Mental Health Literacy of Resettled Afghan Refugees in Australia: An Exploration of How Resettled Refugees Understand Post-traumatic Stress Disorder and its Treatment

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A work of this size would be impossible without the support of some very special people.

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STATEMENT OF AUTHENTICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

(Signed)
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GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Wellbeing</td>
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<td>AMEP</td>
<td>Adult Migrant English Program</td>
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<td>AN</td>
<td>Anorexia nervosa</td>
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<td>ANCORW</td>
<td>Australian National Committee on Refugee Women</td>
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<tr>
<td>AS</td>
<td>Accommodation support</td>
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<td>AWES</td>
<td>Afghan War Experience Scale</td>
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<tr>
<td>BN</td>
<td>Bulimia nervosa</td>
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<tr>
<td>BRFSS</td>
<td>Behavioural Risk Factor Surveillance System</td>
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<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<tr>
<td>CAPS</td>
<td>Clinician-administered PTSD Scale</td>
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<tr>
<td>CDCP</td>
<td>Center for Disease Control and Prevention</td>
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<tr>
<td>DIBP</td>
<td>(Australian Government) Department of Immigration and Border Protection</td>
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<tr>
<td>DVR</td>
<td>Digital voice recorder</td>
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<td>ED</td>
<td>Eating disorders</td>
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<tr>
<td>EPCACE</td>
<td>Enduring personality change after a catastrophic experience</td>
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<td>HREOC</td>
<td>Human Rights and Equal Opportunities Commission</td>
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<td>HSS</td>
<td>Humanitarian Settlement Strategy</td>
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<td>HTQ</td>
<td>Harvard Trauma Questionnaire</td>
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<tr>
<td>KAP</td>
<td>Knowledge, attitudes and practices</td>
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<td>MHL</td>
<td>Mental health literacy</td>
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<tr>
<td>MINI</td>
<td>Mini International Neuropsychiatry Interview</td>
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<td>NSMHLNS</td>
<td>National Survey of Mental Health Literacy and Stigma</td>
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<tr>
<td>NTS</td>
<td>National Trauma Survey</td>
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<tr>
<td>PDPA</td>
<td>People's Democratic Party of Afghanistan</td>
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<tr>
<td>PET</td>
<td>Positron emission tomography</td>
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<tr>
<td>PTE</td>
<td>Potentially traumatic events</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
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<tr>
<td>RCOA</td>
<td>Refugee Council of Australia</td>
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<td>SA</td>
<td>South Australia</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>SHP</td>
<td>Special Humanitarian Program</td>
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<td>TPV</td>
<td>Temporary protection visas</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>VTPU</td>
<td>Victoria Transcultural Psychiatric Unit</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Abstraction

Resettled refugees are at high risk of trauma-related mental health problems, yet there is low uptake of mental health care in this population. Evidence suggests poor mental health literacy (MHL) may be a major factor influencing help-seeking behaviour among individuals with mental health problems. This study sought to examine the MHL of resettled Afghan refugees in Adelaide, South Australia. Specifically, levels of problem recognition, beliefs about severity of problem, beliefs about helpfulness of treatment and treatment providers, help-seeking behaviours and stigmatising attitudes were measured. Further, associations between specific aspects of MHL as outlined above, and individuals’ demographic characteristics (e.g. age, gender, religion, and ethnicity) and symptom levels were examined.

Methods: Face-to-face interviews using a validated protocol were conducted with 150 participants (74 males, mean age = 32.8 years, SD = 12.2). A culturally appropriate vignette describing a fictional person suffering from post-traumatic stress disorder (PTSD) was presented, followed by a series of questions addressing participants’ knowledge and understanding of the nature and treatment of the problem described. Self-report measures of PTSD symptoms and co-morbid psychopathology were also administered. Follow-up qualitative interviews, with the aim of gaining a richer, in-depth and inductive understanding of participants’ MHL, were conducted with 24 of these participants (13 females, aged 18-46).

Results: Thirty-one per cent of the participants identified the problem depicted in the vignette as PTSD, while 26% believed that the main problem was “fear”. Eighteen per cent of participants believed that “getting out and about more/finding some new hobbies” would be the most helpful form of treatment for the problem described, followed by “improving their diet” and “getting more exercise” (16%). A majority reported that they would utilise more introspective activities such as reading the Koran and prayers. In terms of treatment, approximately a third chose readily available remedies, primarily “over-the-counter” non-pharmaceuticals, including vitamins, minerals and herbal medicine. As with other informal help-seeking pursuits, life style choices allowed for a measure of privacy. If deemed necessary, participants elected to see a psychiatrist (43.3%) rather than a general practitioner (15.3%) or psychologist (14.7%). A family member was considered the least
favourable option. Participants recognised that the most likely cause of the problem in the vignette was coming from a war-torn country (31.3%), followed by equal numbers who stated that experiencing traumatic events (20.7%) and family problems (20.7%) were the most likely causes. Half of the participants felt that the problem would be very distressing and very difficult to treat. Interestingly more than half reported that they would be sympathetic towards someone experiencing this problem but believed that others would discriminate against the individual.

Thematic analysis of qualitative interviews confirmed that many participants clearly identified the following as contributing to their mental illness: trauma as a consequence of pre-arrival exposure to war and persecution, loss of loved ones, ongoing persecution as an ethnic minority, and loss of identity. These difficulties were further complicated by post-arrival challenges associated with learning a new language and finding employment, which prevented them from feeling part of the wider Australian community and contributed to a sense of disconnectedness. Participants implied that they were sensitive to the possible criticism of others if they sought help for mental illness. They noted the presence of shame, humiliation, stigma and fear of gossip within the community, which created barriers to help-seeking. More specifically, the fear of being the subject of gossip led participants to avoid treatment, which further exacerbated the mental illness. Some participants preferred to seek help outside the family, preferring their general practitioner, who would protect their privacy. This secrecy appeared to protect attendees from the associated stigma and shame. A substantial portion described how their religion and their faith in God were effective coping mechanisms. Others described religion as a source of oppression.

Conclusion: This is, to our knowledge, the first systematic study of MHL undertaken within the Afghan refugee community.

The results demonstrate aspects of MHL that appear to be specific to Afghan refugees who have resettled in Australia. They indicate the need for health promotion, early intervention programs, and mental health services, to recognise that variation in MHL may be a function of both the cultural origin of the refugee population and their resettlement country. Such recognition is needed in order to bridge the gap between Western, biomedical models of mental health care and the
knowledge and beliefs of resettled refugee populations. Therefore, further research should explore how best to tailor and develop educational and health/psycho-social intervention programs.
CHAPTER ONE INTRODUCTION

Chapter one seeks to review the definition of refugees, asylum seekers and displaced persons. This chapter also reports entrants arriving under the Special Humanitarian Programs (SHP).

1.1 Definition of Refugees, Asylum Seekers and Displaced Persons

Some of the largest population movements in modern times have occurred in the past 30 years (American Psychiatric Association, 2004). Factors such as war, oppressive regimes and civil unrest have forced many to flee their homes to seek safety and protection. The United Nations High Commissioner for Refugees (UNHCR), which is the international body with a mandate to protect refugees, identified 691,000 refugees as being in need of resettlement in 2014 despite having access to only 86,000 global resettlement places each year (United Nations High Commissioner for Refugees, 2014). The UNHCR’s annual 2014 Global Trends Report reported that worldwide displacement was at the highest level ever recorded. It said the number of forcibly displaced people at the end of 2014 had risen to a staggering 59.5 million compared to 51.2 million a year earlier and 37.5 million a decade ago (UNHCR, 2015). Of these, 33.3 million were internally displaced persons, 16.7 million were refugees and 1.1 million were asylum seekers. The current definition of refugees was developed in the aftermath of the Second World War when millions of people were left homeless or living in camps across Europe. The definition is found in the 1951 Convention and Protocol relating to the Status of Refugees (United Nations Refugee convention, 2010):

\[
A \text{ person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.}
\]

According to Australia’s Refugee and Humanitarian programme, Australia is currently the third leading resettlement nation worldwide in offering protection to
refugees through its Humanitarian Program. The program has two important components. The first and by far the largest intake of refugees to Australia is through the offshore resettlement program, which offers protection and resettlement to people overseas who are subject to persecution in their home countries. The offshore resettlement program is divided into two categories: Refugees and the Special Humanitarian Program.

**Refugees** — people who are subject to persecution in their home country, who are typically outside their home country, and are in need of resettlement fall into this category. The majority of applicants considered under this category are identified and referred to Australia for resettlement by the UNHCR. The Refugee category includes the Refugee, In-country Special Humanitarian, Emergency Rescue and Woman at Risk visa subclasses according to the Refugee Convention.

**Special Humanitarian Program (SHP)** — this category is for people outside of their home country who are subject to substantial discrimination amounting to a gross violation of human rights in their home country, and immediate family of persons who have been granted protection in Australia. Applications for entry under the SHP must be supported by a proposer who is an Australian citizen, permanent resident or eligible New Zealand citizen, or an organisation that is based in Australia.

Over the period 2003–2004 to 2012–2013 Australia resettled 146 321 refugees (Refugee Council of Australia 2014a). Each year the Australian Government set the number of visas that may be granted under the Humanitarian Programme. The 2015-16 Programme allocated 13,750 places. This included a minimum of 11,000 places for offshore applicants and up to 1,200 places for Women at Risk visas. The remaining was allocated to those arriving onshore in Australia lawfully (DIBP, 2016).

In addition to refugee and asylum seekers there is a third category of highly vulnerable persons. A stateless person is determined not to be a national resident by any state under the operation of its law. Consequently to be stateless is to be without a nationality or citizenship of any country (United Nations 1954 Convention and Protocol Relating to the Status of Stateless Person, Article 1.1). It means that there is no legal bond of nationality between the state and the individual. As a consequence
Stateless people can be denied access to fundamental community resources including health care, education, accommodation and ability to travel freely between different countries. Human rights violations are commonplace. Children can be excluded from attending school because parents are not able to register the child, despite the provisions of the United Nations Convention on the Rights of the Child (UNCRC), 1989 Article 28, which provides that all children should have access to primary education. Stateless persons are further marginalised as their situation prevents them owning property, signing contracts and getting employment.

Critically, stateless persons are not generally defined as refugees as they do not meet the criteria under the UN convention. This is because they usually remain in their country of habitual residence and may not have been displaced by war or by persecution. For this reason many do not attract the attention of the international media or international agencies. Unfortunately they can also remain invisible to governing states and authorities because of the lack of a population census.

An additional group within this category can formally possess a nationality but remain stateless. The term “de facto statelessness” has often been used to define this group. However, there is no universally accepted definition; rather, the term is used to describe a person who, outside his/her country of nationality is denied diplomatic and consular protection or assistance from his/her country. This situation occurs when the country of nationality refuses to allow a person to return home, even though that country still formally recognises the individual as a national. In such a situation, the person may also fall under the refugee definition.

