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A life in waiting: Refugees' mental health and narratives of social suffering after European Union border closures in March 2016

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ABSTRACT

Rationale: In 2015, an estimated 856,723 refugees, predominantly from Syria, Afghanistan, and Iraq arrived in Greece as an entry point into the European Union. The border of the Former Yugoslav Republic of Macedonia closed in March 2016, blocking a popular route for refugees through Europe, and left around 60,000 people stranded in Greece.

Objective: A mixed-method study was conducted among refugees in the regions of Attica, Epirus, and Samos between November 2016 and February 2017. The epidemiological survey showed that depending on study sites between 73% and 100% of the refugees suffered from anxiety disorder. The explanatory qualitative study aimed to understand refugees' mental health and narratives of social suffering in regards to experienced violence, the effect of current border closures, and the lack of an onward journey.

Method: The explanatory qualitative study included 47 in-depth interviews and five focus group discussions with refugees purposely recruited through the concomitant epidemiological survey, representing both genders and a range of nationalities and ages. Data were thematically analysed to identify emergent patterns and categories using NVivo 11.

Results: The refugees overwhelmingly reported experiencing uncertainty and lack of control over their current life and future, which caused psychosocial distress and suffering. The passivity of life in refugee camps aggravated feelings of meaninglessness and powerlessness. The disruption of key social networks and absence of interactions with the surrounding Greek society led to feelings of isolation and being unwelcome.

Conclusions: Refugees in Greece experience psychosocial distress and social suffering as a consequence of their uncertain and disrupted lives and the loss of social networks. Faster and transparent asylum procedures, the development of meaningful and empowering activities, and fostered social interactions with the surrounding society would contribute to alleviating their psychosocial suffering.

1. Introduction

By the end of 2016, the global refugee population stood at 22.5 million, the highest level ever recorded (UNHCR, 2017). This historical level was mainly driven by the effects of the Syrian conflict and the rise of other conflicts in the Middle-East region and in sub-Saharan Africa (UNHCR, 2017). Within the European context, Greece and Italy have been at the forefront of what media sources and European Union (EU) government officials have named the "migration" or "refugee" crisis. From January to December 2015, an estimated 856,723 people crossed into Greece by sea, mainly departing from Turkey (UNHCR, 2016), making Greece the main gateway to the EU. Most refugees entering were from Syria (47%), Afghanistan (24%), and Iraq (15%) (UNHCR, 2016).

Following official border closures in the Former Yugoslav Republic of Macedonia (FYROM), Croatia, and Slovenia, the "Balkan route" was

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shut down on March 8th 2016. The "Balkan route" refers to a popular route among refugees that usually goes through Turkey and through either Bulgaria or Greece in order to reach Germany or other preferred destination countries. In an attempt to halt irregular migration into the EU, the European Commission (EC) reached an agreement with Turkey, the "EU-Turkey deal", which asserted that individuals crossing illegally from Turkey to Greece after March 20th 2016 should be returned to Turkey if they were not applying for nor were eligible for asylum (The European Council, 2016). The deal also specified that for every Syrian deported from Greece to Turkey, the EU would offer asylum to one Syrian living in a Turkish refugee camp. The EC committed to relocate 160,000 refugees in total to other European countries to ease the pressure on frontier states. However, relocation has been slow and by November 2017, only 31,503 refugees had been relocated (European Commission, 2017). Consequently, around 60,000 refugees became stranded in Greece, of which around 8500 were held on the Greek islands and denied onward travel to mainland Greece. The country was forced to quickly adapt to the situation. Several international non-governmental and human rights organizations have subsequently criticized the "appalling" or "inhumane" conditions in which refugees were left and with clear potential to cause or worsen mental health distress (Amnesty International, 2016; Human Rights Watch, 2017; MSF, 2016).

1.1. Refugee mental health and social suffering

Research on post-conflict and post-migration mental health has led to debate on the best ways to conceptualize and address the mental health needs of refugee populations. One key area of contention is the effectiveness of trauma-focused versus psychosocial approaches, as identified by Miller and Rasmussen (2010). Social scientists have criticized trauma-focused approaches, which purely focus on war trauma, post-traumatic stress disorder (PTSD), and other trauma-related disorders, paying little attention to the lived experience of distress and suffering (Summerfield, 1999; Kienzler, 2008). To capture the life narratives instead of the individualized and medicalized perspectives of psychology and psychiatry, the notion of *social suffering* has been developed (Kleinman et al., 1997; Kleinman and Kleinman, 1997). Social suffering is recognized as the product of the political, social, and cultural context. Hanna Kienzler (2008) argued that the notion of social suffering could be used as a framework for interdisciplinary research that can lead to holistic approaches to health care, taking local perceptions of health and illness, ways of healing, capacities, and needs into consideration (Kienzler, 2008).

