The role of emergent shared identity in psychosocial support among refugees of conflict in developing countries

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The Role of Emergent Shared Identity in Psychosocial Support among Refugees of Conflict

in Developing Countries

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Abstract

In spite of the harsh conditions that refugees of conflicts experience for many years in exile in developing countries, there is evidence showing that refugees of conflict help each other. This study aimed to explore one possible mechanism underlying such support and sought to answer three main research questions: do refugees share an emergent identity that facilitates support among them (similar to people affected by disasters)? Does this identity-based support impact on their health? If so, does this positive impact help to mitigate the negative effect of exile stressors on refugees' health? We carried out two questionnaire surveys among Syrian refugees, first in Turkey (n = 234) and then in Jordan (n = 156). The data were analysed using path analysis to test hypotheses and build a theoretical model. We found evidence suggesting a process of shared social identity-based support among the refugees. We found that general health of refugees to be predicted mainly by stress, but we also found that collective efficacy has a positive association with health, which suggests a buffering effect. These results shed light on the process of social support among refugees of war and suggest the role of shared identity, which can have a limited buffering effect on the health of the refugees, though not enough to fully mitigate the negative effect of secondary stressors. However, we suggest that such a process can be utilised as base for interventions that approach refugees of war as a group (i.e., at community rather than individual level).

Keywords:

 In contrast to the mainstream media image of refugees that presents them either languishing in refugee camps or trying to break through European borders by sea, the majority of refugees live in the cities of developing countries. Developing countries constitute the top ten major host countries of refugees (UNHCR, 2016), where in some cases the refugees constitute a large proportion of the total population (e.g., Lebanon 25%; United Nations, 2017), and are expected to live in exile for many years. International emergency interventions may succeed in saving the life of affected populations, but face serious challenges in providing them with livelihoods in exile for the following reasons. First, the average stay of refugees in a host country is over 20 years (UNHCR, 2016). Second, there are considerable movement and work restrictions on refugees in developing countries and some of them are not part of the 1951 Refugee Convention (UNHCR, 2011). Third, the UN Refugee Agency (UNHCR) response budget is seriously under-funded (e.g., it provided less than 25% of the Syrian response budget in Jordan in 2016) (UNHCR, 2017b).

Such immense challenges should drive us to consider again what we know about the refugee situation for a better understanding that hopefully will lead to new solutions for refugees and the host communities. These solutions should utilise the capacities of the affected communities, which can compensate for the lack of resources available for international relief programmes.

One possible example of such capacities is emergent shared social identity among the affected population as a source of collective resilience, something which has already been recognized in some international guidance (NATO, 2008). In a previous paper (Alfadhli & Drury, 2018b), we presented ethnographic and interview evidence suggesting how refugees of conflict from Syria help each other, and the important role of shared identity in facilitating such support. In the present paper we will shed light on the process of the support mechanism and

examine quantitatively the paths that lead to support in two samples of Syrian refugees. In study 1, we present evidence from a questionnaire survey of Syrian refugees in Turkey (n = 234) that shared social identity is associated with support, in a similar way that was found among people affected by disasters. In study 2, we use an improved design to re-examine the same mechanism in a survey of Syrian refugees in Jordan (n = 156), and then expand the model to include the main challenges refugees face (secondary stressors, and the effect of both stressors and support on the refugees' general health).

Loss of Normal Life

Running away from life-threatening dangers of war is not the end of a refugee's problems, as the prolonged displacement in exile comes with new challenges. On a daily basis, refugees are exposed to secondary stressors (Lock et al., 2012) that arise from their situation as refugees in exile. These are stressors that are socially mediated, rather than arising directly from war (Alfadhli & Drury, 2016). A recent qualitative and quantitative exploration of secondary stressors among Syrian refugees in Jordan (Alfadhli & Drury, 2018a) suggested that these stressors fall into three main groups: first, financial stressors that include poverty, poor residence, education and health expenses; second, environmental stressors including documentation issues, moving into an unfamiliar environment and suffering from instability; third, social stressors that include separation from relatives, prejudice, discrimination and exploitation. These groups of persistent stressors arising from the exile environment are found to have direct and indirect negative effects on the mental health of refugees (Im, Ferguson, Warsame, & Isse, 2017; Jayawickreme et al., 2017; Miller & Rasmussen, 2010; Schafer, Masoud, & Sammour, 2014).

Refugees as a Group

Usually, refugees do not face these conditions individually; rather they face them collectively as a group, either as a family or a community. The idea that groups can be good for one's health and wellbeing by helping one to deal with stress (Jetten, Haslam, & Haslam, 2012) is an argument associated with the 'social cure' approach in social psychology and refers to "the ways in which a person's social relationships, social networks, social support and other social identity-based resources feed into health outcomes" (Haslam, McMahon, Cruwys, Haslam, Jetten, Steffens, 2018, p. 14). The fundamental source for these positive effects is identification with the group or social category. Social identity is "that part of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the emotional significance attached to that membership." (Tajfel, 1974, p. 69). The way through which the social cure entails positive effect on well-being is traditionally explained by identity-based (expected) support which reduces stress and its negative impact on well-being (e.g., Haslam & Reicher, 2006), as in the integrated social identity model of stress (Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005). In addition, there are other known wellbeing-related outcomes of shared social identity, like providing purpose, meaning and validation (Neville & Reicher, 2011), that could also contribute to social cure effects.

One social context where the social identity approach has been relevant and that appears to have some features in common with the situation of refugees, is that of collective responses to an emergency or disaster (Alfadhli & Drury, 2016). In an emergency or disaster, people may find themselves in the same situation as other people who are affected, with their usual support mechanisms gone. Evidence suggests that they also often develop new social relationships with the strangers who share the situation with them (e.g., Rodríguez, Trainor, & Quarantelli, 2006). In addition to the importance of a common situation, it seems that sharing distress in such

situations can also be a driving force to identify with others (Vezzali, Drury, Versari, & Cadesamuro, 2016). Other studies have documented emergent prosocial behaviours in emergencies and disasters (e.g., Rodríguez, Trainor, & Quarantelli, 2006), which could be facilitated by such shared identity to establish a relationship between strangers who share the same situation. Research on group processes in disasters (see Drury, 2012) supports a Social Identity Model of Collective Resilience (SIMCR) according to which circumstances (sense of common fate) can create an emergent shared identity which can operate as a base for psychosocial support, and hence a possible source of efficacy.

One recent study by Drury and his colleagues (2016) examined the SIMCR quantitatively among a large population (n = 1240) affected by the 2010 Chile earthquake. The study involved a survey including scales that measured disaster exposure, common fate, social identification with affected others, expected support, collective efficacy and finally both observing and providing social support (emotional and coordinated social support). The findings revealed that providing emotional and coordinated support was predicted by shared identity, which in turn was predicted by a sense of common fate due to exposure to the disaster. Shared social identity also predicted a sense of collective efficacy, mediated by expected support (Drury, Brown, González, & Miranda, 2016). These findings shed more light on the details of social identity-based support and its outcomes (efficacy) that are highly relevant to the topic of mutual social support among communities of war refugees. Based on the ethnographic research and the similarities to the disaster context, we suggest that a similar process of support base on an emergent "refugee" shared identity may be functional among refugees of conflict. Refugees of conflict – similar to people affected by disasters - suffer from major events that create mass injuries and collateral

loss of possessions, and where the survivors try to cope with secondary stressors in a protracted aftermath.