It is difficult to estimate the exact number of stateless persons; however, at least ten million people worldwide continue to suffer the hardship and indignity of being denied nationality (UNHCR, 2014).

According to the UN convention, many stateless persons have been created as a consequence of the dissolution of Soviet Union, the former Yugoslavia and the partition of East and West Pakistan. Although the causal factors vary between countries and legal dictates, the enduring insecurity, absence of protection, and denial of an identity can result in poor health and life outcomes for this vulnerable group. They remain voiceless and stateless, without any protection from UN
mandates or conventions (1954 Convention Relating to the Status of Stateless Persons).

A large number of refugees and asylum seekers in Australia have arrived from Afghanistan. In this chapter I will present a brief history of the Afghan Hazara minority population, as the majority of the current research participants are from this minority group. A large factor for the current diaspora in this location is fuelled by the continued systematic persecution and marginalisation of the Hazara population in Afghanistan. For those arriving in Australia as new settlers, intergenerational and more recent traumatic events are likely contributors of mental distress and illness.

1.2 Background History of Afghanistan’s Ethnic Hazara Population

In this section I will first present general information about Afghanistan and then move on to look in more detail at the Afghan Hazara population, the primary participants of this research.

Afghanistan (which literally means Land of the Afghan) is a mountainous land-locked country located in Central Asia. It has a culture that dates back some 5000 years. Throughout its long and sometimes chaotic history, Afghanistan has been known by various names. In ancient times, its inhabitants called the land Aryana. In the medieval era, it was called Khorasan, and in modern times it came to be called Afghanistan. The capital, Kabul, has been prized over the centuries for its wealth and strategic geographical location by many great figures, such as the Central Asian conqueror, Zahirudeen Babur. However, owing to past and present-day conflicts, this once great city has fallen into disrepair (Sefati, 2013).

Afghanistan is a multi-ethnic country, with the dominant Pashtuns or Pathans being the largest and most powerful ethnic group in the country. They are followed by Tajiks as the second largest ethnic group, and Hazara and Uzbeks make up the two smaller ethnic groups. Numerous other minor ethnic groups (Nuristanis, Baluchis, Turkmens, Sikhs etc.) also call Afghanistan their home (Sefati, 2013).

The official languages of the country are Pashto and Dari. Although the majority of Afghans (99%) belong to the Islamic faith, there are also small pockets of Sikhs, Hindus and even some Jews (www.afghan-web.com accessed Sep. 2014). Of those
practising Islam approximately 80–89% of the population identify as Sunni, while the remaining 10–19% identify as Shiite (www.afgan-web.com accessed Sep. 2014). There has been a historical divide between these two faiths, which has been a basis for past and present conflicts.

1.2.1 Hazara (Shiite)

The Hazara are believed to have settled in Afghanistan as far back as the thirteenth century and are descended from Genghis Khan and the Mongols. This may account for their distinct appearance, culture and traditions (Pouladi, 1989). They speak Dari and Hazaragi and are Shiite Muslims. Some Ismaili Shiite and a lesser number have adopted the Sunni sector of Islam. They are known for their expertise in rug weaving, embroidery and calligraphy (even though most are illiterate), and their poetry, storytelling and music is an expression of their unique ethnic identity (Mousavi, 1998). Hazara people are easily identified from the wider Afghan population by their unique facial appearance. Unlike other Afghan women, Hazara women fought beside men in battle. Not only do they distinguish themselves from fellow Afghans by their religion, culture and ethnicity, but persecution has also shaped and defined the Hazara identity (Joshua Project, 2012). Shiite Islam has contributed to group cohesion among the Hazara because the tenets of Shiite Islamic laws place the Hazara in opposition to the Afghan state, which is dominated by the Pashtuns and governed by Sunni Islamic law. As a minority ethnic group within Afghanistan, Hazara people are fiercely independent and resist Sunni Pashtun rule. It is this distinct identity that motivates Hazara political activity and social organisation, but also provokes hostility and persecution by the dominant Pashtun majority (Mousavi, 1997).

Hazara populations can be found in Mazzar-e Sharif, Badakhshan, Helmand, the western districts of Kabul, and Herat; however, they are mainly concentrated in their traditional homeland of Hazarajat, which covers approximately 50,000 square kilometres of land in the highlands region of central Afghanistan (Sarabi, 2006). Historically, the geographical boundary for Hazarajat has changed after incursions by various rulers of Afghanistan intent on subduing the Hazara tribes who resisted rule from Kabul (Sarabi, 2006). An example of this was during the reign of Amir Abdul Rahman (1880–1901), when Sunni leaders declared jihad on all the Shiites of
Afghanistan and the Shiite Hazaras suffered severe political, social and economic repression. As Amir Abdul Rahman moved to extend his control of Afghanistan beyond Kabul, he met resistance from the Hazara tribes living in the Hazarajat. Fiercely independent and unwilling to be subjugated, the Hazara were the first minority ethnic group to revolt against Abdul Rahman’s expansionism. In response, Amir Abdul Rahman sent Pashtun tribes to the central highlands of Hazarajat to crush the revolt and suppress further resistance. In the aftermath thousands of Hazara men were killed, their women used as slaves and their land occupied. Those who survived the initial period of the conflict managed to escape to the north (Monsutti, 2003). The ensuing occupation of Hazarajat severely restricted the autonomy of the Hazara, who were subjected to heavy taxation, enslavement and expulsion. It is estimated that during this period 60% of the Hazara population were massacred (Mousavi, 1998). By 1893, Rahman’s Afghan forces occupied the entire Hazarajat region and proceeded to redraw the boundaries, significantly reducing it in size. To consolidate his rule and suppress any resistance, the Rahman’s central government substantially altered the social structures of the Hazara by displacing traditional tribal leaders and decision makers. With their land occupied and hierarchical structures weakened, the Rahman government encouraged Afghan Pashtun nomads to access the Hazara’s cultivated fertile land for use as animal pastureland. Hazara families were displaced and forced into subsistence farming on areas with poor soil and difficult conditions. This had negative economic results for the Hazara and caused a sharp decline in their standard of living. The suppression of the Hazara population continued throughout the 19th century as they were denied state citizenship and forced to conceal their identities in order to obtain state identification (Mousavi, 1998).

The historical events of the 1890s remain a large part of the modern Hazara identity and shape their concept of ethnic identity as one that is in opposition to the Afghan state. Ensuing failed uprisings and subjugation of the Hazara triggered large-scale emigration abroad to the present-day territories of Iran, Pakistan, Russia, and the former Soviet Central Asian republics (Mousavi, 1998). At Amir Abdul Rahman’s death in 1901, his son Habibullah succeeded him. During Habibullah’s reign (1901–1919), Hazara people who had fled to escape the fighting against Abdul Rahman in the 1890s were allowed to return to their land in the Hazarajat. Habibullah granted
the Hazara amnesty for crimes committed in resistance to central government rule and pledged that the land of the Hazara would not be confiscated and given to the Pashtuns, who were moved to the Hazarajat to change the balance of the population (Sarabi, 2006).

Nevertheless, in the early years of Habibullah’s reign, the migration of Hazara continued to Quetta, Pakistan. In 1929 the Hazara initially welcomed Mohammad Nadir Shah as king, but came to resent his policy of sending more government officials to the various regions of the Hazarajat to enforce greater government control. Mohammed Nadir Shah was assassinated on 8 November 1933 by a Hazara youth taking revenge for the execution of his adopted father. During the reign of Afghanistan’s last king, Mohammed Zahir Shah, the political suppression, and socioeconomic and cultural isolation that the Hazara had experienced since 1929 continued as before, but with some improvement from 1963 to 1973. During this period, the king took a more active role in ruling and initiated significant changes that allowed for greater political freedom. It was in this period that a new constitution was signed and enacted that recognised all citizens of the country of Afghanistan as “Afghans,” a term which had previously applied only to Pashtuns.

This change was significant for the Hazara because it recognised their participation and membership in the state on an equal level with the Pashtuns and other ethnic groups, ending, at least formally, a long period of ethnic discrimination (Sarabi, 2006).

In 1973, the monarchy of King Zahir Shah was overthrown by his first cousin, Daud Khan. Daud Khan was known for his progressive policies, his efforts for the improvement of women's rights and for initiating two five-year modernisation plans, which increased the labour force by about 50%, encouraging more people to work. However, in 1978 after five years of presidency he was assassinated as a result of the Saur Revolution, led by the People's Democratic Party of Afghanistan (PDPA).

The seizure of power by the Soviet-supported PDPA in April 1979 marks the beginning of a period of political unification among the Hazara. Prior to the communist coup, the Hazara tribes had been disjointed as localised tribal identities, which prevented them from wider political cooperation. Their fierce opposition to
Soviet-imposed rule triggered an alliance amongst Hazara leaders and they began to organise themselves politically. When the government attempted to impose control over the Hazarajat, the Hazara tribes collectively joined the armed resistance led by the Mujahedeen, an alliance of all ethnic groups (Sarabi, 2006).

After 10 years of Soviet control, on February 15, 1989 the Soviet Union officially withdrew its army from Afghanistan, leaving Communist party leader Dr Najibullah in control. In 1992, following unrelenting armed opposition from the Mujahedeen, the Kabul Communist government finally fell. The Mujahedeen regime that took over was highly factionalised and faced opposition from other groups (Byrd, 2012). The situation soon disintegrated into a vicious and bloody civil war that destroyed Kabul (Dorronsoro, 2005).