Due to the difficulties for researchers to gain sufficient access to refugee camps around the world, research on refugee mental health has mainly focused on the pre- and post-migration (resettlement) phases (Harrell-Bond and Voutira, 2007). Recent studies among refugee populations in camps or in transit concerned populations in a transit situation for years outside Europe (Akinyemi et al., 2016; El-Shaarawi, 2015; Hoffman, 2011), or mainly used epidemiological surveys as methods (Bastin et al., 2013; Crepet et al., 2017). The present study responds to the call made by Kienzler (2008) and others for mixed-methods studies of refugee mental health (Weine et al., 2014). Moreover, the study contributes to the scarce literature on the mental health of recently-arrived/transiting refugees in a European context. The study aims to contribute to the growing body of literature on the impact of Western countries' policies of deterrence on refugee and migrant mental health (Ahearn, 2000; Robjant et al., 2009; Steel et al., 2011; Arsenijević et al., 2018), which has not been extensively explored in a European context.

1.2. Context and study setting

In Greece, refugees are subject to different asylum rules and processes depending on nationality and time of arrival in Greece (e.g. before or after the EU-Turkey deal effected 20th of March 2016). In the days before the effected EU-Turkey deal, refugees were moved from the Greek islands to refugee camps at the mainland in order to create enough space for newly arrived refugees in the reception and identification centres. Refugees who arrived after the effected EU-Turkey deal, were required to remain in the island facilities until the full registration of their asylum claim. Only refugees at the mainland had the possibility to apply for relocation, which is the term used for the transfer from one EU Member State to another of asylum seekers who are in clear need of international protection. As of end of February 2017, the majority of beneficiaries of the relocation scheme were Syrians, with Eritreans and Iraqis as the second and third largest groups (IOM, 2017).

Médecins Sans Frontières (MSF) has been present in Greece since 1991 and has, since 2014, provided primary health care, mental health care, and sexual and reproductive health services to refugees. In 2016, MSF commissioned a study on refugee mental health and experience of violence to inform their operations in Greece. This mixed-methods study consisted of an epidemiological survey and an explanatory qualitative component – the latter is the focus of the present article - and was conducted between November 2016 and February 2017.

The qualitative study took place in four refugee camps on mainland Greece, in the regions of Attica (Ritsona and Malakasa camps) and Epirus (Katsikas and Faneromani camps), in a squatted building in the centre of Athens, and at a reception and identification centre on the island of Samos, the so-called "Samos Hotspot". Like other reception and identification centres, the Samos centre was designed as a closed camp, and even though it did not function as such, the fence and barbwire surrounding the camp signalled a sense of detention. The centre was overcrowded; housing more than 1100 people while having a capacity of 700 and it lacked proper sheltering and basic water and sanitation facilities. While the four camps on the mainland accommodated refugees of the same nationalities (with few exceptions), the reception centre in Samos and the squatted building in Athens included a variety of nationalities. The squatted building in Athens stood out from the other sites in that it was an unofficially organised place by a group of activists and the refugees themselves.

2. Method

2.1. Participants and study procedures

Participants for the explanatory qualitative study were recruited through the epidemiological survey conducted in parallel. The survey consisted of an interviewer-administered questionnaire, targeting 1293 refugees, and collected socio-demographic data and experiences with violence during the journey and in Greece among other issues. To detect symptoms of anxiety, depression, and PTSD, the questionnaire was complemented by a pre-validated anxiety disorder screen (the Refugee Health Screener 15 or RHS-15) (Hollifield et al., 2013). The survey methodology and results for a subgroup of participants have been published in a companion article (Ben Farhat et al., 2018), which reports on violence and mental health of Syrian refugees in Greece. Results from the whole sample have been published in an internal report available online (Ben Farhat et al., 2017).