Aim of the paper

In the last six years, the Syrian conflict produced 6.5 million internally displaced people and five million refugees, most of them living in neighbouring countries (Lebanon, Jordan, Turkey, and Iraq) (UNHCR, 2017). The present study therefore focuses on Syrian refugees and seeks to explore to what extent the social identity model of collective resilience in emergencies can be adapted to explain the dynamics of social support among Syrian refugees in neighbouring countries. We expect this model to explain the process of support based on identifying with other refugees. Based on what we know about conditions of these refugees, we can say that they are treated as a group of "refugees", especially in urban contexts due to the contrast with locals (compared to "all refugees" in the camp environment) and the daily reminders of refugee status, (e.g., food coupons, refugee identification documents and official restrictions) (Alfadhli & Drury, 2018a). Being affected by such similar challenges highlight refugees' common identity as "refugees", which could be a valuable resource to a group that does not have many resources. However, we also acknowledge that there are alternative sources of social support available to refugees in exile, other than emergent shared social identity (e.g., pre-existing social networks), which would be expected to explain some of the variance in the measures of support.

Accordingly, our three main research questions are: do refugees share an emergent (refugee) identity that facilitates support among them, similar to people affected by disasters? Does this identity-based support have a positive impact on their general health? If so, does this positive impact help to buffer the negative effect of exile stressors on the refugees' general health? We

sought to answer these questions through two surveys among Syrian refugees in Turkey (n = 234) and Jordan (n = 156).

Study 1

According to the UNHCR, there are 3,222,000 Syrian refugees in Turkey who have been steadily arriving since the armed conflict in February 2012 (UNHCR, 2017). Most of these refugees experience a prolonged displacement as the civil war is still raging in Syria and the resettlement efforts are targeting less than 1% of the refugee population a year. In this protracted challenging situation, we suggest that urban refugees stranded together and singled out due to their legal and financial situation will develop a new shared identity as refugees, even if they come from different Syrian backgrounds (e.g., regions, tribes, religious sects). Social support based on shared identity can be a valuable resource especially in the face of serious mental health challenges that these people experience (Karaman & Ricard, 2016). Hypotheses tested in this study are depicted in Figure 1.
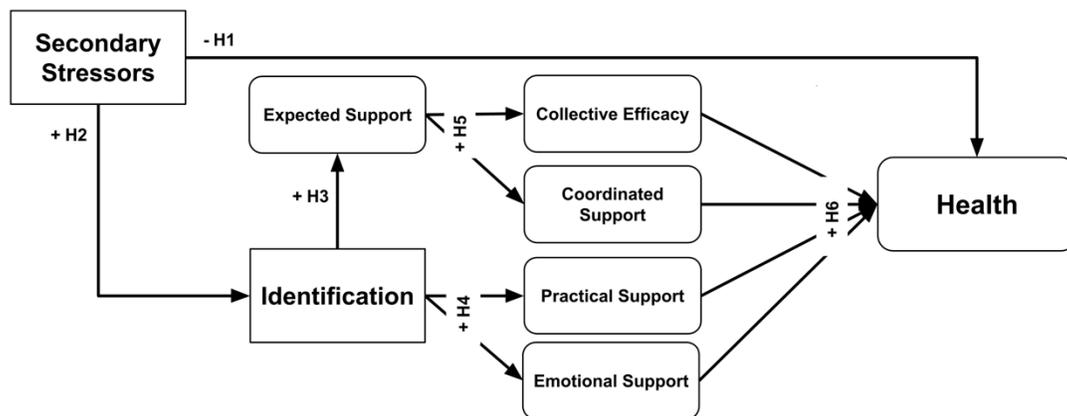

Figure 1. Summary of main hypotheses of Study 1.

Method

Recruitment started on November 2015 by the second author who worked with Syrian refugees in Mersin, a Turkish city near the Syrian borders. The researcher invited participants who met the inclusion criterion (18 years or older Syrian refugee who lives in Turkey) to answer an anonymous paper survey (in Arabic). All scales were translated into Arabic and back-translated into English and checked against the original items to assure the accuracy of the translation. Participation was voluntary and we did not offer any compensation to participants.

Two hundred and thirty-four participants (M_{age} = 33.5 SD = 12) completed the survey, which is an adequate sample size according to the path analysis guidelines that recommend a minimum sample of 50 (Iacobucci, 2010), or 10 cases for each variable (Nunnally, 1967). Participants were 58% male; only 7% of them spent three years or more in Turkey, while 35% of them spent one year or less.

Ethics statement. University of Çukurova research ethics committee approved this study on October 2015.

Measures[1]

Participants were asked to report on a number of topics based on their own experience during the previous month.

Shared social identity. We used a four-item scale based on Doosje, Branscombe, Spears, and Manstead (1998) and Doosje, Ellemers, and Spears (1995) to assess the extent of participants' identification with other Syrian refugees: "I felt at one with the refugees around

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[1] We also included in the questionnaire items to measure social contact, for the purpose of different study.

me", "I identified with the other refugees", "I felt unity with other refugees" and "I felt that other refugees were like me" (α = .80; 1 "Strongly disagree" 7 to "Strongly agree").

Expected support. We used a three-item scale based on Drury et al. (2016) to assess the extent of which participants expect support from other refugees: "I came to expect other refugees to be cooperative", "It became the norm for other refugees to be supportive of my actions" and "Other refugees will give help if I ask for it" (α = .80; 1 "Strongly disagree" to 7 "Strongly agree").

Collective efficacy. We used a three-item scale based on Bandura (1995) and Drury et al. (2016) to assess the extent of which participants believe that their refugee group was capable of dealing with the challenges: "We felt capable of accessing services we needed", "We felt we were able to organize ourselves to improve our situation" and "We felt somewhat in control of things, despite being refugees" (α = .67; 1 "Strongly disagree" to 7 "Strongly agree").

Coordinated support. We used a five-item scale based on Drury et al. (2016), to assess the frequency of which participants provided support in coordination with other refugees: "I participated in groups that organized to locate supplies etc.", "I worked together with other refugees for the good of others", "I acted together with other refugees to improve our conditions", "I participated with others in helping other refugees to move" and "I joined in contributing to funds help with funerals and/or weddings" (α = .79; 1 "Never" to 5 "A lot").

Emotional support. We used a two-item scale based on Drury et al. (2016), to assess the frequency of which participants provided emotional support to other refugees: "I gave emotional support" and "I showed concern for others' needs'" (r = .80; 1 "Never" to 5 "A lot").