One of the examples of this civil war was the massacre of Afshar on 11 February 1993, one of the most shocking episodes of the civil war after the departure of the Soviets and rule by the Northern Alliance. The Afghan Northern Alliance, officially known as the United Islamic Front for the Salvation of Afghanistan. The United Front was assembled by key leaders of the Islamic State of Afghanistan, particularly president Burhanuddin Rabbani and former Defence Minister Ahmad Shah Massoud. Initially it included mostly Tajiks but by 2000, leaders of other ethnic groups had joined the Northern Alliance who received support from Iran, Russia, Turkey, India and Tajikistan (https://www.britannica.com/topic/Northern-Alliance). Hundreds of Hazaras were massacred in west Kabul under the direct command of President Rabbani and his defence minister, Ahmad Shah Masood (Mousavi, 1998). The inhabitants of Afshar, a predominantly Hazara enclave, were attacked from four sides and within two days hundreds of Hazaras were killed or went missing. It was reported that President Rabbani’s soldiers killed, raped and tortured, and took young boys and girls captive and set fires to homes and properties (Mousavi, 1998). It should be noted that despite the massacre being condemned by regional and international governments and human rights organisations, those responsible have not been prosecuted to date (The battle for Kabul, 2005). Much of the country descended into violence led by various warlords, along with brutal human rights abuses and criminality. This created the conditions for the emergence of the rapid expansion of the Taliban movement starting in 1994, which took over Kabul by 1996.
The Taliban were a radical Sunni militia who were opposed to Shiite Muslims (Fisk, 2001). During the Taliban regime (1996–2001) there were further massacres of Hazara as well as the Uzbek and Tajik populations of Mazar-e Sharif (Afghanistan: The Massacre in Mazar-e Sharif, 1998). Accessed December 29, 2005). The objective of the Taliban was to clear the north of the Shiite sect. This was made clear in a mosque announcement by Mullah Manoon Niazi, who said that Hazaras shall have only three options: convert to Sunni, leave the city and go to Iran, or die (Rashid, 2000, p. 125). The harsh treatment of the Shiite Hazara by the Taliban is the most recent example of trauma and human rights violations enacted on behalf of the central Afghan Government. Many Hazara compared their experiences at the hands of the Taliban to the treatment of previous generations by Rahman in the 1890s.

The Shiite Hazara are historically the most repressed ethnic minority group in the state, and have seen little improvement in their situation despite recent wars and American intervention. Although President Karzai did appoint six Hazaras to his cabinet, there appears to be no less discrimination against the majority of the Hazara population of Afghanistan. Economically the Hazara remain one of the poorest ethnic peoples in the country. They receive minimal government support and their social, psychological and medical needs have been generally neglected by successive governments. Most live in isolated difficult mountainous areas where the soil is poor and the weather conditions harsh. They have been denied access to education and careers that would lift them out of poverty (Sarabi, 2006).

Historically, there have been waves of Hazaras fleeing Afghanistan during various regimes. Once again, Afghan Hazaras were forced to flee Afghanistan for fear of persecution when the Taliban came to power in 1996. The majority of Afghan Hazaras migrated to Iran and Pakistan and lived there illegally with no work rights or support from extended families. The first surge of Hazara Afghan refugees arriving by boat and seeking asylum in Australia occurred in 1999. Upon their arrival these refugees were placed in detention centres and most were granted temporary protection visas. They were then granted approval to apply for permanent visas and family reunification began. Refugees fleeing and seeking asylum in host countries often arrive after having been exposed to different pre-displacement experiences.
They do, however, share some similarities in their post-displacement experiences. In the next chapter I will first review the mental health of refugees in two separate sections: pre-displacement and post-displacement factors. In the pre-displacement section I will review refugee experiences prior to leaving their homeland, these include witnessing and experiencing war trauma, physical and psychological torture, imprisonment, and the loss of family and friends through kidnappings, murder, displacement and even genocide. This will be followed by post-displacement factors language and employment, housing, social isolation, social connection and discrimination and racism.
CHAPTER TWO: THE MENTAL HEALTH OF REFUGEES

Over the past two decades there has been a surge of research examining the mental health outcomes of refugees because of their exposure to potentially traumatic events (PTEs), both before and after displacement from their homelands (Porter and Haslam, 2005).

In the section below, a review of the literature on pre-displacement factors, post-displacement factors and associated mental health outcomes is presented. More specifically, the section looks at defining PTSD; its prevalence in the general broader community and specifically the refugee population, PTSD co morbidity, risk factors, and how exposure to torture and trauma prior to arrival can impact on refugee settlement. This is then followed by a review of literature on post-displacement factors such as language and employment, social isolation, social connection, and discrimination and racism, all of which have been identified as contributing to the resettlement journey of refugees offered asylum in Western nations.

2.1 PTSD Definition

Briefly, PTSD is an anxiety disorder that develops following exposure to extremely traumatic events (American Psychiatric Association, 2002, Creamer, Burgess and McFarlane, 2001). It is characterised by symptoms of re-experiencing the traumatic event(s), avoiding reminders of the event, feeling emotionally numb, and/or experiencing hyper-arousal. Response to the triggering event may involve intense fear, helplessness or horror (Slewa-Younan, 2010).

The DSM-IV-TR conceptualises it as a response to a specified stressful event(s) with distinctive symptoms that can be classified as intrusive thoughts, avoidance, alterations in cognition and mood, and autonomic disturbances (American Psychiatric Association, 2002). It is noted in DSM-IV-TR that it is important to understand that variations may be present in the expression of trauma in different cultures, leading to the expression of symptoms of PTSD through different idioms. As Marsella (2010) pointed out, culture can shape various psychological aspects of our response to traumatic events, including meanings attached to the event, the role of beliefs in destiny or fate, assumption of responsibility for the event and response,
and most importantly, the social networks, status and structure, patterns of coping, and religious and related belief systems.

A robust relationship has been found between the number of traumatic events and the severity of PTSD symptoms reported amongst refugees (Mollica, McInnes, Sarajlic, Lavelle, Sarajlic, & Massagli, 1999), a phenomenon referred to as the “dose response” theory of trauma (McNally, 2003). For example, Steel, Silove, Phan and Baumann (2002) found that refugees reporting three or more trauma events had eight times greater risk of mental illness.

Other factors thought to contribute to the emergence and severity of PTSD includes proximity to and the personal intimacy of the trauma event. For example, in a snowball sample of 126 Bosnian Muslim refugees, PTSD status and associated disability were measured using the clinician-administered PTSD Scale (CAPS) for DSM-IV. It was noted that amongst four trauma factors (human rights violation, threats to life, traumatic loss, and dispossession), threat to life was a significant predictor of the presence of PTSD. Furthermore, when a threat to life was coupled with other traumatic loss, further increases in symptom severity and disability were associated with PTSD (Momartin, Silove, Manicavasagar & Steel, 2003).

Although past research has shown that greater numbers of traumas result in greater risk of PTSD, only a few studies have examined the specific types of traumas that create the greatest vulnerability. Mollica, Wyshak, de-Marneffe, Khuon, and Lavelle (1987) and Kroll, et al. (1989) noted that the loss of more immediate family members, for example a spouse among Cambodian women, increased vulnerability to PTSD and other psychopathology (Kroll, Habenicht, et al. 1989; Mollica et al. 1987). Supporting this was a study conducted in Freetown, Sierra Leone by Médecins Sans Frontiers following a period of intensive violence that occurred in January 1999. In this study, a survey of exposure to traumatic events, the psychological impacts of these events and the number and frequency of non-specific health complaints were assessed in 245 participants. Results indicated that loss of loved ones and witnessing violent deaths were serious risk factors for the development of mental disorders such as PTSD. Specifically, 50% reported the loss of someone to whom they were very close and 41% stated they had witnessed their loved one’s death. Other traumatic events reported in this study included the
witnessing of torture, execution, attempted amputation, people being burned in their houses and public rape (de Jong, 2000).

Studies conducted on resettled refugees suggest that around one in four will have been subjected to torture or severe psychological violation prior to displacement, although this figure is mediated by their country of origin (Iredale, Mitchel, Rogelia, & Pittaway, 1996). Nonetheless, the impact of torture in the development of PTSD is clear (Gorst-Unsworth, 1992; Gorst-Unsworth, Van Velsen and Turner, 1993). For example, in a study of Bhutanese refugees in Nepal, a random sample of 526 tortured refugees compared with an equal number of non-tortured refugees matched on age and sex indicated that those exposed to torture endorsed more than 15 out of 17 DSM-III-R PTSD symptoms, which was statistically different from the control group. Common torture methods reported in this group included severe beatings (97%), followed by threats to life (89%) and verbal sexual humiliations (77%). Finally, it was noted that tortured refugees reported higher anxiety and depression scores and presented with more musculoskeletal and respiratory symptoms (Shrestha, Sharma, Van Ommeren, Regmi, Makaju & Komproe, 1998). In addition, traumatic events can be classified in many different ways and this often creates difficulties in comparing their distribution in different settings. Therefore, it is important to understand that the prevalence of specific traumatic events appear to reflect historical, cultural and political factors that vary across region.

2.2 Prevalence of PTSD in general population:

A number of studies on the epidemiology of PTSD have recently been published from various countries, using innovative methodologies. Such work has not only documented the prevalence of PTSD in different settings, but has also shed new light on the PTSD conditional risk associated with specific traumatic events, and on the morbidity and co-morbidities associated with these events. The prevalence of PTSD in the general American adult population is noted by the National Co morbidity Survey (NCS). The estimated lifetime prevalence of PTSD among adult Americans is (7.8%) with women (10.4 %) twice as likely as men (5 %) to have PTSD at some point in their lives. However, findings from the Australian National Survey of Mental Health and Well-being, indicate that the estimated 12-month prevalence of PTSD was 1±33%, which is considerably lower than that found in comparable North
American studies. Although females were at greater risk than males, within the sub-sample of those who had experienced trauma, the large gender differences noted in some recent epidemiological research were not replicated. Prevalence was elevated among the never married and previously married respondents, and was lower among those aged over 55 years. For both men and women, rape and sexual molestation were the traumatic events most likely to be associated with PTSD. A high level of Axis 1 co-morbidity was found among those with PTSD. This study concluded PTSD is a highly prevalent disorder in the Australian community and is routinely associated with high rates of anxiety, depression and substance disorders (Creamer, M. Burgess, P and McFarlane, A.C, 2001).

2.3 Prevalence of PTSD in refugee Population

Refugee populations have attracted interest of researchers due to the large variation of the reported prevalence rates of disorders, ranging from 0% to 99% for PTSD and from 3% to 80% for depression (de Jong, 2000; Hashemian, Khoshnood, Desai, Falahati, Kasl, & Southwick, 2006). This wide variation of prevalence rates has been attributed to a number of factors, including methodological issues such as multiple instruments used in data collection, through to variations in sampling and analysis techniques (Hollifield, Warner, Lian, Karakow, Jenkins, Kesler, Stevenson, & Westermeyer, 2002). Other more qualitative/substantive factors that have been raised can be related to the notion that refugees are a heterogeneous population whose response to PTEs may be mediated by cultural and ethnicity differences, socio-demographic factors, and location of displacement and/or resettlement (Hollifield, Warner et al., 2002).

To date there have been a number of systematic reviews and meta-analyses of the refugee mental health literature, in order to address some of the inconsistencies in reported prevalence rates and factors associated with symptom severity.

In one of the largest studies at the time of publication, Fazel et al., 2005 conducted a meta-analysis on the data from 20 surveys of refugees resettled in high-income nations (primarily Western countries). It was reported that prevalence rates for PTSD and major depression were 9% and 5% respectively (sample size = 6743). The authors noted that there may be a number of factors contributing to wide variation in
the prevalence rates, including differences in the populations studied, sample sizes and research design. Overall, it was concluded that studies with larger sample sizes had lower prevalence rates of disorders (Fazel, Wheeler, & Danesh, 2005).