For the purpose of the study, a refugee is defined as a person living in one of the selected sites who has fled his/her country of origin, regardless of the political status afforded to that person. All refugees above the age of 18 years were eligible to participate in the qualitative study. We used purposive sampling to gain diversity in terms of nationality, ethnicity, gender, and age (Table 1), and snowball sampling was adopted to recruit participants for focus group discussions (FGDs). Forty-seven in-depth interviews (IDIs) were conducted with a total of 56 refugees of nine different nationalities, with the majority being of Syrian nationality (n = 21, 44.7%). Twenty-one IDIs were conducted with men, 17 with women, eight with pairs of people (primarily couples, as well as one father and his adult son), as they expressed a wish to

Table 1
Sites, data collection methods, and participants' nationality/ethnicity.

Athens squat	- IDIs (N = 4; three men and one woman) - IDI, couples (N = 1)	Five Syrians (three of whom were Kurdish), two Afghans and one Iranian
Faneromani	- IDIs (N = 5; two men and three women) - IDIs, couples (N = 2)	Iraqis (Yazidis)
Katsikas	- IDIs (N = 7; four men and three women) - IDI, couple (N = 1) - FGD (N = 1; five participants, women aged 31 – 48 years)	Syrians (three of these were Palestinians)
Malakasa	- IDIs (N = 6; two men and four women) - IDIs, couples (N = 2) - FGDs (N = 2; three to five participants per group; eight participants in total; one with women aged 35–52 years, and one with men aged 37–43 years)	All were Afghans, except for one who was Iranian
Ritsona	- IDIs (N = 7; four men and three women) - IDIs, couples (N = 1) - FGDs (N = 2; seven participants per group; 14 participants in total; one with women aged 18–40 years, and one with men aged 23–58 years)	Syrians (seven of these were Palestinians)
Samos	- IDIs (N = 9; six men and three women) - IDI, couple (N = 1)	Three were Kurdish Iraqis. The six others had Afghan, Algerian, Congolese, Kuwaiti, Iranian, Pakistani, Sudanese and Syrian nationality

Table 2
Participant information for individual and couples in-depth interviews.

Site	Sex	Age group	Family situation	Departed from	Months in Greece
Ritsona	M	18–24	Single	Raqqa (Syria)	9
Ritsona	M	25–34	Married + children	Afrin (Syria)	9
Ritsona	F	25–34	Widowed + children	Damascus (Syria)	9
Ritsona	M	35–44	Married + children	Damascus (Syria)	9
Ritsona	F	45–54	Married + children	Al-Hasakah (Syria)	9
Ritsona	F	25–34	Married + children	Aleppo (Syria)	9
Ritsona	F/M	25–34	Married + children	Deir ez-Zor (Syria)	9
Ritsona	M	45–54	Married + children	Aleppo (Syria)	9
Malakasa	F	45–54	Widowed + children	Balkh (Afghanistan)	9
Malakasa	F	35–44	Married + children	Kabul (Afghanistan)	9
Malakasa	F	35–44	Married + children	Kabul (Afghanistan)	9
Malakasa	F	35–44	Widowed + children	Iran	9
Malakasa	M	25–34	Married + children	Kapisa (Afghanistan)	9
Malakasa	F/M	35–44	Married + children	Parwan (Afghanistan)	9
Malakasa	M	45–54	Widowed + children†	Kabul (Afghanistan)	9
Malakasa	F/M	35–44	Married + children	Logar (Afghanistan)	9
Katsikas	M	45–54	Married + children	Damascus (Syria)	10
Katsikas	M	25–34	Married + 1 child	Deir ez-Zor (Syria)	10
Katsikas	M	25–34	Married + children	Idlib (Syria)	9
Katsikas	M	25–34	Married + 1 child	Aleppo (Syria)	9
Katsikas	F	25–34	Married + children	Damascus (Syria)	9
Katsikas	F	25–34	Married + children	Deir ez-Zor (Syria)	9
Katsikas	F/M	45–54	Married + children	Idlib (Syria)	10
Katsikas	F	35–44	Married + children	Aleppo (Syria)	9
Faneromani	M	35–44	Married + children	Sinjar (Iraq)	9
Faneromani	M/M	25-34/45-54	Married + children/Married + children	Sinjar (Iraq)/Sinjar (Iraq)	9 9
Faneromani	M	35–44	Divorced	Sinjar (Iraq)	9
Faneromani	F	45–54	Married + children	Sinjar (Iraq)	9
Faneromani	F	18–24	Married + children	Sinjar (Iraq)	9
Faneromani	F	65–74	Widowed + children	Sinjar (Iraq)	9
Faneromani	F/M	45–54	Married + children	Sinjar (Iraq)	9
Squat Athens	M	25–34	Single	Iran	13
Squat Athens	M	65–74	Married + children	Aleppo (Syria)	11
Squat Athens	M	18–24	Single	Al-Hasakah (Syria)	3
Squat Athens	F	45–54	Divorced + children	Aleppo (Syria)	5
Squat Athens	F/M	45–54	Married + children	Aleppo (Syria)	12
Squat Athens	F/M	25–34	Married	Herat (Afghanistan)	11
Samos	F/M	25-34/35-44	Married + children	Mosul (Iraq)	2
Samos	F	25/34	Divorced + children	Iran	3
Samos	F	45–54	Widowed + children	Kabul (Afghanistan)	3
Samos	M	25–34	Single	Algeria	1
Samos	M	25–34	Married + 1 child	Congo	2
Samos	M	18–24	Single	Raqqa (Syria)	3
Samos	M	25–34	Married + children	Kuwait	6
Samos	M	25–34	Married + children	Pakistan	6
Samos	M	35–44	Single	Sudan	2
Samos	F	45–54	Divorced + children	Dohuk (Iraq)	3