Practical support. We used a three-item scale, to assess the frequency with which participants provided support in a practical manner to other refugees: "I shared some of my

things with other refugees", "I helped new refugees by giving them information" and "I gave

other refugees advice about services" (α = .79; 1 "Never" to 5 "A lot").

General health. To measure general health, we used five items from the General Health

Questionnaire (Minowa, 2003) as adapted in Eller, Cakal, and Sirlopu (2016). The scale included

the following items: "Have you been very anxious and nervous", "Have you felt so down in the

dumps that nothing could cheer you up", "Have you felt calm and peaceful", "Have you been

happy" and "Have you felt downhearted and blue" (α = .62; 1 "Not at all" to 5 "Often").

Secondary stressors. To measure secondary stressors, we used the 26-item Afghan Daily

Stressors scale (Panter-Brick, Eggerman, Mojadidi, & McDade, 2008), which included a wide

spectrum of stressors that arise from exile environment, e.g., "Not being able to find work",

"Roadblocks", "Feeling lonely" (α = .69; 1 "Not at all stressful" to 3 "Very stressful).

Results

Table 1 shows that shared social identity correlated significantly with most of the

variables, but notably more with expected support, collective efficacy, practical, emotional and

coordinated support. General health was correlated only with collective efficacy. Coordinated

support, practical support and emotional support were highly correlated, although in EFA they

appear as different factors. The analysis showed that the stressors scale (the Afghan Daily

Stressors Scale) was not usable for the purpose of the study; although the scale scored a

reasonable overall reliability score (α = .69), it did not show a good structure in the factor

analysis nor a good model fit in the path analysis and so was dropped from the analysis. The

issues might be due to differences in the Afghan context than the Syrian exile in Middle East or

due to issues of translation to Arabic. The emotional support scale was also dropped from the

analysis to improve the fit of path-analysis model, which was better without the emotional

support.

Table 1. Descriptive statistics and correlations

	Min Max	M	SD	1	2	3	4	5	6
1. Collective efficacy	1/7	4.58	1.83						
2. Expected support	1/7	4.56	1.96	.267***					
3. Practical support	1/5	3.40	1.18	.197**	.072				
4. Shared social Identity	1/5	2.22	0.99	.201**	.582***	.167*			
5. Coordinated support	1/5	3.14	0.66	.110	.129*	.560***	.193**		
6. Emotional support	1/7	5.01	1.56	.093	.124	.608***	.212**	.434***	
7. General health	1/5	3.45	1.20	.205**	.094	.079	.100	.112	.006

*$p < .05$, **$p < .01$, ***$p < .001$

Path analysis. All standardised factor loadings achieved satisfactory levels of above .50 (Kline,

2011). We used bootstrapping with 5000 resamples to fit our predicted model (Figure 2) which

fit the data well ($\chi^2 = 9.91$, $p = .19$, $df = 7$, CFI = .98, RMSEA = .042, SRMR = .040; good fit is

indicated by non-significant χ^2 / df ratio lower than or equal to 3; 06 or lower for RMSEA; .95 or

higher for CFI; and .08 or lower for SRMR; see Bentler, 2007; Hu & Bentler, 1999).
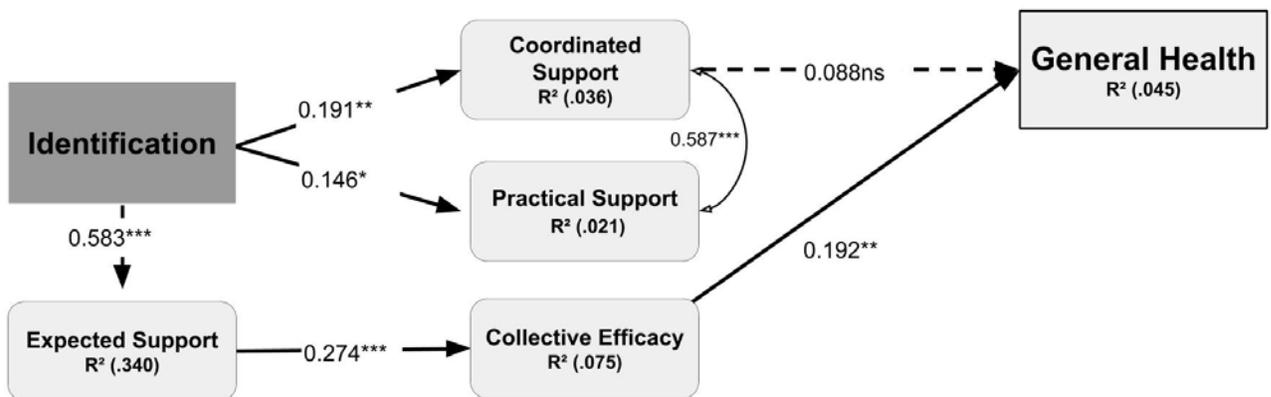
Figure 2. Standarised results of path analysis using multiple regression analyses.

In line with our predictions, identification with other refugees significantly predicted expected support (β = .58, *SE* = .07, *p* < .001), participation in coordinated support (β = .19, *SE* = .07, *p* = .011) and providing practical support (β = .14, *SE* = .07, *p* = .035). Expected support predicted collective efficacy (β = .27, *SE* = .06, *p* < .001) which in turn predicted general health (β = .19, *SE* = .06, *p* = .004). Coordinated support had a weak and non-significant effect on general health (β = .08, *SE* = .06, *p* = 0.16). We predicted that expected support to be a mediator of identification effect on coordinated support, but it was not.

We found a significant indirect effect of shared social identity on general health via expected support and collective efficacy, β = .031, 95% CI [.011, .060]. Shared social identity also had a significant indirect effect on collective efficacy via expected support, β = .159, 95% CI [.096, .232].

Discussion

Apart from not being able to test the hypothesis related to the stressors, most of our predictions regarding the support process and its relation to the refugees' health were supported and the model displayed very good fit. This suggests that, in Turkey, Syrian refugees' identification with each other does facilitate multiple forms of social support and feeds into a sense of collective efficacy, with a limited effect on general health, which are important findings given the stressors that refugees face and the scarce resources at their disposal. The analysis suggested that the same pathways and relationships found in the case of disasters (Drury et al., 2016) were found here. In particular, the perception that other refugees would be supportive as a function of identification with them plays a pivotal role. In addition, the more that refugees identified with each other, the

more likely they were to provide practical support to each other and participate in coordinated activities for the good of the whole refugee community. Expected support was associated with increases in refugees' sense of efficacy – their belief that they can act and achieve things. This sense of efficacy, as well as participation in coordinated support activities, was associated with increased general health (cf. Shumaker & Brownell, 1984; Muldoon et al., 2017).

To address some of the limitations of this study, we decided to improve the measurements, add new ones and use a more focused recruitment process for a new study to collect more data from Syrian refugees in Jordan.