A more recent systematic review examined prevalence rates of reported PTSD and depression amongst Iraqi refugees living in Western countries (Slewa-Younan, Uribe, Heriseanu & Hasan, 2015). Specifically, six studies reported PTSD prevalence (n = 1912) ranging from 8% to 37.2% and another seven studies reported depression rates ranging from 28.3% to 75% (n=1647) (Slewa-Younan, Uribe, et al., 2015). It was noted that the prevalence of PTSD and depression is high amongst this population and should be taken into consideration when developing mental health early intervention and treatment services.

2.4 Co morbidity and risk factors for PTSD

Posttraumatic stress disorder (PTSD) commonly co-occurs with other psychiatric disorders. Data from epidemiologic surveys indicate that the vast majority of individuals with PTSD meet criteria for at least one other psychiatric disorder, and a substantial percentage have 3 or more other psychiatric diagnoses (Brady KT, Killeen TK, Brewerton T, Lucerini S, 2000). A significant number of epidemiological studies revealed that there are high rates of co-morbid PTSD, reaching 19–35% (Breslau, Davis and Schultz, 2003; Kessler, et al., 1995). Specifically, it was reported that substance use ranged from 30–58% in those with a lifetime prevalence of PTSD, and 20–38% for current PTSD (Najavits, Weiss & Shaw, 1997). This would seem to suggest that there is a complex relationship between substance abuse and chronicity of PTSD. Indeed, it has been noted that such co-morbidity is associated with poor treatment outcomes and prognosis (McLellan, Alterman, Woodi, & Metzger, 1992; Najavits et al., 1997). It has been postulated that individuals who have experienced trauma may be looking for ways to relieve the intense feelings associated with re-experiencing trauma and hyper-arousal responses. A survey of Indochinese refugees living in the United States (Yee, Castro, Hammond, John, Wyatt, & Yung, 1995) examined whether people were using substances as a coping mechanism to overcome their problems and the consequences of such behaviour. Eight hundred and forty refugees participated in the survey and 90% of the participants were of Vietnamese background. Amongst participants, 44%
reported that they were sometimes using alcohol and drugs, including tobacco, to deal with their issues; however, 6–12% reported using them most of the time. The remaining 45% reported that their drunken behaviour caused them to get into trouble with others in the community. The author concluded that in the highly traumatised Indochinese refugee population, adjustment and mental health problems, combined with lack of institutional support, could be the primary reason for using substances. Addiction problems amongst immigrants and refugees further supported the notion that failure to adjust may be the factor behind resettled refugees using drugs (Westermeyer, 1996). In his earlier research, Westermeyer, 1989 noted that that substance use do not arise until at least five to 10 years after resettlement, well after efforts to address their basic survival needs (e.g. housing, language, education, and health) have been attempted. In particular, alcohol usage is a very common problem in displaced individuals. A cross-sectional survey of alcohol disorders on 1206 adult internally displaced persons in northern Uganda revealed that the prevalence of probable alcohol disorder was 17% of all participants and 80% reported drinking alcohol once a month or more frequently. Factors associated with increased likelihood of having an alcohol use disorder were being male, being older in age and being exposed to a greater number of traumatic events (Roberts, Felix Ocaka, Browne, Oyok & Sondorp, 2011). It is not clear whether those who misuse drugs and alcohol to medicate their trauma symptoms are vulnerable or more susceptible to stress-related disorders (Breslau, Kessler, Chilcoat, Schultz, Davis, & Andrews, 1998). In contrast, others have suggested that substance use and its associated effects contribute to the development of PTSD (Murphy, Yurasek, Dennhardt, Skidmore, McDevitt-Murphy, MacKillop, Martens, & Murphy, Dennhardt, 2013). It is reported that comorbid PTSD and substance use disorder is associated with a more complex and costly clinical course when compared with either disorder alone, these include increased chronic physical health problems, poorer social functioning, higher rates of suicide attempts, increased risk of violence, worse treatment adherence, and less enhancement or improvement during treatment (McCauley, J.L, Killeen, T. Gros, D.F., Brady, K.T., and Back, S.E (2012).
Apart substance abuse PTSD is highly co-morbid with other mental health disorders including major depressive and anxiety disorders, which I will briefly consider next.

Research suggests that co-morbidity between post-traumatic stress disorder (PTSD) and major depressive disorder is common, with approximately half of people with PTSD also having a diagnosis of major depressive disorder (MDD) across diverse epidemiological samples (Flory J.D, Peters J.J, and Yehuda, R. (2015)).

It has been reported, for example, that 99% of Vietnam veterans with chronic PTSD had, at some stage, qualified for another DSM-III-R diagnosis, compared with 41% of those without PTSD (Kulka et al. 1990). The most prevalent co-morbid disorders in that study were substance abuse or dependence (75%), generalized anxiety disorder (44%) and major depression (20%). Similarly, Breslau et al. (1991) found that 83% of a non-veteran PTSD sample met the criteria for at least one other psychiatric disorder compared with 44% of those without PTSD. The most common conditions were substance abuse or dependence (43%), major depression (37%) and agoraphobia (22%). The National Comorbidity Survey (NCS) (Kessler et al. 1995) reported that 88% of men and 79% of women with chronic PTSD met criteria for at least one other psychiatric diagnosis. Odds ratios in that study showed a consistently significant relationship between lifetime PTSD and a range of other affective, anxiety, and substance use disorders in both men and women.

2.5 Pre-displacement Factors

Each year a significant number of individuals flee their homelands as result of persecution and conflict (Obermeyer, Murray & Gakidou, 2008). Over the past two decades there has been a surge of research into the mental health outcomes of refugees because of their exposure to potentially traumatic events both before and after their displacement from their homelands (Porter & Haslam, 2005). In this section below, a review of the literature on pre-displacement factors and associated mental health outcomes will be attempted.

It has been reported that common pre-displacement refugee experiences can include witnessing and/or experiencing war trauma, physical and psychological torture, imprisonment, and the loss of family and friends through kidnappings, murder, displacement and even genocide (Keyes, 2000). Of interest to researchers has been
the relationship between such experiences and its impact on psychological wellbeing and mental health outcomes of refugees (Fazel, Wheeler & Danesh 2005; Porter & Haslam 2005; Steel, Chey, Silove, Marnane, Bryant, & van Ommeren, 2009). Not surprisingly, many refugees may experience trauma-related psychological distress, with the psychiatric conditions of PTSD and depression commonly reported (Murray, Davidson, & Schweitzer, 2008).

In another meta-analysis, pre- and post-displacement factors were examined with respect to their role in refugee mental health (Porter & Haslam, 2005). Porter and Haslam reported on 56 papers (total number of surveys = 59, yielding a sample size of 22,221 refugees versus 45,073 non-refugees in the comparison group). Factors associated with poor mental health in refugees included inappropriate accommodation, restricted economic opportunities, internal displacement within their own country and ongoing conflict in the country of origin. Additionally, those from rural backgrounds or those with higher pre-displacement educational or socioeconomic backgrounds also reported poorer outcomes. The authors concluded that refugees had worse outcomes than individuals in the comparison control group and that their poorer outcome involved an interaction between pre- and post-displacement factors. In the most recent and largest meta-analysis to date, Steel and colleagues (2009) examined 161 articles on refugees and conflict-affected populations. Reviewing a total of 181 surveys, a total subject pool of 81,866 subjects from 40 countries was identified. It was noted that weight prevalence rates across the surveys were 30.6% and 30.8% for PTSD and depression respectively. Methodological factors such as non-random sampling, small sample sizes and self-report scales accounted for a larger proportion of inter-survey variation. When examining the substantive factors associated with prevalence rates, reported torture, cumulative exposure to PTEs, time since conflict and the assessed level of political terror in country of origin all featured significantly.

2.6 Post-displacement Factors

Post-displacement stressors are different from those experienced by refugees during the pre-displacement phase. In contrast to their pre-displacement experiences, refugees generally report feeling safer and experiencing a sense of freedom (Beiser, 1990). This leads to feelings of excitement and relief during the early stage of
resettlement. However, this period may transform into a phase of adjustment during which refugees must adapt to a different language and new culture, secure employment and other immediate basic needs, and deal with feelings that may arise because of separation from family and friends and the absence of a social network (Beiser, 1990). Consequently, it is noted that during this phase of adjustment, initial feelings of relief and happiness can be displaced by a sense of loss and grief, leading to a decline in refugees’ mental health (Pernice & Brook 1996). In the section below, the literature on resettlement issues and the possible impact on the mental health of refugees will be reviewed.

2.6.1 Language

Difficulties with the host country’s language can cut across all aspects of interaction including an ability to access public transport and understand health, social and legal systems (Doney, 2011). It can impact on compliance with government requirements, such as the ability to understand and comply with letters and official forms. It can impact on social and family dynamics, such as being able to assist children with homework tasks and interact with schools. Finally, perhaps the most obvious impact of language proficiency is the important influences it exerts on refugee employment and economic adaptation (Doney, 2011).

In Australia, free English language tuition is available to migrants and humanitarian entrants who do not have functional English. This program is funded by the Department of Immigration and Border Protection (DIBP) (DIBP, 2014). Refugees and humanitarian entrants who are under the age of 25 and have low levels of schooling are eligible for up to 910 hours of English classes. Humanitarian entrants over 25 years old are eligible for 610 hours. All other migrants are eligible for 510 hours. Adult Migrant English Program (AMEP) classes are delivered by service providers around Australia in more than 250 locations. This program provides a range of learning options from full-time to part-time study in the formal classroom, community settings or home study, either through distance learning or through the home tutor scheme (DIBP, 2013).

It can be reasonably assumed that English language training and its availability is a significant factor in the development of English language proficiency. Support and
specialised service language programs could significantly aid in the resettlement of refugees and reduce their dependency on welfare agencies (Hemenway, Rohani & King, 1999). The impact of language poses additional barriers to newly arrived refugee children and can affect attainment of educational goals. Starting school in a new country requires significant cultural and linguistic adaptation. Refugee children often struggle with unrealistic demands in environments that are foreign (Cassity & Gow, 2005; Gunton, 2007). This is particularly the case where students have had little or no prior education, often arising because most have been born en route to the host country or in refugee camps (Kirk & Cassity, 2007).

Although research has demonstrated that language barriers can pose an academic disadvantage to refugee students, there can also be social and psychological costs (Davies, 2008; McEachron & Bhatti, 2005; Miller, 1997). It has been reported that cultural and linguistic adjustments can affect a refugee’s sense of identity (Bash, 2006; Xu, Connelly, He & Phillion, 2007), although children often adapt more easily to their new environment than adults do. This in turn can alter established family dynamics, especially related to authority, leading to impaired child–parent relations (Palmer, 2000).