Note. To protect anonymity only the respondent's country is disclosed in some cases.

be interviewed together (Table 2). Five FGDs (three with women and two with men) were conducted and included 27 participants in total (Table 1).

To gain an in-depth understanding of refugees' experiences, we chose the episodic interview method, which allows both focused and narrative interviewing (Flick et al., 2017). We collected narratives about experiences of violence, suffering, psychosocial distress, and well-being, which were connected to the different life events of the interviewees (e.g. life in home country, escape and flight from home country, and life in Greece). To create a comfortable atmosphere with privacy, most interviews took place either in an MSF on-site clinic, in the shelter of the person being interviewed (e.g. container, tent, or hotel room) or in the back of the research team's van (reception and identification centre Samos). A qualitative researcher conducted the interviews, with the assistance of interpreters when the interview was conducted in a language other than English or French (e.g. Arabic, Farsi, and Kurdish (Kurmanji)). On average, the interviews lasted 85 min. Five FGDs were conducted and provided insight into everyday life problems and challenges faced by the refugees as a community at the different sites (e.g. poor sanitation facilities, complex asylum procedures, lack of work/education opportunities). With FGDs, it was possible to identify consensus and disagreements within the refugee population, which guided the initial analysis. On average, the FGDs lasted 60 min and the discussions took place in the MSF on-site clinic. IDIs and FGDs were audio-recorded and transcribed into English by research assistants.

2.2. Analysis

A combination of thematic analysis and grounded theory were used for qualitative data analysis (Corbin and Strauss, 2014; Ulin et al., 2004). We used an iterative approach, reviewing interview transcripts as they were transcribed in the field to draw initial observations related to the research questions. Then, an initial set of conceptual codes were identified and systematically applied to blocks of text (usually of three to five sentences in length), using NVivo11. Interpretation of data included discussions with the research team, comparing theme frequencies, and identifying theme co-occurrence. The latter part of data analysis was conducted by the qualitative researcher. Attention was paid to the role of the researcher in shaping data analysis and interpretation; emergent themes were tested by examining exceptions and counter examples, and findings were triangulated by the different data sources (e.g. IDIs and FGDs).

2.3. Research ethics

The Ethics Review Committees of the National School of Public Health in Greece and the London School of Hygiene & Tropical Medicine in the UK approved the study. The study was conducted in accordance with the principles of the Helsinki Declaration (World Medical Association, 2013) and the EU guidance note “Research on refugees, asylum seekers and migrants” (European Commission, 2013). Participants were included in the study following verbal informed consent, and a consent process which provided information on confidentiality, data storage, and audio recording. The study team presented themselves as data collectors or researchers conducting a study on behalf of MSF and explained that they were not clinicians (doctors, nurses, psychologists, or psychiatrists) nor working on behalf of the Greek asylum services. Study participants were informed that their decision not to participate in the study would have no implications in terms of access to health services or on their asylum case. Participants were reminded of their voluntary participation and sharing of information as well as their right to terminate the interview at any point; the team also informed all participants about the offer of free on-site mental health services provided by MSF.

