficulties because they did not have a qualified job to access health services. In addition, they reported that they experienced financial problems because of the cost of transportation services.

Hospital appointments are another reason for the inability to access hospital services. Almost all participants stated that they had difficulty finding an appointment and could not benefit from hospital services because they could not communicate in Arabic with the hospital staff at the hospital call centre. They stated that they thought their mental disorders could not be diagnosed on time because they could not book appointments. Some participants noted that this barrier was not due to their current status in the country, reporting that it was due to the waiting time for appointments being too long. One participant added that booking an appointment on the online platform took too long.

When the medication report expired, I tried to make an appointment, but I could not find the name of the doctor who had treated me for 2 years in the system. I tried to make an appointment for 3 months, but the doctor's name was not visible. I did not want to go to another doctor for treatment. After a while, I learned that the doctor had resigned from the hospital and opened a private clinic. (Participant 16).

4.3.4 | Obstacles experienced during service procurement

In this subtheme, the participants conveyed their negative experiences while receiving health services. For example, some individuals stated that they needed help with healthcare services because of the limited time allocated to them by health professionals and because they were unable to take care of themselves, they did not follow the treatment processes, and they even neglected them.

The psychiatrist does not act like a doctor here. He sits and does not speak. He does not understand you; he does not support you. 'No, just take this medicine and go home', he says. He practises psychiatry but is not like other psychiatrists. He does not know what the complaint is or what problem the patient has. He prescribes medicine and sends us home. Does it have side effects or not? Did you benefit from the medicine or not? I used these drugs for 3 years, but I did not improve, and my condition worsened until I came here. They stopped those drugs and gave me another drug. I did not get any benefits at the hospital. It is good that they opened this place

and started to serve. Because after using the previous drug, my condition declined. Thank goodness, I came here and benefited. (Participant 5).

According to one participant, the number of health professionals was insufficient, privacy and confidentiality were not ensured during examinations and interviews, and reviews were ineffective because one physician handled all Syrian individuals.

… there is one doctor for all Syrians, and the rest are for Turks. The examination is swift when the hospital is crowded; the doctor takes 10 patients simultaneously. I was embarrassed and felt like an insect. We are like animals; they take 10 people simultaneously and check and send them away quickly. (Participant 10).

Some participants said they went to immigrant health centres where health professionals who spoke Turkish and Arabic were employed to facilitate the access of immigrants living in Turkiye to health services and monitor their health regularly. Although participants stated that they could express themselves better to the health professionals in these centres, they were often prescribed the same drugs because of the lack of specialists at the centre.

There are no specialist physicians in the family and immigrant health centres here. The doctors there are not experts. I mean, they are general doctors. The doctor there understands me because he speaks Arabic. At the immigration health centre, I can convey my pain. Unfortunately, he is a general doctor. I have a complaint about urology. He says that it is not his area of expertise. Sometimes we have stomach complaints, and the doctor says again, 'It is not my area of expertise'. He gives the same drugs to 80% of the patients who go to him. (Participant 7).

4.4 | Theme 2: Coping with negative experiences in Turkiye

Some participants explained their methods for coping with their negative experiences in Turkiye. Two subthemes are related to coping strategies: problem-focused strategy and emotion-focused strategy.

4.4.1 | Problem-focused strategy

Some participants tried to change their current situation by actively attempting to cope with the discriminatory, stigmatizing and harmful experiences they experienced. Some of the participants tried to understand the real cause of the problem by analysing the problem under the adverse conditions they experienced and finding different solutions; others stated that they kept calm and defended their rights without getting angry.

I just told you before. Carelessness, rushed examination, failure to provide a diagnosis and lack of effort to listen… You might not grasp the situation because you did not go to the hospital. I went there three times. I have no positive experience in the hospital. In such a case, I try to stay calm and explain. I answer them, I did nothing bad to you, what happened is not about me. (Participant 10).

4.4.2 | Emotion-focused strategy

The participants also coped with their negative experiences by controlling their emotions. In addition, they sought emotional support from their social environment.

If they do not understand me or do not listen to me, I sit and cry. I tell my neighbour or friend. Not only is the healthcare system terrible but we are generally mistreated. Wherever we go, they make fun of us; it is getting worse and worse. (Participant 13).