2.6.2 Employment

As previously noted, the links between language proficiency and employment have been well established in the literature. Findings from this study suggest that there is a positive correlation between English proficiency and employment, with rates of successful employment higher amongst those with good-to-excellent language skills and lower amongst those with poor language skills (Arkoudis, Hawthorne, Baik, Hawthorne, O’Loughlin, Leach, & Bexley, 2009). This is supported by the qualitative study of seven Bangladeshi participants in Australia, of whom five were employed and two unemployed. Six of the participants claimed that proficiency in English played a very important and a vital role in getting a job in the Australian job market (Roshid & Chowdhury, 2013).

Other research has indicated that other factors beyond language proficiency may also impact on employment rates for refugees. Specifically, McAlister (1991) noted in a survey of 245 employed Vietnamese refugees that tertiary education qualifications,
period of residence in Australia and living with their parents in Australia statistically predicted their ability to secure employment (McAlister, 1991).

Another factor linked to the issue of employment and refugee mental health is related to the under-utilisation of skills and education. Refugees may be forced, out of economic necessity, to accept employment that is not matched with their skill level, educational background, or work experience (RCOA, 2012). For instance, in a survey in Western Australia of 150 resettled refugees from three groups (former Yugoslavs, black Africans and those from Afghanistan and the Middle East), it was noted that recent humanitarian arrivals were concentrated in niche labour markets. These included cleaning services, aged care, meat processing, taxi driving, security and building services. It is interesting to note that apart from the building construction industry, these employment niches are situated in the “secondary labour market”, comprising low-status and low-paid jobs that locals avoid. It was concluded from these results that resettled refugees often experience a substantial loss of occupational status and that there is in existence a segmented labour market hierarchy where refugees make up the bottom level regardless of their number of years of formal education (Colic-Peisker & Tilbury, 2006).

These issues can turn some refugees and migrants into endless outsiders from society, sometimes hindering their economic and social progress. Their only option to social networking is to rely on the support of relatives, friends or people from the same ethnicity. At the same time, this limited support further isolates them from the wider community, consolidating their outsider status. Therefore in the following sections the literature on housing, social isolation, social connection, and discrimination and racism will be reviewed.

2.6.3 Housing

In Australia, the DIBP-funded Humanitarian Settlement Strategy (HSS) (previously called Integrated Humanitarian Settlement Services [IHSS]) is responsible for ensuring that entrants have accommodation on arrival and assistance in securing long-term accommodation as soon as possible (DIBP, 2014). The accommodation support (AS) service is designed to help entrants establish themselves in stable, affordable and appropriate longer term accommodation soon after their arrival, with
access to temporary accommodation in the interim. However, criticisms of this service include inadequacy of funds provided to meet the startup costs of four weeks rent, bond and utility connection costs (DIBP, 2009). Additionally, it has been noted that these funds only poorly meet the needs of larger families requiring different types of accommodation. The preference amongst new-arrival refugees has been to access long-term accommodation soon after arrival. Unfortunately, this option was not been viable owing to the nature and size of some family groups, the lack of proper information from overseas posts prior to the families’ arrival, and problems sourcing housing in areas that offer suitable services such as public transport (DIBP, 2014).

In consultation with refugee families across Australia, the RCOA (2014b) identified that a lack of affordable and appropriate housing had a significant negative effect on the health and wellbeing of refugees. Refugee families reported that they had no option but to live in poor-quality houses, contend with high rental prices, experience problems with tenancy rights due to lack of English language skills, and in some cases, face discrimination. These findings have been replicated in studies of African refugees. Black African refugees, in particular, are the most vulnerable group, with the highest unemployment rate and the lowest full-time employment rate of all immigrant groups to Australia (Colic-Peisker & Tilbury, 2006). This was supported by the Department of Education and Early Childhood Development, who found that, in general, families of refugee background are especially vulnerable to housing costs and stress because of poverty, lower employment and lack of English proficiency (Department of Education and Early Child Development, 2011).

The commonly reported complication of having a torture and trauma background can pose additional barriers to securing housing. It is well accepted that one of the first steps in undertaking treatment of traumatised refugees is to address primary needs such as financial assistance and housing (Kinzie, 2001). Indeed, the importance of having appropriate housing cannot be underestimated as it helps to establish a sense of safety, stability and predictability (Keyes, 2000). Similarly, social withdrawal symptoms of depression and avoidance symptoms associated with PTSD can pose severe barriers to refugees interacting with government employment and housing officials (Hermann, Kaplan and Szwarc, 2010).
Service providers have clearly identified a need for further development and improvements around the housing needs of new-arrival entrants at the local, state and national levels. Unfortunately, state housing authorities are not in a position to respond decisively to the needs of refugee entrants as they already have significant waiting lists and alternative priorities, including selling off existing houses. There have been recommendations for the development of partnerships and services pathways with peak real estate bodies to help address the critical housing shortages. This may be a means of helping to house refugee entrants who are vulnerable: those groups facing mental health challenges and requiring the most basic of human needs shelter and security (RCOA, 2014).

Housing plays a critical role in the health and wellbeing of individual Australians (Chambers, 2013). The availability of affordable, sustainable and appropriate housing reinforces good health and the social, educational and economic participation of individuals. Ideally, refugees should be placed in rental accommodation where the rent is affordable, the house can accommodate large families, is located close to public transport and schools and is within neighbourhoods with people of the same ethnic group (Taylor, 2004). Residing in a community with people who share common ethnic backgrounds is likely to minimise social isolation. It allows individuals to converse in their language, share stories and get answers to problems and questions more readily than is the case for families who have dispersed across diverse locations. These types of more communal living inevitably ameliorate social isolation. The importance of finding appropriate and safe housing in aiding and facilitating successful refugee resettlement cannot be underestimated. It is one of the key factors related to post-displacement stressors. Unfortunately, especially for larger new-arrival refugee families and single people, a shortage of larger houses and rental accommodation reduces the chances of securing accommodation (Refugee Council of Australia, 2014b).

2.6.4 Social isolation

Feelings of isolation and loneliness are common amongst refugees resettling into a new environment. Issues such as separation from family, change of status, learning a new language, adapting to a new environment and occasionally feeling overwhelmed by resettlement challenges are all ongoing long-term realities for many. Babacan and
Babacan (2007) aptly described this migration process as a difficult and challenging transition and one that uproots and transplants people into an alien environment. They emphasised that the very act of migration always involves personal elements of people’s lived experiences and can trigger reactions to the new environment, that significant social changes brought about through migration can result in both a physical and a psychological impact, which in turn effect adjustment in their new country (Babacan & Babacan, 2007).

Although, as already noted, feelings of isolation and loneliness are common amongst refugees resettling into a new environment, for some, the resettlement experiences can be moderated if they arrive with family members or join family members already settled in the host country (Beirens, Hughes, Hek, & Spicer, 2007). Bhugra, Leff, Mallett, Morgan, and Zhao (2010) sought to review the relationship between migration and mental illness among some migrant groups in the United Kingdom. They postulated that for those with little or no family support, experiences of isolation can be a daily reality. More specifically, it was found that the loss of daily contact with family members, as well as the predictability and comfort of routines, rituals and activities as carried out within a family context, or with neighbours and friends in the previous homeland, was a significant factor contributing to a sense of not belonging and disconnection.

Research also highlights the important role that social networks can play by providing the practical and emotional support necessary to alleviate social exclusion and promote integration within a new community. Such concepts are referred to in the literature as social bonds, social links and social bridges: all are vital elements required for the reduction of social exclusion (Babacan, 2007). However, government policies tend to favour the development of social bridges at the expense of social links and social bonds (Beirens, Hughes et al., 2007). For example, Joly (1996) and Robinson (1999) noted that the UK settlement policies encourage the geographical distribution of refugees by settling or locating individuals and families some distance away from their wider kinship networks. Such policies clearly ignore the findings that support the need for close family and kinship connection. Joly suggested that by locating refugee families away from their established ethnic communities there is a likelihood that this will lead to eventual social isolation.
Further divisions can occur, as disconnected families or individuals experience problems building trusting relationships with people of the host country and within the community (Joly, 1996; Robinson, 1999). Where newly arrived refugees have difficulties with building social ties, social exclusion can be lessened by positive adjustment by the host community towards the refugees.

Nonetheless, social isolation remains a critical factor in the settlement of refugees, even for those who have resided in the country long-term. This was highlighted in a study by Sulaiman-Hill and Thompson (2012) of 81 Afghan and Kurdish refugees who resettled in Perth, Western Australia. This cross-sectional study, focused on Muslim refugees who resettled up to 20 years ago. At the time of data collection self-reported psychological distress among participants fell within the moderate-risk distress category; however, female and unemployed refugees were at higher risk of psychological distress. A mixed-methods approach was used and participants were given the opportunity to talk about their settlement difficulties, quality of life and sources of stress. The authors found that even eight to 20 years following initial settlement, most participants identified a range of ongoing stressors, including unemployment, social isolation and acceptance within Australian and New Zealand society. They questioned if they would ever fit into this society. Those who were interviewed expressed concerns about negative factors affecting their quality of life. For example, one negative factor was having too much time to introspect and worry about past experiences and current reminders. The difference between their previous occupational and social positions and their present reality continued to cause them psychological stress. The authors noted that these experiences or views may also be linked with cultural and especially religious concerns that point more towards the wider societal attitudes about refugees from Muslim backgrounds (Colic-Peisker & Tilbury, 2007).

Research indicates that inadequate specialised settlement support for women from minority backgrounds can be a primary cause of isolation. For example, Bouma and Brace-Govan, (2000) found that women who reported major difficulties in their settlement reported feeling homesick. This was particularly significant for Muslim women as a result of their traditional caregiver role in the family. Bouma and Brace-Govan (2000) found that lack of language skills and few friends with whom to share
shopping ventures left women feeling confused, isolated and frightened to go out in public.

As noted, the migration process is a difficult transition that can alienate the person. However, the impact of the resettlement experience can be moderated to some extent if they arrive with their families or have family support around them (Beirens, Hughes, et al., 2007). In addition, practical social networks and social support are necessary to alleviate social exclusion and promote integration of refugees in their host country. Subsequently locating individuals and families close to the kinship network needs some consideration. However for some people the question of belonging remains constant and continues to cause them psychological, cultural and religious concerns regardless of the length of time in the host country.