3. Results

3.1. Epidemiological survey: summary of key findings

Results from the whole sample (1293 respondents) and the subgroup of Syrian refugees (728 participants) did not differ with respect to experience of violence and positive screening for anxiety disorder. The following key results are from the whole sample as reported in the internal report (Ben Farhat et al., 2017). The results of the survey showed that depending on study site, between 12.9% and 66% of the respondents had experienced at least one violent event in their country of departure and the most common types of violence were “being bombed”, “being beaten”, and “receiving threats” (Ben Farhat et al., 2017). Moreover, between 9.9% and 44.8% (depending on study site) experienced at least one violent event while in Turkey; the main type of violence was “being beaten”, perpetrated by state authorities (police/army). In Greece, between 4.6% and 23.1% (depending on study site) had experienced at least one violent event; the main type of violence was “being beaten”, perpetrated by mainly other refugees or state authorities (Ben Farhat et al., 2017). In total, 630 respondents aged 15 years or older were screened for anxiety disorder using a pre-validated anxiety disorder screening tool (Refugee Health Screener-15) (Hollifield et al., 2013). Depending on study site, between 73.6 and 100% of respondents screened positive for anxiety disorder, revealing a shocking picture of the poor state of mental health of these refugees. A large proportion (34%–71.4%) of respondents that screened positive for anxiety disorder declined referral to on-site psychology services (Ben Farhat et al., 2017). Of particular note, there was no statistical difference in the prevalence of anxiety disorder between victims and non-victims of violence (Ben Farhat et al., 2017).

3.2. Explanatory qualitative study

Qualitative data analysis led to the identification of three key themes causing suffering to the refugees in Greece: (1) uncertainty and lack of control, (2) disrupted lives, and (3) the loss of social networks.

3.2.1. Uncertainty and lack of control

Uncertainty was a frequent concern in refugee narratives. First, it was related to both spatial and temporal uncertainty (i.e. the uncertainty of not knowing in which country one would end up and when this departure would take place). Second, uncertainty was referred to as a feeling of powerlessness and lack of control over one's own life:

> “*I wonder what will happen in our situation. We cannot go back to Afghanistan, we cannot go back to Iran, either, because of family issues, and we cannot stay in Greece. How long will this process last? Will they [Europe] help us to move forward, or to improve our lives in any way?*” (Afghan woman, age group 35–44)

The closed border was often talked about as a hindrance, experienced as a solid wall standing between participants and their projected futures, rather than a dotted line on a map. At the time of the interviews, the only legal option for moving forward for refugees in Greece was through the official asylum procedures within the context of European policy. However, when going through official asylum procedures, the refugees faced new or ongoing forms of uncertainties, as the different asylum procedures and processes were unclear to them and limited or no information was provided. Some of the participants were unsure if they were in a process of relocation or family reunification and others did not know if they were in an asylum process at all.

At the reception and identification centre in Samos, the pressure on the asylum system created long delays, primarily between registration and the start of the admissibility procedure to asylum. As Syrians were initially the only nationality group being processed, other nationalities faced significant delays and postponement of their admissibility interviews. Multiple postponements without explanation increased

uncertainty and feelings of discrimination among the non-Syrian refugees. A couple of participants saw the postponement as a sign of future deportation, an outcome that they dreaded. Among the Afghan refugees and the refugees in Samos, crossing the border by illegal means was often the subject of daily discussion within families and seen as the only option:

> *"I am thinking of sending my children by smugglers, because I am out of options. […] I think of the smugglers as murderers, and they are murderers. They take our money and tell us 'because the police are not involved, I can do whatever I want with you'. Now the conditions are awful [in the camp], and I have to choose between bad and worse. I fear sending my children abroad with smugglers but I do not see any other option.* (Afghan woman, age group 35–44)

Choosing the "smuggler" pathway introduced risks such as being cheated, exposed to violence and threats by smugglers, and getting caught and detained by enforcement authorities. For those who stayed behind in Greece while sending other family members (often children) with smugglers, worry and uneasiness constituted a big part of everyday life.