Some participants turned to or reinterpreted religious pursuits to obtain positive results. Others stated that they should be optimistic and accept the situation because they could not change the existence of the problem. One participant said that he had only positive experiences with health care and had never had a negative experience. Even if he did, he said that he should respect the individuals they receive service from because he is a refugee in Turkiye and will not take any action.

I will give a simple example: the interview took at least an hour, and the psychologist also provided medication for my benefit. We have not seen anything negative here. Nothing happened; even if it did, we would not do anything; we are refugees here. We have to respect those who provide services. Most of all, we should keep our emotions in check. Thankfully, everything has been positive, and I have not experienced anything negative. (Participant 16).

4.5 | Theme 3: Satisfaction with mental health services

The satisfaction of the participants with the healthcare and nursing care they received was examined. Their satisfaction levels were generally positive, especially with regard to the behaviours and approaches of the health professionals, their ability to benefit from free health services, Turkiye being a safer country than Syria, and their positive experiences in receiving psychiatric nurses' care.

4.5.1 | Caring healthcare professionals

The participants reported that the healthcare professionals were helpful, motivating and attentive to patients and offered appropriate treatment. They compared their previous experiences with mental health and other healthcare services in their own country with those in Turkiye. The participants were grateful for the quality service, care and effective therapies they received from health professionals; they feel valued because they had time for themselves and were listened to and understood. They also stated that they feel motivated and hopeful towards the treatment process because of improvements in their current mental state. They reported that the

mental health services and nursing care provided in Turkiye were better than those provided in Syria. For example, one participant said that when he went to the hospital, the nurses treated him well either because the nurses empathized with him or because of the training that the nurses received.

I am going to talk about general nurses and not psychiatric nurses. The nurses here are more interested in us compared to the nurses in Syria. Nursing care there [in Syria] is different from nursing care here. Nursing care is better here, maybe because we are refugees. Perhaps it is because we were exposed to war or nurses here received specialized education. It is slightly better here. (Participant 4).

Some participants added that mental health professionals did not exhibit stigmatization or discrimination behaviours and described them as competent. Although the participants struggled with the existing obstacles in the healthcare system, many of them said that they were satisfied with the quality of the mental health services they had received in recent years. Even during the pandemic period, regular medication follow-ups and appointment reminders were provided, the healthcare professionals took care of them, their treatments were efficient, and they made positive progress with regard to their mental health. One participant stated that his psychologist demonstrated genuine interest, listened to him and supported him in his approach. The patient achieved positive treatment outcomes.

I talked to the psychologist at the Turkish Red Crescent twice and was very relieved. I am currently waiting for the third meeting. I sit with him and explain my situation. I appreciate having someone advise me, someone who hears us and someone who directs us. He told me there is an obstacle like a stone in my way and that he will help me until this obstacle is removed. I am very relieved. (Participant 11).

4.5.2 | Free health care

When the participants were asked to explain their experiences in Turkiye, they stated that health services were free because they were registered with the Turkish Health System and Social Security Institution (SSI). As for their experiences in Syria, they reported that all health services in their country were subject to fees that must be paid.

Everyone knows about Syria. Whenever we visit a doctor, we bring money with us because we do not have health insurance. Sick patients are able to consult a private doctor by paying the fees. And then we must buy our medicine. I cannot compare Turkiye and Syria. Turkiye has SSI for every person here. There is no such thing as SSI in Syria. The system in Turkiye is incomparable. (Participant 7).

According to some participants, they had not previously received mental health services in their country, they needed mental health services after the war and migration, and they did not know whether such services were available in Syria. Other participants said that although they had the opportunity to receive mental health services in Syria, they did not prefer it, with some explaining that they obtained psychotropic drugs directly from the pharmacy and changed the drug dose without a doctor's examination or advice. As for their experience in Turkiye, the participants stated that they could receive treatment thanks to the free mental health services and the provision of these opportunities.

When I was in Syria, I did not go to a psychiatrist. I used to go to the pharmacy and buy medicine without knowing if it would actually benefit me. If it did not help, I would increase the dose. But I did not actually go to a psychiatrist. But here [in Turkiye], they provided me with an opportunity. We are allowed to consult a psychiatrist and talk as much as we want. (Participant 1).

4.5.3 | Safety

The participants stated that they had been in Turkiye for many years and that they should follow the rules set by the laws and regulations issued by the country's public institutions. Some of them stated that they were safe in their own country prior to the war. However, given the current situation, they found Turkiye safer than Syria; Turkiye was free from war, and they were protected and received services in a safe environment. They stated that the war continues in Syria. Meanwhile, they reported that their living conditions in Turkiye present challenges.