2.6.5 Social connection

Social networks and social connections have beneficial effects on mental health outcomes, including stress, anxiety, depression and psychological wellbeing (Kawachi & Berkman, 2001). Greater levels of community participation, social support and trust in others in the community have been associated with reduced experience of psychological distress (Berry & Rickwood, 2000). Ozer and Fredrico (2014) conducted a survey of 177 Kurdish community members in Australia who arrived from 1970 onwards. They obtained information from interviews and group discussions with the aim of understanding the background of participants and the impact this had on their settlement within the Australian community. Participants spoke about the impact of war and various forms of oppression and the association with psychological wellbeing and sense of belonging. They reported a different political culture in Australia compared with that experienced by Kurds in their homeland and differences in family culture across generations. Many had encountered relationship difficulties with their children as the children were keen to adopt the more liberal Australian lifestyle and model of parenting. The term “isolation” in this study refers not only to the lack of relationship and communication with Australians but also to the lack of direct communication with their relatives back home. In addition there was conflict between those Kurds who had been in Australia for many years and those newly arrived, owing to differing values and beliefs around adapting to Australian social and cultural norms. Such relational
difficulties within the ethnic communities had exacerbated a sense of social isolation, and a lowered sense of belonging resulted in psychological distress for those newly arrived (Ozer and Fredrico, 2014).

In regard to the role of family and its relevance to social isolation, researchers have highlighted intergenerational conflict and its impact on family unity (Doney, Eckert and Pittaway, 2009). In the 2011 conference organised by the Australian National Committee on Refugee Women (ANCORW), participant mothers reported their concerns about the rights and freedoms given to children in Australia (Doney, 2011). The women articulated them as “rights without responsibilities”, citing examples of how children in Australia are supported and encouraged to live separately from their families. The mothers acknowledged the rights of children but felt that their rights and authority as parents were undermined and in stark contrast to their children’s expectations in their home country.

The concept of social belonging and influence of the community was identified in a study by Beiser and Hou (2001). The study of 1,169 adult Southeast Asian refugees who fled Vietnam to refugee camp in Laos defined social linkage as a connection with a co-ethnic community and having an intact marriage. They reported that social support from the ethnic community and an intact marriage moderated the risk of developing depressive symptoms, therefore it would follow that social support enhancing one’s sense belonging would help with adjustment and should be encouraged.

Other research shows that, acculturation is another factor affecting social connection and belonging. Acculturation is described as the shedding of an old culture and the taking on of a new culture in order to adapt better (Flannery, Reise, & Yu, 2001). Flannery emphasises that acculturation is an important part of resettlement in a new environment and to feel part of the community, refugees have to adapt to overcome the feeling of isolation. In cases where the adaptation does not happen the individual will feel isolated and this can lead to higher incidents of acculturative stress. Monat and Lazarus (1991, p. 3) defined acculturative stress as “any event in which environmental demands, internal demands are both lax or exceed the adaptive resources on individual.”
Other authors noted that acculturative stress is present when a person has integrated his or her own culture and values with the culture and values of the host country (Berry, 1987; Nwadiora & McAdoo 1996). Berry indicated that acculturative stress can be defined as an individual’s or group’s experience in adapting to a new culture. It usually manifests as a reduction in the psychological, somatic and social balance of individual or groups. According to Berry, 1987 other factors influence the development of acculturative stress, including personality, level of education, gender, age, language, ethnicity and strength of emotional and spiritual beliefs, as well as the political and social behaviours of the host culture. Understanding about acculturative stress can contribute to the understanding of mental health amongst refugees (Nicolas, Bernal and Christman, 2010).

In conclusion, living in a foreign country will require some adaptation in order to overcome isolation. Belonging and sense of belongingness as well as connection with family and kinship groups is vital, as is the understanding of family and support for family unity. All play an important role in positive outcomes for the long-term wellbeing of the individual and his/her community. Dispersing refugee families away from their established ethnic communities will eventually lead to social isolation. Consequently, a range of ongoing stressors including unemployment, social isolation and acceptance within Australian society, causes the refugee continuing psychological stress.

2.6.6 Discrimination and racism

Racism can be defined as “a set of beliefs, ideologies and social processes that discriminate against others on the basis of their supposed membership of a ‘racial’ group” (Jary & Jary, 1991, P.404). Racism results when groups are treated less favourably because of their cultural or racial group membership. In Australia, racism continues to be an issue of concern and in recent times international events have brought it into sharp focus. This was confirmed in a project conducted by the Human Rights and Equal Opportunities Commission in 2003, which investigated racial discrimination towards Arab and Muslim Australians in New South Wales and Victoria. The study reported that following the 1991 Gulf War, the September 11 bombings in the USA and other international and domestic events, the number of racially based attacks on Arab and Muslim populations increased dramatically.
(Poynting, 2006). It appeared that international conflicts and terrorist attacks triggered and escalated anxiety and panic amongst the non-Muslim population in Australia (Dunn, 2001; Poynting & Noble, 2004). Given this dynamic there is reason to assume that the political instability and conflict in other parts of the world directly affect the way people perceive different ethnic populations and religions within Australia. More recently arrived refugees from Afghanistan and Iraq, after escaping persecution and war, had the added indignity of being associated in the media with terrorists because of previous bombings and conflict (Mansouri, 2002). Racism and discrimination is widespread and not confined to any specific group. Onsando and Billet (2009), who studied African students from a refugee background in Australian TAFE institutes, reported that the majority of participants expressed concerns about daily incidents of racial discrimination which can have a detrimental impact on their wellbeing. The students reported racist behaviour during group-work activities. They were excluded from activities, assumed their ideas were not considered relevant, and they felt stereotyped as inferior. Onsando and Billet (2009) noted that students who perceive racism experience stress that hinder their concentration. The authors also found that many participants reported that because of their past trauma, their mental health and fragility was further tested and sensitivities heightened. It was concluded that being discriminated against and feeling marginalised added to psychological distress. Noh, Beiser, Kaspar, Hou and Rummens (1999) studied the association between depression and racial discrimination using data obtained from 647 Southeast Asian refugees in Canada. Their study also found that refugees who encountered racial discrimination had higher levels of depression.

The socio-political context of the refugee experience is inextricably linked with refugee mental health, therefore, resettlement humanitarian efforts that improve conditions for refugee populations are likely to have a positive impact (UNHCR, 2007). Such efforts can reduce post-migration difficulties resulting from compatibility issues with the culture of the host country and nature of the resettlement program (UNHCR, 2014). Therefore, the interaction between person and environment during resettlement cannot be overlooked and is critical to individual and group outcomes.
2.7 The Mental Health of Afghan Refugees

In 2011, the UN High Commissioner for Refugees, Antonio Guterres, referring to Afghan refugees, stated that a multiplication of new crises had led to the fact “that last year, we had the highest number of new refugees in the last decade”. He noted that 70% of Afghan refugees under the UN mandate had been refugees for more than five years, and it had become increasingly more difficult to support them and find solutions for them; and further, that 80% of all Afghan refugees live in the developing world. For example, 1.7 million Afghans live in Pakistan and a million Afghans live in Iran (Guterres, 2011). These facts point to the increasing size and severity of the humanitarian crisis that is emerging from Afghanistan, leading to the notion that the mental health and wellbeing of Afghan refugees following displacement represents the one of the most serious concerns (Dadfar, 1994).

A study of the validity and clinical utility of PTSD in Afghanistan among 320 adults (160 women and 160 men) in eight of Kabul’s 16 districts, showed that PTSD symptoms were highly prevalent and correlated as expected with exposure to traumatic stress amongst this group of participants. There was also a high level of exposure to war-related violence and the loss of a family member. The two culturally specific measures, the Afghan Symptom Checklist (ASCL) and the Afghan War Experience Scale (AWES) were used. Eighty-five per cent of the participants had witnessed the destruction of their family homes, 49% reported that at least one family member was killed, 53% reported injuries to themselves or one or two member of their families and 83% reported displacement to neighboring countries at some point. Other forms of psychiatric symptomology, including depression and culturally specific measures of general distress, correlated more with traumatic stress than they did with PTSD (Miller, et al., 2009).

To date, little research has been conducted on the mental health of Afghan refugees resettling in Western nations, partly because of their relatively recent arrival in such countries. In a study of Afghan and Kurdish refugees who settled 20 years ago in New Zealand and Western Australia, it was noted that even after 20 years of settlement, participants still felt overwhelmed by settlement challenges, resulting in psychological distress (Sulaiman-Hill & Thompson, 2012). A mixed-methods approach was used and participants were given the opportunity to talk about their
settlement difficulties, quality of life and sources of stress. The authors found that even 8–20 years after their initial settlement, most participants identified a range of ongoing stressors, including unemployment, social isolation and acceptance within Australian society. Those who were interviewed expressed concerns about negative factors affecting their quality of life, such as having too much time to introspect and worry about past experiences and current reminders, the difference between their previous occupational and social position and the reality of life causing them continuing psychological stress.

In the first study of its kind, in 2002, the Center for Disease Control and Prevention (CDCP) and other collaborating partners performed a national population-based mental health survey in Afghanistan (Cardozo, Bilukha, Crawford, Shaikh, Wolfe, Gerber, & Anderson, 2004). The aim of the study was to provide national estimates of the mental health status of two groups — the disabled and non-disabled Afghan population aged 15 years and over. The population-based mental health survey of 799 adult household members (699 non-disabled and 100 disabled respondents) aged 15 years or older was conducted from July to September 2002. Participants for this study were randomly selected from one village, resulting in 150 households generating a total of 750 participants. The results of the study showed that a total of 407 respondents (62.0%) reported experiencing at least four traumatic events during the previous 10 years. The most common trauma event experienced by the respondents was lack of food and water (56.1%) for non-disabled persons and lack of shelter (69.7%) for disabled persons. The prevalence of respondents with symptoms of depression was 67.7% and 71.7%, and symptoms of anxiety 72.2% and 84.6% for non-disabled and disabled respondents, respectively. The prevalence of PTSD symptoms was similar for both groups (42.1%). Women had significantly poorer mental health status than men. Respondents who were disabled had significantly lower social functioning and poorer mental health status than those who were not disabled. Discussions about coping mechanisms indicated the importance of religious and spiritual practices. It was also noted that meeting basic needs by having a higher income, better housing, and more food and access to medical assistance were all related to improved mental health status. The study concluded that in this nationally representative survey of Afghans the prevalence rates of symptoms of depression, anxiety, and PTSD were high and it was recommended that health care planners
urgently address the lack of mental health care resources, facilities, and trained mental health care professionals in Afghanistan (Cardozo, et al., 2004).

Physical and Mental health issues were also found to be prevalent amongst resettled Afghan refugees residing in the Netherlands. A population-based survey was carried out in the Netherlands between June 2003 and April 2004 amongst 178 adult refugees and 232 asylum seekers from three countries: Afghanistan, Iran and Somalia. The study noted that participants from Afghanistan had more frequent contact with general practitioners (Guterres, 2011), and higher rates of mental health service utilisation (Gerritsen et al., 2006).