3.2.2. Disrupted lives

Being stranded in Greece and having no clear idea about whether, when, and where one would be able to move, affected the refugees' daily lives. Some spoke of their life as only consisting of sleeping and eating. Instead of being an integrated part of their lives, the experience in Greece was one of waiting for life to resume, pending a resolution on their asylum case:

> "*For one year, I have been waiting for the telephone to ring. Every day, I am waiting by the telephone the whole day. I do not do anything. I do not go out the whole day. After five o'clock, then my life starts.*" (Syrian woman, age group 45–54)

While days passed slowly, there was still a strong feeling of being delayed, and of wasting or losing time. There was also the sense of missing out on life in general, and of children missing out on their education and the chance to have a good future. As the duration of the stay in Greece increased, so did concerns about postponed education, livelihoods, and sustainable solutions to the situation at hand.

The everyday lives of the refugees held few activities and consisted of the same routines: standing in lines (for food, health, and administration services), visiting and talking to other refugees, taking care of children, and performing household chores. A predictable everyday life that however lacked stability:

> "*We need stability […] the same kind of stability, as we had before. In the sense that life feels normal again and not like this situation. Education of our children and to find work that is the most important thing - to have a normal life again*." (Syrian woman, age group 25–34)

The refugees did not have the right to work and were often unable to get access to public services. This lack and denial of rights made many feel socially marginalized. The male refugees described how the inability to work deeply affected them and made them feel undervalued:

> "*What did I come here for? I did not come here to eat and drink. I am an engineer and I wish to work. My wife is a hairdresser, we want to work in Europe […] All my family is in Germany but I just want to settle in a country and work, and I want to live. I do not want to be idle in Greece*." (Syrian man, age group 35–44)

Being dependent had negative connotations, as an Afghan women expressed: "*I do not want to be a burden. I am disgusted by eating free bread.*" Types of dependence on aid relief included receiving money (monthly cash transfers), food (three times a day), shelter, and second-hand clothes. In relation to regaining self-determination, the refugees wished to be able to buy food and cook for themselves instead of receiving ready-made meals, which they found of low quality and unpalatable. Actually, many participants used their monthly cash transfers (90 Euros for an individual, 140 Euros for a couple or a parent with one child, and 190 Euros for family of three) to buy food they could prepare themselves.

3.2.3. Loss of social networks

Another major contributor to disruption was the loss of social networks. Refugees had little interaction with the surrounding Greek communities. At the time of the study, it was only in the Ritsona camp and in the squatted building in Athens that daily interactions with international and/or national volunteers took place. These interactions were emphasized as something particularly positive, giving the refugees a break from the "refugee" life and identity:

> *"A Spanish volunteer friend took us out to have a drink in a coffee house. It was a really nice day; we relaxed and forgot for once that we are refugees. It was like being home in our country. We felt human again."* (Syrian woman, age group 25–34)

In the Malakasa camp and at the Samos reception and identification centre, interactions with volunteers were limited. There were fewer NGOs and the refugees felt isolated. Some refugees narrated how they felt unwelcomed and consequently did not like to wander outside the camps:

> "*Here we do not feel welcomed by the Greeks. During the summer, when we went under the trees to seek shadow, the looks we would get from the people, it was very embarrassing. They would give dirty looks. We could see that they did not like us at all. We felt heartbroken and hopeless.* " (Afghan woman, age group 25–34)

Being separated from family members also caused worry and pain. Some had been separated during the journey; some had family members in other European countries, while others were still in their home countries. Seven participants had experienced being separated within Greece from their adult children, adult siblings, or other family members. Having lost these key social networks caused additional pain, worries, and distress. While the new life situation was already difficult, not being with family members made it worse.

3.2.4. Suffering

The refugees reported experiencing suffering on an intimate personal level when they described how they could not work, how they missed their families, and how they felt depressed or anxious as a result of their living conditions in Greece. Yet, this personal suffering was inseparable from social, political, and institutional conditions and processes, what Kleinman et al. labelled as social suffering (1997). The refugees spoke of how uncertainty, life disruption, and loss of social networks caused deep suffering and contributed negatively to their wellbeing. They described feelings, emotions, and states such as stress, sadness, loneliness, depression, worrying, insomnia and, in few extreme cases, suicidal thoughts. Uncertainty was often directly linked to poor psychosocial wellbeing:

> "*I am not like before. I have insomnia and I am hysteric. Last night, I was awake until 4 am and then I woke up at 8 am. Recently, I have started to smoke cigarettes, but it does not calm me down. […] I overthink. I feel that my head wants to explode. I start crying. I do not know our future and it freaks me out.*" (Iranian woman, age group 25–34)

Several of our participants described how worries and fears led them, their family members or other refugee friends to smoke, drink or, in a few instances, use drugs.