Study 2

Jordan is a clear example of a developing host country where the refugees are a substantial part of the total population of 7.5 million, including 656,170 Syrian refugees who fled the armed conflict in their country since 2012 (UNHCR, 2017), in addition to 2,117,361 Palestinian refugees in Jordan since 1967 and before (UNRWA, 2017). Though a third of the population are registered refugees (or asylum seekers), Jordan is not part of the 1951 Refugee Convention (UNHCR, 2011) and resists integration of refugees, as there are still Palestinian refugee camps (in urban areas now) in Jordan from 1967. The movement of refugees to Jordan across the northern border with Syria stopped officially in April 2015 (The Jordan Times, 2015; UNHCR, 2015), which makes most Syrian refugees in Jordan familiar with the situation in their host country, due to their long stay.

Study 1 suggested that a support process based on shared social identity exists among refugees, which was linked to their general health. We failed to get a sense of how this support

mechanism behaved in the context of the stressors facing refugees, due to an unsuitable measure of secondary stressors. In study 2, we introduce a secondary stressors scale that we developed in a separate study of Syrian refugees in Jordan (Alfadhli & Drury, 2018a). We also employ new scales to measure stress and depression as additional health outcomes, and we included a common fate scale as a possible source of identification among refugees. Hypotheses tested are depicted in Figure 2.
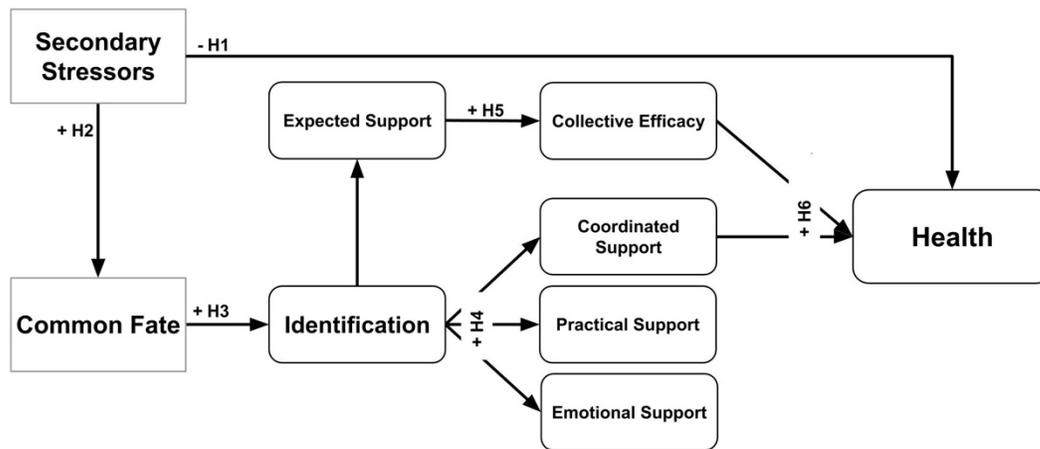
Figure 3. Summary of main hypotheses of Study 2.

Method

Sample and recruitment. Based on our experience working with Syrian refugees, we found that many of them use social media (Facebook and WhatsApp) actively to stay connected to family and friends scattered in exile. Hence, we recruited participants through snowballing on Facebook. Although the recruitment was online, the process involved considerable engagement between the researcher and each potential participant through direct and interactive communication through all stages of the process (personal invitation, filling the survey and after). We started inviting possible participants – one by one – in February 2017 and for six

weeks using the first author's own friends' list of Syrian refugees and Facebook groups dedicated to Syrian refugees in Jordan. Invitations were sent to members of these groups who met the inclusion criterion (18 years or older, Syrian hometown, and living in Jordan). Using his public Facebook profile, the first author contacted potential participants directly and invited them to participate in the survey. As a compensation for their time, participants were offered a mobile phone credit equivalent to £3.50. The first author was available online to answer any questions from the participants, some who had questions about the researchers' identity and the purpose of the study or needed further clarifications about how to answer the questions.

Two-hundred and ninety-six personal invitations were sent and 166 ($M_{age} = 30.4$, $SD = 8.8$ years) participants completed the online survey; 10 responses were excluded due to low engagement (survey completion time < 4 minutes). 63.9% of participants were male; 84.5% of the participants had spent four years or more in Jordan. The sample size (n = 156) is adequate according to the path analysis guidelines that recommend a minimum sample of 50 (Iacobucci, 2010), or 10 cases for each variable (Nunnally, 1967).

Ethics statement. The University of Sussex Ethics Committee approved this study in February 2017.

Measures[2]

We introduced a number of measurement improvements on the previous study that included: refinement of the same measures used (i.e., rephrasing some questions and the answer anchor, adapting a five-point Likert scale for all the measures); substituting the 5-items short version of general health measure with the full 12-items general health scale; and use of a secondary stressors scale we developed for Syrian refugees in the Middle East (Alfadhli & Drury, 2018a)

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[2] We used a depression scale (PHQ-9) scale adapted into Arabic by Al Hadi et al. (2017), as an alternative health measure, but it was not included in the analysis.

that measures exposure to the stressors instead of the extent of stress caused by these stressors (e.g., Panter-Brick et al., 2008).

We adopted six scales from the previous study; shared social identity (α = .84), expected support (α = .65), coordinated support (α = .83), practical support (α = .76), collective efficacy (α = .65), and emotional support (α = .68) after adding to it a third item "showed respect to others".

Common fate. We used a scale of four items adapted from Drury et al. (2016) to assess the extent of which the participant felt that the refugees around him shared a sense of common fate in relation to the situation of being a refugee: "Refugees are all in a similar situation", "All refugees face same challenges and problems", "All refugees feel similar suffering" and "All refugees face similar challenges during adapting" (α = .85; 0 "Strongly disagree" to 4 "Strongly agree").

Secondary stressors. We used seven items from a scale we developed with the same population (Alfadhli & Drury, 2018a) to assess the extent of participants' exposure secondary stressors related to financial challenges, services, and relations with locals: "High cost of living", "Being unemployed", "Not having enough money to get stable survival foods", "Not knowing about aid or services offered by non-profit organizations", "Lack of recreational activities", "Jordanian people try to take advantage of others", "Jordanian people are trustworthy" (reversed), and "Jordanians think that Syrians are not trustworthy" (α = .63; 0 "Never" to 4 "All the time" for items on financial and services, and 0 "Strongly disagree" to 4 "Strongly agree" for relation with locals items).

General health. We used the twelve-item GHQ scale (Minowa, 2003). The scale included items like "Lost much sleep over worry", "Been thinking of yourself as worthless" and "Felt constantly under strain" (α = .76; 0 "Never" to 4 "Very often").

Stress. We used the ten-item Arabic version of Perceived Stress Scale (PSS-10) (Chaaya, Osman, Naassan, & Mahfoud, 2010). The scale included items like "felt that things were going your way", "found that you could not cope with all the things that you had to do" and "felt nervous and stressed" (α = .81; 0 "Never" to 4 "Most of the time").

We followed the same approach as in Study 1 to translate the additional scales in this study.