I had two therapy sessions. Living in Turkiye has advantages and disadvantages. We have security here, and the country is not at war. However, life can be difficult, and our financial situation is terrible. I have two children who had to work to help with our household expenses. They left us and went to Syria because of the difficult living conditions and the racism they were exposed to. (Participant 11).

4.5.4 | Psychiatric nursing care

The participants reported that they had not seen a psychiatric nurse in Syria, and most stated that they had learned about psychiatric nursing in Turkiye. They noted that the psychiatrists and mental health nurses in Turkiye closely monitored their treatment, communicated with them regularly, approached them equally without discrimination and considered their needs. In addition, they said that they were satisfied with the care and services they received and that their experience positively affected their mental health.

We were having difficulties with our doctor before the psychiatric nurse came. For example, we were having challenges with our appointments, medication and many other things. Previously, a female translator was involved. Regardless of how knowledgeable she was, she cannot be like a nurse. Nevertheless, she made a big difference, and her presence was not harmful in any way. Meanwhile, the nurse's presence greatly helped us and our doctor. We cannot find a similar psychiatric nurse in hospitals. She follows protocols

very well; she is also fine with other dating-related stuff. Thank you. (Participant 4).

5 | DISCUSSION

This study examined the experiences of Syrian refugees in receiving mental health services and psychiatric nursing care in Turkiye. The results indicated that Syrian refugees face obstacles in accessing and receiving health services. The participants reported dealing with language barriers, stigma and discrimination, which caused them to feel anger, anxiety and fear. The language barrier is a major obstacle that refugees experience and is described widely in the literature (Doğan et al., 2019; Hendrickx et al., 2020; Javanbakht et al., 2019; Kiselev, Pfaltz, Haas, et al., 2020; Kiselev, Pfaltz, Schick, et al., 2020; Tekkeli-Yesil et al., 2018). Doğan et al. (2019) found that Syrians living in Turkiye could use the services in a limited way because of the language barrier and experience problems making appointments. In overcoming the language barrier, interpreters are deployed for translation; however, the presence of interpreters in examinations affects patients' privacy (Doğan et al., 2019). In this respect, health professionals who can speak both the mother tongue of refugees and the host country's native language should be employed, the time allocated to patients must be increased, and attention must be paid to patients' privacy.

Being a refugee increases the risk of mental disorders because of various negative factors, such as exposure to psychological and physical violence due to migration, traumatic memories and economic problems. Trauma-related disorders, anxiety disorders and depressive disorders are pervasive among refugees; thus, refugees are in great need of mental health services (Acartürk et al., 2021; Hendrickx et al., 2020; Javanbakht et al., 2019; Kiselev, Pfaltz, Haas, et al., 2020; Kiselev, Pfaltz, Schick, et al., 2020; Mesa-Vieira et al., 2022; Tekkeli-Yesil et al., 2018); however, they use these services less frequently than the general population (Kallakorpi et al., 2019; Kiselev, Pfaltz, Haas, et al., 2020; Kiselev, Pfaltz, Schick, et al., 2020). In this study, the participants stated that they did not receive mental health services in their own countries but received these services in Turkiye. This situation can be explained by the fact that individuals require these services because of the war they experienced, their traumatic memories, and their migration. However, the participants stated that they did not receive mental health services in their own countries and that they would be labelled and marginalized if they did. Thus, although attitude towards mental disorders is often unfavourable in Turkiye (Çam & Bilge, 2013), it may be better than that in Middle Eastern countries. In addition, the refugees stated that they were exposed to stigma not only because they received mental health services but also because they were refugees. Similarly, the literature has reported that refugees can be stigmatized and discriminated against in the procurement of health services, as in many other areas of life (Doğan et al., 2019; Hendrickx et al., 2020; Javanbakht et al., 2019; Kiselev, Pfaltz, Haas, et al., 2020; Tekkeli-Yesil et al., 2018).