In summary, the literature review would suggest that majority mainstream populations have difficulty recognising mental illnesses and responding appropriately. However, the MHL of Non-Western populations maybe even more problematic with low rates of both recognition and response. This is more concerning due to studies that show Non-Western population and more specifically Afghan populations have high rates of symptoms of depression, anxiety, and PTSD but lower rates of recognition than that of Western populations and nations. Research on the MHL of resettled refugees is minimal and yet warranted if strategies are to be developed to address refugees’ problematic recognition and utilisation of mental health services. To date, little research has been conducted on the mental health of Afghan refugees resettling in Western nations, partly because of their relatively recent arrival in such countries. There is also limited literature available on the mental health of the Afghan population in Afghanistan, perhaps owing to lack of resources as well as the current situation of unrest in Afghanistan.

Evidence suggests that those Afghan populations who have been exposed to war and persecution, human rights violations and tremendous trauma and who are also dealing with settlement issues are at high risk of mental health problems. It has also been reported that mental health issues too often go undiagnosed; therefore, the need for this research cannot be underestimated.

In light of the significant risk factors associated with poor mental health in refugees and the under-utilisation of mental services, investigating MHL is an important first step in developing an understanding of this particular community group’s responses
to mental illness. It has already been noted that good MHL can confer a range of benefits, such as prevention, early recognition, intervention and reduction of stigma. Given the wide-ranging benefits of increased MHL for refugee populations, there is a pressing need for further research.

2.8 Mental Health Service Utilisation and Refugees

The under-utilisation of mental health services raises concerns for mental health professionals because it prevents and or delays necessary treatment. To date, research has demonstrated that people from a refugee background and minor ethnic groups are less likely to use mental health services than those who were born in the host country (Boufous, Silove, Bauman and Steel, 2005; Klimidis & Victorian Transcultural Psychiatry Unit, 1999). When individuals become mentally ill, their help-seeking behaviour is based primarily on their personal experience and on the recommendations of their social network. But the beliefs of those seeking help and those of the social network are often affected by popular ideas on health, diseases, and treatment concepts (Lauber, Nordt, Falcato & Wulf Rössler, 2001). In the mental health context, Rickwood Thomas and Bradford (2012) noted that help-seeking has been characterised primarily as an adaptive coping reaction to mental health problems that involves a search for assistance from external sources, including informal sources.

2.8.1 Formal or Professional help-seeking

Paradoxically, most of the literature on this has focused on only formal or professional help-seeking sources, rather than informal sources; however, the literature highlighted some reluctance to accessing formal help. This was clearly examined in the Australian-based study comparing annual, age-standardised hospital admission rates in Victoria for people born in refugee-source countries and people born in Australia (Correa-Velez, Sundararajan, Brown, & Gillford, 2007). The research found that participants from a refugee background were 30% less likely to have mental or behavioural admissions than those born in Australia. This was supported by a study by Li and Browne (2000) of Asian Canadians aged 41–43 in the province of British Columbia, which reported that Asian Canadians consistently underutilise mental health services. It was determined that the causal factors of this
under-utilisation included a lack of English language skills as well as a poor understanding of mainstream culture. The study analysed six areas that defined a mental health problem or symptom: purpose in life, loneliness, lack of adaptation to a new environment, high levels of anxiety, describing mental illness as a somatic illness and the fact that mental illness is not a treatable condition. Over all, Li and Brown’s findings highlighted that people who were reserved about seeking professional mental health assistance or who prematurely terminated their treatments were at greater risk of developing severe chronic mental health problems.

2.8.2 Informal or non-professional help-seeking

Non-professional help-seeking or informal help-seeking is defined as assistance from informal social networks, including immediate family members or friends. It encompasses those kinds of helpers with whom the help-seeker has a non-professional or personal relationship (Rickwood et al., 2012). Informal help-seeking behaviour can become the first source of support when refugees feel hopeless or do not know where to seek help. This was supported in research of refugee adolescents by de Anstiss, Ziaian, Procter, Warland and Baghurst (2009). The study held 13 focus groups with 85 refugee adolescents aged 13–17 years from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. The study was part of a wider investigation of mental health service utilisation by refugee parents of children aged 4–17 years, and by adolescents aged 13–17 years. With respect to the adolescents, the focus group findings indicated that most were very reluctant to venture beyond their close friendship networks for help with their psycho-social problems owing to a range of individual, cultural, and service-related barriers. In another study, mental health service utilisation of Ethiopian Immigrants and Refugees in Toronto was investigated. A cross-sectional epidemiological survey of 342 randomly selected adults was conducted, based on a conceptual model of healthcare utilisation suggested by Anderson and Newman. The results suggested that 5% of the respondents sought mental health services from healthcare professionals and 8% consulted no healthcare professionals. Although Ethiopians’ utilisation rate of mental health services was not greatly different from the rates of the general population of Ontario (6%), only a small proportion (12.5%) of Ethiopians with mental disorders used services from healthcare professionals, mostly family physicians. The data also
suggested that Ethiopians were more likely to consult traditional healers than healthcare professionals for mental health problems (18.8% vs. 12.5%) (Fenta, Hyman & Noh, 2006). This was also evidenced in a Netherlands study where undocumented migrants were more likely to approach informal help sources, such as friends and religious institutions, than formal help sources (Teunissen, Sherally, Muijsenbergh, Dowrick, Weel-Baumgarten and Van weel, 2014).

2.8.3 Other factors Influencing Service Utilisation in Refugees

Cultural or religious beliefs about the nature and treatment of mental illness can be another reason for delaying mental health service utilisation. For instance, early studies of predominantly rural Turkish populations reported a devotion to traditional beliefs and the use of magico-religious therapeutic practices (Oztürk, 1965). One hundred patients were randomly selected from the psychiatric and neurological clinics of the University Of Ankara Faculty of Medicine, and divided between those who reported obtaining previous treatment by traditional healers (60%) and those who said they had not had any contact with traditional therapy (40%). The beliefs of the 60 patients who had experienced traditional treatment were then studied in detail. Of those patients studied, 33 attributed their illness directly or indirectly to janns (roughly equivalent to demons). Other researchers also noted that traditional sources of help including spiritual healers, and supernatural and religious methods — are more commonly used as a source of treatment in developing countries. For example, Mubbashar and Farooq (2001) examined 139 participants’ mental health statuses using a two-stage design: a general health questionnaire, followed by a diagnostic interview. The classification used by faith healers is based on the spiritual cause of disorders: Saya (27%), jinn possession (16%) or churail (14%). Sixty-one per cent of attendees were given a research diagnosis of mental disorders and of those, 24% were diagnosed with major depressive episode and 15% with generalised anxiety disorders.

Stigma related to mental illness remains one of the most common reasons for why refugees do not access mental health services. In their, study of stigma and barriers to discussing mental health in refugee populations Shannon, Wieling, Simmelink-McCleary, and Becher looked at refugees perspectives on why it was difficult to discuss mental health. In this study thirteen focus groups were selected with 111
refugees from Burma, Bhutan, Somali, and Ethiopia between 2009 and 2011. Participants of the study believed that fear, the belief that talking is not helpful, lack of knowledge about mental health, avoidance of symptoms, shame, and culture were reasons why refugees do not seek help (Shannon, Wieling, Simmelink-McCleary, Becher, 2015). Fear and shame contributed to difficulties with openly discussing the issue and attested to the stigma associated with mental illness and its potent effect on behaviours. These negative connotations with mental illnesses were also researched by Majumder and colleagues, amongst a vulnerable group of refugees unaccompanied refugee minors. In this study the perceptions of mental health and services by unaccompanied refugee adolescents was looked at. Fifteen unaccompanied adolescents engaged with mental health services were interviewed, and a thematic analysis was employed exploring relevant issues. The unaccompanied minors’ views reflected that many held negative attitudes toward mental health and had a lack of trust in services (Majumder, O’Reilly, Karim, 2015). Blignault and colleagues (2009) also considered stigma in their two-phase project examining the impact of stigma on mental health utilisation among the Macedonian community in Sydney. In phase one, about 100 Macedonian participants were interviewed over the phone and asked about their attitudes and beliefs regarding mental illness. Generally, participants responded with negative views and expressed negative attitudes and discrimination towards people with mental illness. In the second phase of the study, information gained from phase one was used to deliver targeted educational programs for the group of participants. It was determined that following the educational sessions, participants responded more positively about mental illnesses and were more aware of the illness and use of appropriate services.

Kira and Colleagues undertook a study of internalised stigma and mental illness (ISMI) amongst Arab American, Muslims, and refugees. This study explored the relationships between internalised stigma of mental illness (ISMI), different trauma types, and post trauma spectrum disorders. ISMI, posttraumatic stress disorder, other post trauma spectrum disorders, and cumulative trauma measures were administered to a sample of 399 mental health patients that included Arab (82%), Muslim (84%), and refugee (31%), as well as American patients (18%). Age in the sample ranged from 18 to 76 years with 53.5% males. Hierarchical multiple regression, t tests, and path analyses were conducted. Their results indicated that ISMI predicted
posttraumatic stress disorder and other post trauma spectrum disorders after controlling for cumulative trauma. Further ISMI was associated with other chronic collective identity traumas (Kira, Lewandowski, Ashby, Templin, Ramaswamy, & Mohanesh, 2014).

As a general theme, researchers have tracked changes in the levels of stigma towards people with mental illnesses in general population. In particular, in 2012 Reavley and Jorm assessed if stigma levels had changed over eight years (2003/04 – 2011), with a community-based sample of over 6,000 Australians aged 15 years and over. The data from this survey suggests there were non-significant trends which indicate that levels of stigmatising attitudes may be improving, however the belief that people with depression are dangerous and unpredictable had increased since 2003 (Reavley, & Jorm, 2012). This study confirms that stigma is wide spread and present throughout main stream populations. It can be said that it is not exclusive amongst refugee populations.

Lack of accessible and appropriate mental health services can be another factor delaying help-seeking behaviours and treatment options. In a study conducted in St Johns, a small Atlantic town in Canada, Reitmanova and Gustafson (2009) set out to examine access to information about mental health services and barriers to their utilisation in a small immigrant population of diverse religious and cultural backgrounds. Initially, the researchers conducted an environmental scan of print and Internet material to identify the range of existing mental health care services in St. Johns. It was noted that information about mental health services was limited or targeted to the visible minority: the immigrants. Next, a series of semi-structured interviews with immigrants was undertaken and it was determined that they found seeking mental health support difficult because of a number of factors: the physical and financial limitations, limited computer access, language and literacy issues, a general mistrust and stigma of the primary mental health care services, and long waiting times to see professionals (Reitmanova & Gustafson, 2009). Notably, it has been suggested that it is important for practitioners to recognise that the needs of refugees may vary significantly and there is need for development of a consultation model of community interventions (Measham, Rousseau & Nadeau, 2005). This diversity and differentiation could be catered for with the use of alternative
approaches, including traditional healers, family and community-based approaches (Miller & Rasco, 2004; Pinkoane, Greeff & Williams, 2005). Such treatment alternatives take into consideration the diverse nature and beliefs of new-arrival populations and offer responses commensurate with the diverse values and traditions of the refugee population. More importantly, tailoring a response that results in effective and timely treatment requires consideration of the gaps in knowledge or attitudes present within the refugee population. Such attitudes can create barriers that impair help-seeking.