Results

Table 2. Descriptive statistics and correlations

	Min Max	M	SD	1	2	3	4	5	6	7	8	9	10
1.Shared Identity	0/4	2.41	1.01										
2.Expected Support	0/4	2.02	0.90	.609**									
3.Collective Efficacy	0/4	1.82	0.78	.381***	.392***								
4.Practical Support	0/4	1.83	1.22	.313***	.137	.116							
5.Coordinated sup.	0/4	1.24	1.03	.298***	.233**	.105	.591***						
6.General Health	0/4	2.11	0.66	.152	.156	.234**	.098	.187*					
7.Stress	0/4	2.09	0.60	-.068	-.066	-.117	-.086	-.182*	-.570***				
8.Common Fate	0/4	2.16	1.06	.418***	.419***	.069	.167*	.235**	-.042	.13			
9.Secondary Stressors	0/4	1.98	0.73	.088	.032	-.024	-.013	-.275**	-.09	.280***	.085		
10.Emotional support	0/4	2.89	1.00	.288***	.212**	.271**	.404***	.298***	.166*	-.043	.068	.230**	
11.Time in Exile	1/5	4.12	0.83	.057	-.046	-.089	.116	.068	.058	.082	.137	.163*	320***

*p < .05, **p < .01, ***p < .001.

Predictions

The analysis of study 2 showed a negative relation between the exposure to secondary stressors and health, which is mediated by stress. We could not find a significant relation between exposure to secondary stressors and common fate as predicted in H2; but when accounted for time spent in exile, the interaction showed that high exposure to secondary stressors leads to a sense of common fate among refugees who spent longer time in exile, which could support the emergent shared social identity explanation.

Regarding the social support process, the results confirmed the presence of a shared identity-based support process, similar to what was found in study1. The analysis of specific indirect effects (table 3) showed a weak positive impact of the support process on the general health of the refugees.

In order to test the buffering hypothesis in detail, we tried to isolate the contribution of the support process to the general health of refugees by conducting the path analysis on the theoretical model twice to compare the full model (Figure 5) with the model without the secondary stressors / stress path (Figure 4). The comparison showed that the support process does contribute to the health of refugees but not enough to counter the - around three times greater - negative effect of stress.

Path analysis. We fitted our theoretical model employing the same approach as in Study 1. The model (Figure 4) demonstrated an excellent fit to the data ($\chi^2 = 11.51$, $p = .319$, $df = 10$, CFI = .99, RMSEA = .031, SRMR = .038)
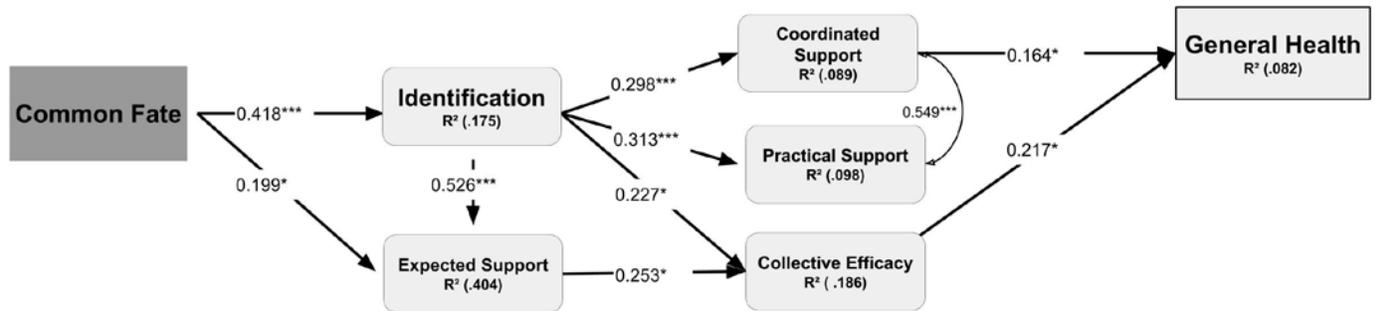
Figure 4: Standardised results of path analysis using multiple regression analyses.

The support process. Common fate was found to be a strong predictor of shared social identity (β = .41, SE = .08, p < .001), which in turn was a strong predictor of both practical support (β = .31, SE = .07, p < .001) and coordinated support (β = .29, SE = .07, p < .001). Expected support was found to be predicted by shared social identity (β = .52, SE = .07, p < .001) in addition to common fate (β = .19, SE = .08, p = .015). Collective efficacy was found to be predicted by expected support (β = .25, SE = .10, p = .018) and shared social identity (β = .22, SE = .11, p = .039). Finally, health among the refugees was predicted by collective efficacy (β = .21, SE = .09, p = .021), in addition to engaging in coordinated support efforts (β = .16, SE = .08, p = .045).

We found significant indirect effects of common fate on general health via shared social identity and collective efficacy β =.021, 95% CI [.006, .054]. and via shared identity and coordinated support β =.020, 95% CI [.004, .050].

Full model. To explore any possible positive effect of the previous support process on the general health of the refugees and compare it to the negative effect of secondary stressor, we built a full model (Figure 5).

The model demonstrated an excellent fit to the data (χ^2 = 21.195, *p* = .44, *df* = 21, CFI = .99, RMSEA = .008, SRMR = .051).
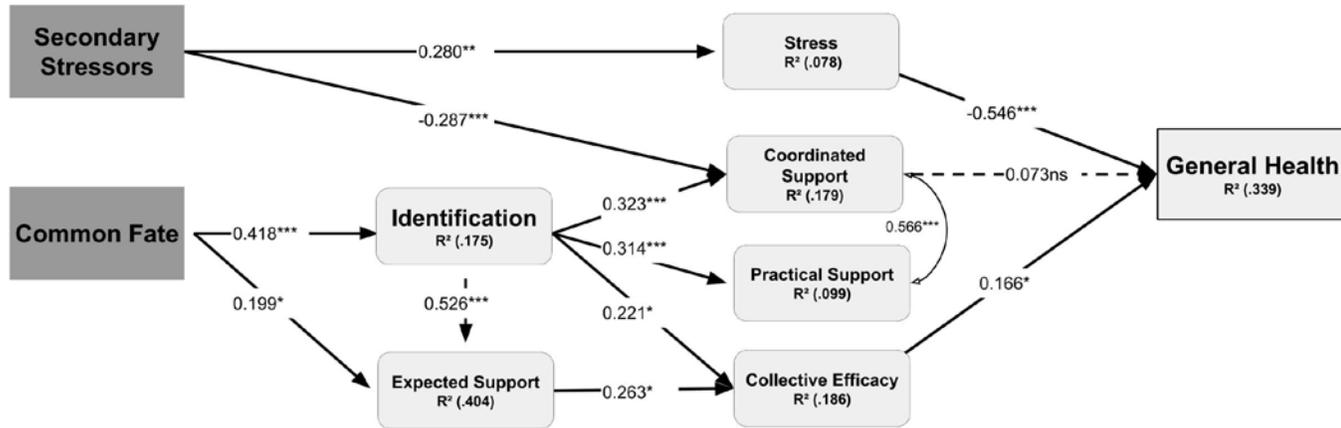

Figure 5. Model of the process of shared identity-based support among the refugees and its effect on their general health, in the presence of secondary stressors (full model).