At times, the refugees also linked their distress to past traumatic events experienced in their home countries or during their harrowing journey to Greece. However, current uncertainty, life disruption, and loss of social network were given prominence as direct causes of distress and social suffering. Some conveyed how past trauma was left

unresolved or was made worse by the current life situation in Greece:

> "*They [Daesh] started killing people. They would burn human heads of people still alive, and they said "this is what we will do to you". All the problems we experienced were a result of Daesh. These all had their toll on me. […] If we had gone quickly to a country, they could directly treat the mental problems. But now, after a year here [in Greece], there is another addition to the mental problems.* (Iraqi man, age group 25–34)

Living in an uncertain situation, being in a passive life situation without work, school, and a "normal" social network, added to already existing mental health problems. Linking psychosocial distress to current uncertainty, life disruption, and loss of social network made the refugees reluctant to use mental health services. They expressed that they found it meaningless to consult a psychologist, while they remained in the same situation that was the source of their distress:

> *"I do not think it will be useful to see the psychologist. Our psychological issues are caused by being here [in camp, Greece], and they will remain, as long as we are here."* (Syrian woman, age group 25–34)

The refugees interviewed prioritised practical assistance such as finding accommodation outside the camp (hotel/apartment) and fast-tracking asylum procedures over mental health consultations.

4. Discussion and implications

This study has revealed the high levels of psychosocial distress and social suffering experienced by refugees who became stranded in Greece following the closure of European borders in March 2016. Refugees have been forced into a situation where responsibility for and control over their own lives has been taken away from them. Their existence and future is uncertain, and many experience a constant fear of being deported. The powerlessness and uncertainty they experienced concerning the asylum decision was often identified as the main cause of their current distress. Studies have shown that asylum processes often generate uncertainty that has negative implications for mental health (Brekke, 2010; El-Shaarawi, 2015). A study of asylum seekers in Australia showed that psychological wellbeing is dependent on the certainty of a predictable future, documenting a substantial decrease in symptoms of PTSD, anxiety, and depression in the four months following the granting of refugee status to asylum seekers (Silove et al., 2007). Our study illustrates how different asylum procedures remain unclear for refugees in Greece, and suggests that little information or practical assistance has been provided to explain these processes. Therefore, one recommendation is to advocate for fast and transparent asylum processes combined with provision of information and legal assistance to refugees.

Forced passivity over long periods of time can be harmful for mental wellbeing (Bala, 2005; Thorud and Kolstad, 2010). In addition, lack of right to work (Mayblin, 2014; Popescu, 2016) and lack of activities (Crepet et al., 2017) can have negative consequences for mental wellbeing. Our study corroborates such findings, as the refugees narrated how lack of meaningful activities such as work, school, etc., made time in Greece seem empty and pointless. As Michel Agier describes, the refugee camp is "a place of waiting apart from society" (2008, p. 30). For the refugees in Greece, being dependent on aid relief was seen as shameful and humiliating, an experience that has also been described by Fleay and Hartley (2016). To address the lack of autonomy felt by refugees in Greece, cash transfers for food could be a solution, so that the refugees are at least independent to make decisions about what they want to buy and eat.

The refugees interviewed in Greece had little contact and interaction with the surrounding Greek communities. The feeling of not being welcome led some to withdrawal into isolation within the camps. Experiences of discrimination predict higher distress level among refugees (Beiser and Hou, 2016; Mölsä et al., 2017). People with a weak social network find it more difficult to cope with stressful situations and generally have more psychological problems than people with a large and close social network (Wallin and Ahlström, 2005; Wells, 2011). Many of the refugees had their social and family networks disrupted when they fled their home countries. The narrow definition of "core" or nuclear family should be enlarged to include more family members to keep important social and support networks for refugees intact.