The participants stated that Turkiye was free from war and that they felt safe. Nevertheless, they also experienced economic, transportation and bureaucratic difficulties and could not always book healthcare appointments. Refugees often leave their country and their existing lives behind, and they have to go on with their lives in a new geography while experiencing economic problems (Doğan et al., 2019; Javanbakht et al., 2019; Kiselev, Pfaltz, Schick, et al., 2020; Tekkeli-Yesil et al., 2018). In addition, refugees worldwide deal with bureaucratic difficulties, which cause them to experience more stress. Although many procedures and agreements are made for refugees to receive health services (Doğan et al., 2019), refugees still face bureaucratic obstacles, such as identity registration and a lack of information about the country's health system (Kiselev, Pfaltz, Schick, et al., 2020). These structural barriers also cause refugees to experience more depression and anxiety (Acartürk et al., 2021). This condition shows that the past traumatic experiences of refugees and the stressors they experience negatively affect their mental health. These problems must be addressed through studies on refugees and implement appropriate laws and policies for their protection.

The participants preferred problem- and emotion-focused methods for coping with negative experiences. In addition to understanding and trying to solve the current situation using problem-oriented methods, the participants used emotion-focused methods to control their emotions and seek social support from their environment. Studies have shown that refugees must cope with traumatic memories and current stressors and adapt to the new country's culture (Acartürk et al., 2021; Hendrickx et al., 2020; Kiselev, Pfaltz, Haas, et al., 2020; Kiselev, Pfaltz, Schick, et al., 2020). However, mental disorders and trauma negatively affect individuals' coping methods, sometimes causing them to use ineffective coping methods (Acartürk et al., 2021). The emotion-focused methods used in this study revolve around the idea that refugees lose social support when they leave their country or during war (Hendrickx et al., 2020). Meanwhile, problem-focused methods can be reflected in the fact that traumatized refugees might experience post-traumatic growth and become more resilient (Ersahin, 2022).

The participants' satisfaction with mental health services and psychiatric nursing care in Turkiye is striking. They appreciated the mental health professionals' interest in them, their ability to access services free of charge, the sense of safety they feel, and the benefits they receive from the psychiatric nursing care process. They stated that they felt valued, motivated and hopeful. Similarly, in a study examining the experiences of refugees in receiving psychiatric nursing care in Finland, the participants stated that psychiatric nurses paid attention to intercultural points in their care and that they felt safe and accepted; they also found their communication and willingness to help sincere, and they were satisfied with the care they received (Kallakorpi et al., 2019). The participants also stated that they often receive and pay for mental health services in private hospitals or examinations in their own countries. Under the pre-war Syrian health system, the number of health professionals was insufficient, standardization in health services was lacking, the budget allocated to the health system was inadequate, and the increase

in private sector services was uncontrolled (Hendrickx et al., 2020). Although similar problems exist in Turkiye (Kaya et al., 2018), the participants of the current study stated that they were empathized with, were not deprived of these services even during the pandemic and were satisfied with the services they received. These findings may be attributed to the institution where the data were collected, which provides psychosocial support within the scope of an international project (Mental Health and Psychosocial Support, MHPSS) (Turkish Red Crescent Community Centers, n.d.).

5.1 | Limitations

The data obtained from this study are limited to the participants' experiences and statements. Another limitation is the fact that this study was conducted in an institution supported by an international project and the focus group interviews of the researchers might have affected the participants' statements about the institution and psychiatric nurses. In addition, this study examined the experiences of Syrian refugees only, although the population immigrating to Turkiye is increasing daily.

6 | CONCLUSIONS

This study determined that Syrian refugees face language barriers, stigmatization and discrimination while accessing and receiving mental healthcare services. Although they reported dealing with economic, transportation and bureaucratic stressors and difficulties in booking appointments, they received free MHPSS within the project's scope and were very satisfied with this service. They stated that mental health professionals in Turkiye approached them with empathy, particularly those in psychiatric nursing. Accordingly, global policies should be developed to reduce the bureaucratic obstacles experienced by refugees and ensure integration. In addition, health professionals should be trained in culturally sensitive care, and their awareness should be expanded further.

AUTHOR CONTRIBUTIONS

All authors have agreed to the final version of the manuscript and meet at least one of the following criteria recommended by the ICMJE. Gizem Öztürk, Kübra Timarcioğlu, Gül Dikeç, Ece Karali, Hamza Nacaroğlu, Hanife Çakir, Arzu Kader Harmanci Seren: Made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. Gizem Öztürk, Kübra Timarcioğlu, Gül Dikeç, Ece Karali, Hanife Çakir, Arzu Kader Harmanci Seren: Involved in drafting the manuscript or revising it critically for important intellectual content.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors. The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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DATA AVAILABILITY STATEMENT

The data of the study is available upon reasonable request.

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