The results showed a strong negative effect of secondary stressors on refugees' general health, mediated by stress. Compared to the last model, this model (Figure 5) has three new significant pathways, whereby secondary stressors predicted stress (β = .28, *SE* = .08, *p* < .001) and coordinated support (β = -.28, SE = .05, *p* < .001), in addition to stress predicting general health (β = -.54, *SE* = .05, *p* < .001).

Focusing on general health, we can see it has a negative association with stress three times stronger than its positive association with collective efficacy. From comparing the R^2 for the general health between the two models (Figures 4 and 5) we see that stress contributes to at least three-quarters of the variance in general health. This result suggests that there is a buffering effect by collective efficacy against the stronger negative effect of stress on general health.

In addition to comparing the positive and negative relations with general health and the change of R^2 between the models, we can notice that secondary stressors seem to have a double

effect on general health. From comparing the two models (Figures 4 and 5), it seems that the secondary stressors weaken the positive associations between coordinated support and general health, in addition to having an indirect effect on general health mediated by the stress. The full model (Figure 5) shows that high exposure to secondary stressors is associated with a significant decrease in engagement in coordinated support, which could be responsible for diminishing the positive association between coordinated support and general health, from ($\beta = .16$, $SE = .08$, $p = .045$) to ($\beta = .07$, $SE = .06$, $p = .28$). We also notice that the presence of secondary stressors and stress decreases the positive association between collective efficacy and general health, from ($\beta = .21$, SE = .09, $p = .021$) to ($\beta = .16$, SE = .07, $p = .025$).

Table 3. Indirect specific effects

					β	95 % CI
Secondary Stressors ➔			Stress ➔	General health	-.153	-.231, -.076
Secondary Stressors ➔			Coordinated support ➔	General health	-.021	-.055, .010
Common Fate ➔	Shared Social Identity ➔		Collective efficacy ➔	General health	.015	.004, .043
Common Fate ➔		Expected Support ➔	Collective efficacy ➔	General health	.009	.001, .03
Common Fate ➔	Shared Social Identity ➔		Coordinated support ➔	General health	.010	-.003, .031
Common Fate ➔	Shared Social Identity ➔	Expected Support ➔	Collective efficacy ➔	General health	.010	.002, .029
	Shared Social Identity ➔		Collective efficacy ➔	General health	.037	.007, .094
	Shared Social Identity ➔		Coordinated support ➔	General health	.024	-.009, .068
	Shared Social Identity ➔	Expected Support ➔	Collective efficacy ➔	General health	.023	.003, .065
		Expected Support ➔	Collective efficacy ➔	General health	.044	.006, .115
Common Fate ➔	Shared Social Identity ➔		Collective efficacy		.092	.026, .187
Common Fate ➔		Expected Support ➔	Collective efficacy		.052	.013, .120
Common Fate ➔	Shared Social Identity ➔	Expected Support ➔	Collective efficacy		.058	.019, .116

Common Fate ➜	Shared Social Identity ➜		Coordinated support	.135 .073, .214
Common Fate ➜	Shared Social Identity ➜		Practical support	.131 .072, .213
Common Fate ➜	Shared Social Identity ➜	Expected support		.220 .146, .311
	Shared Social Identity ➜	Expected Support ➜	Collective efficacy	.138 .043, .252

Note. Bootstrap is based on 5000 re-samples. When confidence intervals do not include zero this shows that there is a significant indirect effect (Preacher & Hayes, 2008; Williams & MacKinnon, 2008). Standardized coefficients are shown.

The analysis of indirect effects (Table 3) confirmed the suitability of the support process paths in the full model (Figure 5), especially the paths from common fate and shared social identity to general health through collective efficacy as a distal mediator. Also, the indirect effect of secondary stressors on health through stress was significant, $\beta = -.153$, 95% CI [-.231, -.076].

We found significant indirect paths from common fate to general health; the strongest path involved shared social identity then collective efficacy as mediators $\beta = .015$, 95% CI [.004, .043]; a second path involved shared social identity, expected support and collective efficacy as mediators, $\beta = .010$, 95% CI [.002, .029]; the last path involved expected support and collective efficacy as mediators $\beta = .009$, 95% CI [.001, .030].

Indirect paths from shared social identity to general health of the refugees had stronger effects; the first path was mediated by collective efficacy, $\beta = .037$, 95% CI [.007, .094]; the second path involved expected support and collective efficacy as mediators, $\beta = .023$, 95% CI [.003, .065].

Moderation Analysis

As mentioned in the introduction, one difference from a disaster setting is that enduring conditions of the exile environment pose a considerable challenge in the face of refugees having a "normal life". Based on that, we anticipated that the secondary stressors to contribute toward the sense of common fate among the refugees. But the results showed that secondary stressors did not significantly predict common fate (β = .126, SE = .13, p = .287). However, we did find that time spent in exile moderated this relation (Figure 6) (β = .473, SE = .13, p < .001), (ΔR2 = .07, $F(5.139)$ = 151, p < .001), whereby refugees who spent more time in exile showed a stronger association between secondary stressors and common fate than those who had been refugees for less time.
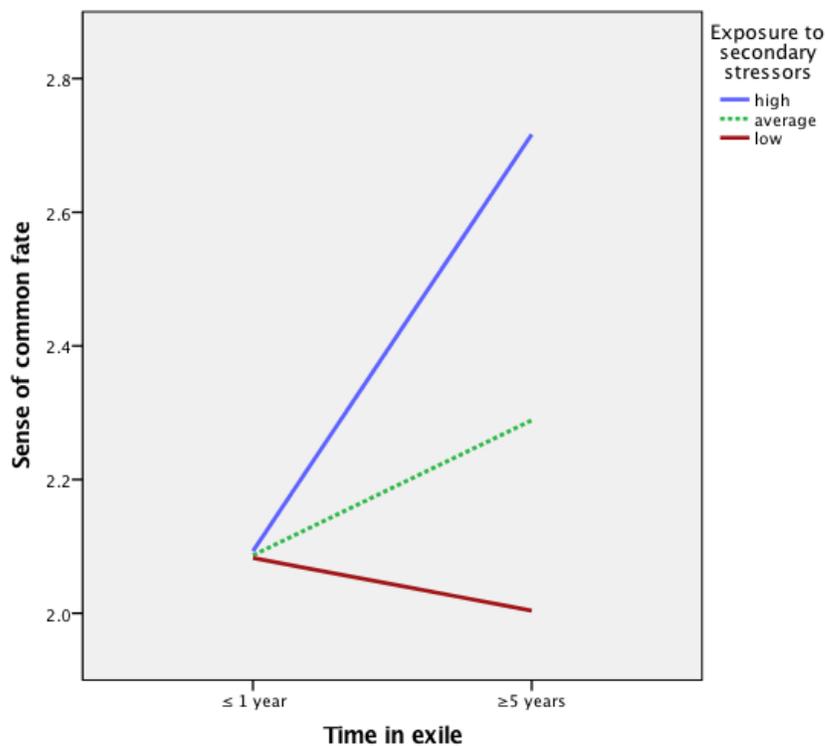

Figure 6. Interaction between time spent in exile, sense of common fate, and exposure to secondary stressors.