Over 73% of the respondents from the epidemiological survey screened positive for an anxiety disorder, however, there was no significant difference shown in the prevalence of anxiety disorders between victims and non-victims of violence. Between a third and three quarters of respondents declined referral to psychological services (depending on sites), a decision further explained by the findings of the qualitative study, where the refugees reported a preference for practical assistance over mental health consultations. The appropriateness of introducing interventions that deal exclusively with mental health in situations where social, economic, and political needs have not been met, has been questioned (Almendon and Summerfield, 2004; Summerfield, 1999). Furthermore, some clinical guidelines now advocate for a phased approach to intervention that emphasizes the provision of direct practical assistance and the reinforcement of social networks as a first stage of mental health care (Inter-Agency Standing Committee (IASC), 2007; Rosen and Frueh, 2010; Rousseau et al., 2011; UNHCR, 2013). The impact of interventions that follow a phased approach has rarely been explored as such interventions are still uncommon, especially in resource-poor settings where refugee populations are often located. A recent study among asylum seekers in Montreal, Canada, provides qualitative evidence that an intervention, a community day centre, embodying a phased approach, had positive implications for mental health outcomes (Chase and Rousseau, 2017). By targeting key issues for wellbeing i.e. safety, rights, and social networks, through a range of practical and social activities, the community day centre improved mental wellbeing among its users (Chase and Rousseau, 2017). In the Greek context, similar initiatives (e.g. community centres) could be established to address issues of powerlessness, lack of information, and social isolation and to promote empowerment, agency, and re-establishment of social networks. Such centres should be designed with the participation of refugees to foster engagement and empowerment. Centres could include information sharing, recreational, and educational activities. To reduce feelings of discrimination and isolation and to link refugees more closely to Greek and European society, international and national volunteers could also play a role in such community centres. The above-mentioned recommendations, together with a fast and transparent asylum system, would mitigate the distress experienced by refugees and could create a better foundation for mental health interventions in Greece.

Using the lens of social suffering has enabled us to show how the refugees in Greece highlighted current uncertainty, life disruption, and loss of social network as direct causes of distress, or, in some situations, as worsening already existing mental health traumas. It calls for the provision of holistic refugee mental health interventions. With this analysis, we have strived to respond to the call made by Kienzler (2008) on interdisciplinary research which can lead holistic approaches to health care and integrate insights from social sciences into the psychiatric and psychological discourse of trauma (Kienzler, 2008). Our analysis also calls for advocacy on policy changes in relation to European asylum practices and policies, which have increased measures of deterrence in recent years, (Harvey, 2018; Women's Refugee Commission, 2016). In Greece, this includes poor living conditions within camps, long bureaucratic and non-transparent asylum procedures - issues that are preventable, however, the political will to alleviate them, may be lacking (Gattinger, 2018; MSF, 2017a). To create a powerful evidence base to advocate for policy change, research needs to be done on how politics of deterrence in European transit countries influence refugees' mental health and integration into European society. Additionally, research should assess the impact of phased approaches to mental health interventions.

4.1. Limitations

One limitation of this study was the lack of privacy in which some interviews were conducted, especially in those sites where MSF did not have an on-site consultation clinic (Samos reception and identification centre, Athens squat and Faneromani camp). Instead, these interviews were conducted in the shelter of the participant, often with other family members present. Thus, respondents may under-reported certain experiences, including sexual and gender-based violence, which was only mentioned by four participants but has been raised as a pertinent issue in Greece (MSF, 2017b; Women's Refugee Commission, 2016). Another limitation was that we were unable to conduct FGDs at the sites mentioned above since there was no space to facilitate the intimacy of such sessions.

5. Conclusions

This study has described how refugees in Greece, in the context of the European border closures of March 2016, are experiencing deep psychosocial distress and social suffering because of the uncertainty of their future, worsened by impediments of bureaucracy, and because of the serious disruption of their lives compounded by the loss of social networks. Refugees experience little or no attachment to, or connection with, the surrounding Greek and European society and therefore feel socially marginalized and isolated. Consequently, it is not surprising that many also report that they experience distress in addition to existing mental and emotional trauma from the experiences which rendered them refugees in the first place. To reduce the risk of severe mental health problems and outcomes, asylum procedures should be fast-tracked, and meaningful and empowering activities should be offered to refugees while they are waiting. Finally, measures should be taken to keep families and support networks intact and to encourage interactions between the refugees and the surrounding community.

Within the last decade, there has been increasing recognition that the conditions in which refugees, migrants, and asylum seekers live can be a major source of mental health problems and hence an emphasis for a phased approach to mental health interventions. Future research should focus on the impact of such approaches and the correlation between politics of deterrence, being forced into a “life in waiting”, and the mental health and integration into European society of refugees.

Declarations of interest

None.

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