Discussion

The results support the idea of a shared identity-based support process active among Syrian

refugees in Jordan with a positive and limited association with their general health, as found in

the previous study. In addition, this study showed that secondary stressors are associated with

stress, which was found to have a negative association with the general health of refugees.

Secondary stressors were also found to have a negative association with coordinated support,

which implies that high exposure to secondary stressors might hinder the possibility of refugees

engaging in coordinated support activities.

Although this study showed that the main variables had similar relations to that found in the

case of earthquake study by Drury et al. (2016), this study showed a slightly different pattern of

indirect effects. First, we found that expected support is predicted by common fate in addition to

be mainly predicted by identification, which could be due to the stigmatic nature of the "refugee"

identity which might reduce its role as a mediator. Second, coordinated support is predicted by

shared social identity, but not through expected support, which could be due to the prolonged

displacement of refugees that reduces the sense of emergency and the expectations of collective

response, or a shift toward tasks that require less cooperation. The significance of such variations

will be discussed in the following general discussion section.

The indirect paths analysis showed multiple paths of effects from common fate and shared

social identity to the general health of refugees, which gives some support to the hypothesis that

the identity-based support process has a positive effect on the general health of the refugees.

We predicted that high exposure to secondary stressors would be associated with common

fate (and thus to identification with other refugees). However, we found no significant direct

relation between the two variables but found that time spent in exile increased the chance of

exposure to secondary stressors (arising from the exile environment) being associated with

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common fate with other refugees (Figure 6). This result is important for two reasons. First, it is in line with the idea of the emergent nature of shared social identity (based on common fate) by showing rise in the sense of common fate after displacement. Second, mere displacement and being in exile is not enough to develop a sense of common fate among the refugees; those who were exposed to fewer stressors showed less common fate with other refugees than those exposed for five years. We argue that this result could support the hypothesis of emergent shared social identity, as the refugee identity is a new identity that displaced people acquire in exile and the more they get exposed to stressors of the exile environment - many of which target them as a group - the more they identify with other refugees who share the same situation with them.

General Discussion

Addressing the first main research question "do refugees share an emergent identity that facilitates support among them (similar to people affected by disasters)?", the findings support the suggestion of a shared identity-based support process. This identification with other refugees is associated with providing practical support, expected support, and collective efficacy, similar to what has been found among populations affected by disasters.

With regards to the second and third research questions "Does this identity-based support impact on their health? If so, does this positive impact help to mitigate the negative effect of exile stressors on refugees' health?", we found that this core process is linked to a sense of collective efficacy and has a limited positive relationship with the general health of the refugees, which seems to buffer the negative effect of secondary stressors (mediated by stress).

In addition, we found a further indication that supports the emergent identity hypothesis, whereby the participants who spent more time in exile seems to have a higher sense of common fate and identification with other refugees.

Shared Social Identity

Moulin (2010, p. 365) described how identification with other refugees' *"refugeeness"* happens through "the displaced nature of their everyday experience" such as restrictions on mobility and common perception of assistance they receive from the local authorities, were found among the Syrian refugees who reported sharing a sense of membership with other refugees based on shared struggle (Alfadhli & Drury, 2018b). Our analysis of the survey data in study 2, shows evidence that exposure to secondary stressors is associated with a sense of common fate (which is the main predictor of identification) only among the refugees who spent a longer time in exile, but not refugees who were recently displaced. We take this result as supportive evidence that the shared social identity among refugees is an emergent identity. People who face more stressors tend to feel and share more common fate and thus more expected to identify with others who face same challenges. This is an expected coping strategy in line with the Social Identity Model of Identity Change (SIMIC; Jetten & Pachana, 2012), which assumes that people can deal with stress caused by losing old identities by replacing them with new identities. The SIMIC explains how they not only substitute the old grounding and sense of belonging with new ones, but also provide a base to receive and give social support (Jetten & Pachana, 2012). This is especially true among our participants, most of whom seemed to adopt the new "refugee" identity (Figure 7), which was found to be helpful for the refugees when facing their stressful situation.
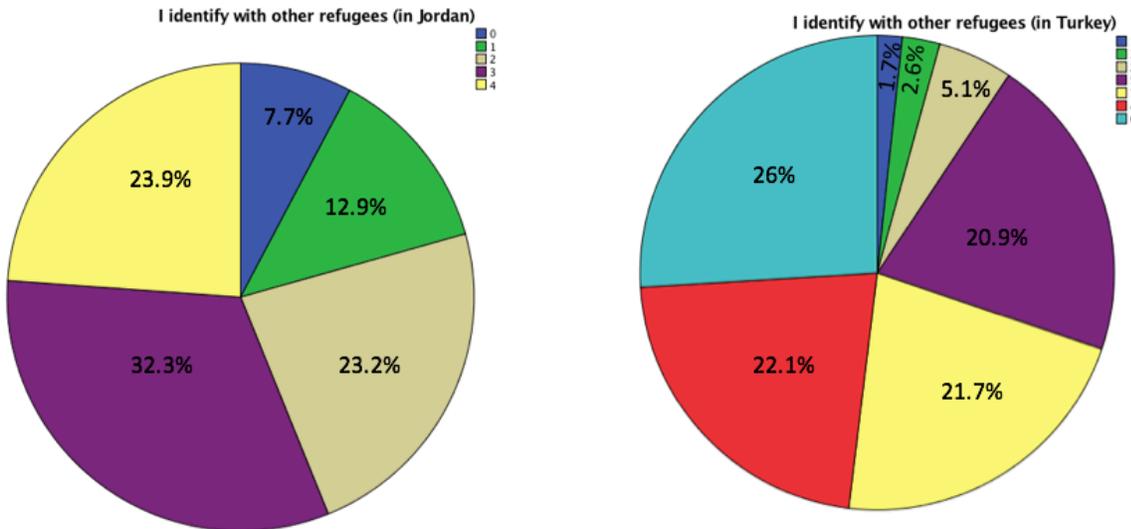
Figure 7. Response of participants to a question about identification with other refugees (from 7 "Strongly Disagree" to 1 "Strongly Agree").

This sense of belonging to an active group of members with common challenges, which motivates them to act in solidarity and provide mutual support, is a reminder of a pattern of solidarity among strangers which has been documented in emergencies and disasters (e.g., the 2005 London bombings; Drury, Cocking, & Reicher, 2009), where many people who do not necessarily know each other start to feel and act like a group, which facilitates support and coordinated efforts toward common goals.

However, membership in the refugees' group also has a dark side due to the stigma attached to it, which is expected to have a negative effect on the refugees' wellbeing and health, as found in other cases of identifying with stigmatic labels (e.g., homeless people; Walter, Jetten, Parsell, & Dingle, 2015). Although understanding the role of stigma was not within the scope of this project, we do believe that it is important to focus on how the refugees see themselves and are seen by others in order to fully understand the intersections between social identity, well-being and collective resilience among refugees of conflict in developing countries.

Support process

The analysis of the surveys we conducted among Syrian refugees in Jordan and Turkey also supports the central role of shared identity while providing more details regarding the process. Common fate was found to be a base for shared identity, which is a major motivation for providing different kinds of support. This pattern of social identity-based support is in line with the Social Identity Model of Collective Resilience (SIMCR), where common fate is an antecedent of people to share social identity that has consequences both cognitive (shared definitions and goals) and relational (trust, expecting support and giving support), which in turn increases coordination and sense of efficacy (Drury, 2012).

Our path analysis results showed results similar (more details in study 2) to the social identity-based process found among people affected by the 2010 Chile earthquake (Drury et al., 2016). Here, exposure to the disaster - through a sense of common fate - predicted shared social identity, which in turn predicted expected support and providing emotional support, in addition to predicting a sense of collective efficacy and coordinated support (both mediated by expected support). In the case of refugees, we found that high exposure to secondary stressors led to a sense of common fate only among participants who spent a long time in exile (three or more years), but common fate was found to be a strong predictor of shared social identity among refugees. Shared social identity was found to be a strong predictor of expected support and providing practical and coordinated support, in addition to predicting collective efficacy (mediated by expected support).

These results provide initial evidence that shared social identity-based support does exist among Syrian refugees in neighbouring countries (and possibly among refugees of conflict in

developing countries in general), and that the process of such support is similar to what has been documented among people affected by mass emergencies and natural disasters.

The buffering effect

The previous literature has established the negative effect of the secondary stressors on mental health and general health of the refugees (Miller & Rasmussen, 2010). Our analysis indeed shows a strong negative effect of secondary stressors on the health of the refugees and that this negative effect of stressors is mediated by stress, which is a pattern also found in relevant literature (Nelson & Simmons, 2003). When combining both the negative and positive effects on refugees' general health, we find that shared identity-based support process seems to have a weak buffering effect to the negative effect by stressors. This effect is similar to what was found among survivors of earthquakes, where community identification and collective efficacy were found to mediate the relation between earthquake experience and well-being (Muldoon et al., 2017).

However, we emphasise that this buffering effect - although important - is not enough to encounter the three times stronger effect of the stressors on general health, which explains why the refugees are in serious distress and in need of external support. In addition to significant negative general health effects, secondary stressors seem also to hinder the engagement of refugees in collective support efforts to help other refugees, which makes sense as struggling with secondary stressors can be exhausting in time, effort and resources.

Nevertheless, we suggest that such support process can be an effective base for interventions that approach the refugees as a group at community level, rather than simply as individuals. The presence of self-help mechanisms in the refugees' community co-existing with negative state of general health among them does not necessarily show its inefficiency, rather that the magnitude

of serious challenges posed by the exile environment, or the lack of resources to utilise such mechanisms that sometimes manifest as a network of social relations capable of mobilising resources quickly and in high efficiency (Alfadhli & Drury, 2018b).

Emergent Identity

We suggest that time is a crucial factor in any attempt to understand the psychosocial support dynamics and general health of refugees in exile, and we were not surprised to find that time spent in exile increases the association between exposure to secondary stressors a sense of common fate with other refugees. However, we would like to emphasise that this suggestion needs more investigation, because the majority of our study 2 participants (84.5%) spent four years or more in Jordan, which is expected due to the fact that Jordan officially closed its borders with Syria in 2014 (The Jordan Times, 2015; UNHCR, 2015). We suggest this effect should be tested among additional samples that have a larger number of refugees who spent a shorter time in exile to have more confidence in drawing conclusions about the moderation effect and to what extent it can support the emergent shared identity hypothesis.

Contribution

Although the literature on social support and solidarity among refugees of conflict across different disciplines has highlighted the importance of identity (Chatty, Mansour, & Yassin, 2013; Curley, 2009; Moulin, 2010; Palmgren, 2013), the present paper is the first to shed light on the process of support and the central role of shared social identity in these mechanisms. Other studies described the emergence of shared identity among refugees without exploring its role in social support dynamics or providing a quantitative analysis of this process (e.g., Moulin, 2010). In addition to highlighting the role of shared social identity as a strong mediator and predictor of providing many kinds of support, we also highlighted the importance of expected support as a

predictor of collective efficacy, which could guide future interventions that target enhancing collective efficacy among refugee communities in developing countries.

The second major contribution goes beyond extending the theoretical model of shared identity-based support in emergencies, to extend the model conceptually and situating it in a larger context, by including general health as an ultimate output of support, in addition to including secondary stressors for their crucial role in the life of refugees of conflict.

Although our analysis showed a relatively weak effect on general health of refugees by the identity-based support process, we would like to emphasise that the shared social identity was a strong predictor of providing different forms of social support and a sense of collective efficacy, which are valuable outcomes to a challenged population like refugees in developing countries.

Implications

We emphasize that secondary stressors among refugees of conflict have a considerable impact on the well-being of refugees of conflict in developing countries. We advocate a comprehensive approach to such challenges by showing that there is more to do than attempting to decrease the exposure to secondary stressors, by highlighting the fact that refugee communities have mutual social support systems. Introducing shared social identity as an important resource in protracted conflict settings can inform the response guidelines to one additional strength in the refugees' community, that could be utilised to improve the conditions of refugees and empower them.

Specifically, we recommend social identity-based interventions (e.g., countering social isolation), which have been found to be beneficial for mental health (Haslam, Cruwys, Haslam, Dingle, & Chang, 2016). Such interventions can best utilise the capacity of refugees by including them in the intervention design and approaching them as a group, instead of as individuals. Field

guidelines for practitioners working with refugees can also benefit by being aware of the positive role of shared "refugee" identity and how it can be empowering instead of stigmatizing. Indeed, refugees do help each other, but it is important to understand that refugees are not independent from external help and they have a far greater capacity to do even better if provided with much needed resources.

Limitations and Future Work

For the purpose of this project, we used convenience samples, and thus we do not assume that participants were representative of the population of Syrian refugees in Middle East, as the recruitment locations (Online & paper questionnaires) are expected to exclude some refugees who have no access to such locations. Due to the differences in exile conditions, we also anticipate some differences in Syrian refugee experiences across different host communities in Middle East like suffering different secondary stressors (e.g., language barriers or legal restrictions). In addition, both studies were cross-sectional and could not provide insights to causality relations between the variables.

Although the sample of this study may not be representative, the results suggest the presence of an identity-based support process among the refugees and thus encourages us to further test our model and develop our hypothesis using a more representative sample with a longitudinal design, perhaps in other refugee populations.

Data Availability

Data used in the research project has been made available and can be accessed through the following links:

Turkey survey: https://figshare.com/account/articles/7117076

Jordan survey: https://figshare.com/account/articles/7116842

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