Gender and ethnicity also plays an important role in service utilisation of mental health services. So far limited research has examined ways in which gender and race-ethnicity are associated with individuals’ perceptions and attitudes towards mental illnesses and service utilisation. This study focussed on gender and ethnicity and its data collected from the 2002 National Survey on Drug Use and Health. Multi-variate analyses showed that non-Latino white male status is positively associated with stigma avoidance and mistrust/fear of the mental health care system. Findings implied that a need to review the roles of gender, race-ethnicity, and socio-economic status within investigations of psychosocial barriers to care (Ojeda & Bergstresser, 2008). On the other hand Albizu-Garcia (2001) examined whether the predictors of seeking help for a mental health problem differ by gender. A survey for a total of 3,221 community respondents were undertaken in 1992–1993 and in 1993–1994 among a probability sample of adults (18–69 years), residing in poor areas of Puerto Rico. They reported that males and females were found to use mental health services equally. Gender did not have a main effect on use when other covariates were controlled. Having a definite need for mental health care and poor self-rated mental health had a larger effect on predicting use of services for men than they do for women. The authors conclude that strategies designed to improve access to mental health services for minority disadvantaged populations should take into consideration gender differences as the predictors of use (Albizu-Garcia, Alegria, Freeman & Vera, 2001).

In summary, mental health utilisation amongst refugees and immigrant communities is well below that of people born in the host nations. Multiple factors have been suggested as influencing this disparity, including socio-demographic factors, cultural
views of mental illness, stigma and lack of access to appropriate services. Interestingly, factors such as these are thought to also influence an individual’s MHL.

Chapter three reports on the literature on knowledge and attitudes towards mental health disorders. The chapter opens with studies of MHL in Western countries before moving on to other relevant studies. This will be followed by discussion of the studies on the knowledge and beliefs of non-Western populations. The chapter will also report investigation of mental health literacy in special populations.
CHAPTER THREE: KNOWLEDGE AND ATTITUDES TOWARDS MENTAL HEALTH DISORDERS

3.1 Mental Health Literacy

The term mental health literacy (MHL) was first coined by Anthony Jorm and colleagues in 1997 to mean “knowledge and beliefs about mental disorders that aid their recognition, management or prevention” (Jorm, Korten, Jacomb, Christensen, Rodgers and Pollitt, 1997). Specifically, MHL is thought to consist of several components, including the ability to recognise specific disorders, knowledge about the causes and risk factors, knowledge and beliefs about available professional help, self-help interventions and how to seek information about mental health. The concept of MHL was first proposed following observation by Jorm and colleagues that the general public had knowledge and understanding of how to react or respond to particular physical health issues; consequently, individuals could respond and act to ensure good physical health outcomes, including diet, smoking cessation, exercise, recognising stroke and heart attack. It is accepted that such knowledge is critical to early intervention and treatment (Jorm, 2012). However, such literacy was far less developed in relation to understanding mental health and, more importantly, early intervention and prevention of mental health distress and disorders. Consequently, the need to improve MHL was required.

Since then, research seeking to examine public knowledge of mental health has utilised two different approaches. The first of these studies sought to measure public attitudes towards people with mental illnesses, beliefs about people with mental illnesses, and how they should be treated (Bhugra, 1989). The second of these studies examined MHL through presenting participants with hypothetical vignettes of a person suffering mental illness followed by a series of questions in order to find out their understanding of specific mental illnesses (Jorm et al., 1997).

In terms of measuring public attitudes towards people with mental illnesses, Barney and colleagues examined community help-seeking intentions and stigmatising beliefs associated with depression. A total of 1312 adults randomly sampled from the Australian community completed a questionnaire providing a depression vignette and measures of self and perceived-stigmatising responses, source-specific help-seeking
intentions, current depressive symptoms and depression experience. Results of the study suggested that many people reported they would feel embarrassed about seeking help from professionals, and believed that other people would have a negative reaction to them if they sought such help. Some expected professionals to respond negatively to them. The study concluded that self- and perceived-stigmatising responses to help-seeking for depression are prevalent in the community and are associated with reluctance to seek professional help. It was suggested that interventions should focus on minimising expectations of negative responses from others and negative self-responses to help-seeking, and should target younger people (Barney, Griffiths, Jorm & Christensen 2006). Stigmatising, labelling and social isolation remain influential and hence have been of interest for researchers. In a study of undergraduate students (96 female, 72 male), participants read 3 scenarios depicting either male or female characters with symptoms of depression, alcohol abuse, and common stress. Participants then completed measures assessing their attitudes about the character in the scenarios, as well as their level of social dominance, orientation, empathy, adherence to traditional gender roles, and familiarity with mental illness. As predicted, participants who labelled the target mentally ill were more likely to view the target as dangerous. This, in turn, led to an increased desire for social distance. The author concluded that, empathy, although associated with increased likelihood of labelling, was associated with decreased desire for social distance (Phelan & Basow 2008).

Other research has examined whether large scale anti-stigma campaigns could lead to increased levels of help-seeking, as 70% of people with mental illnesses do not receive treatment (Henderson, Evans-Lacko, & Thornicroft, 2013). Resistance to accessing treatment was found to be due to a number of factors: the lack of knowledge to identify features of mental illnesses; lack of knowledge and education on how to access treatment; as well as stigma and discrimination against people with mental illnesses (Henderson, Evans-Lacko, & Thornicroft, 2013). The authors reported that following a brief campaign, overall levels of discrimination were reduced. The reduction was from a number of sources including family, friends, neighbours and employers. However there was no reduction in reports of discrimination from mental health professionals or physical care professionals. In recent years, Beyond Blue reported on a community-based survey with 2,000 people
aged 18 years and over, assessing the levels of personal stigma for both depression and anxiety, using the Depression Stigma Scale and the Generalised Anxiety Stigma Scale. This research suggests that stigma continues to exist, to varying degrees. The levels of stigma associated with depression are generally higher than anxiety (Beyondblue, 2015).

Research seeking to examine public knowledge of mental health by examining MHL has been the focus of research by Jorm and colleagues. Their research found that the Australian public’s recognition of mental health disorders, in other words their mental health literacy and beliefs about treatment, has changed significantly over sixteen years (Reavley & Jorm 2012). In their first study of MHL, Jorm and colleagues (1995) undertook an initial survey of the Australian public. A vignette of a person with depression or schizophrenia was presented. Results of the study suggested that recognition of disorders in the vignette was poor. Only 39% of participants correctly identified depression and 27% recognised that the person in the vignette was suffering from schizophrenia. Link and colleagues (1999) studied public conceptions of mental illness. Data were derived from an experiment included in the 1996 General Social Survey that employed vignettes. Respondents (n = 1444) were randomly assigned to 1 of 5 vignette conditions. Four vignettes described psychiatric disorders meeting the diagnostic criteria, and the fifth depicted a "troubled person" with subclinical problems and worries. Results indicated that the majority of the public identified schizophrenia (88%) and major depression (69%) as mental illnesses and that most report multi-causal explanations combining stressful circumstances with biologic and genetic factors (Link, Phelan, Bresnahan, Stueve and Pescosolido, 1999). More recent studies suggest that mental health literacy has since improved. For example Kilimidis et al. (2007) reported that recognition of schizophrenia improved by 50% and Jorm et al. (2006), reported that recognition for depression improved even further to 60-70%.

In 2007, another survey of youth mental health literacy was conducted using a national sample of 3746 young people aged 12-25 years and 2005 of their co-resident parents. The survey was based around vignettes chosen to complement the range of mental disorders that might occur during this period of life. There were four vignettes: depression, depression with substance abuse, psychosis (schizophrenia)
and social phobia. The results showed that nearly half of young people were aware of Beyond Blue and awareness was associated with better mental health literacy (Morgan & Jorm 2007).

In 2011, a National Survey of Mental Health Literacy and Stigma (NSMHLS) was conducted, suggesting that the recognition rate of mental illnesses varies considerably between types of mental illnesses. In this survey, 75% of those given the depression vignette were able to correctly label the disorder. Approximately one third of those given the schizophrenia and PTSD vignettes were able to do so (Reavley, 2011).

National surveys of mental health disorders in the USA and other countries however showed that the prevalence of some mental health disorders is high. Many people delay seeking help or they do not seek help at all. For instance, the World Health Organisation (WHO) examined surveys from 17 developed and developing countries (Wang, Aguilar-Gaxiola et al., 2007). It was found that the number of respondents using any 12-month mental health service was generally lower in developing countries than in developed countries (e.g. only 2% in Nigeria compared to 18% in the US). While results of the surveys differed from one country to another, in general, under-recognition of mental health problems was a common feature across all counties (Dahlberg, Waern & Runeson, 2008; Jorm, Christensen, Yoshioka, Griffiths & Wata, 2005; Klineberg, Biddle, Donovan & Gunnell, 2011; Wang, Aguilar-Gaxiola et al., 2007). Participants in Sweden (Dahlberg et al. 2008 and Japan (Jorm, et al. 2005) were given the vignette for depression and fewer than 50% recognised the symptoms. The same survey was administered in Australia and Canada and 75% of participants correctly recognised depression (Jorm, et al. 2005; Wang, Aguilar-Gaxiola et al. 2007). In another study carried out in the USA participants were provided with a vignette of a child suffering from depression and 58% correctly recognised that the child had depression (Pescosolido et al., 2008). However, in the same study recognition of other disorders such as anxiety and schizophrenia was much lower than recognition of depressive illnesses (Jorm et al., 2005; Pescosolido, Jensen, Martin, Perry, Olafsdottir & Fettes, 2008; Warren, 2007).

It has already been noted that MHL can confer a range of benefits for both practitioners and clients, including prevention, early recognition and intervention,
and the reduction of stigma (Jorm, Barney, Christensen, Highest, Kelly & Kitchener, 2006). Knowledge about mental health disorders will help with problem recognition and prevention of the disease. However, as the research shows, MHL is low even in Western culture, pointing to an existing gap in the education of communities of all origins about this issue. The next section presents the literature on knowledge and beliefs about mental health and treatment practices held by non-Western populations and compares symptom recognition of MHL in those populations.

3.2 Mental Health Literacy of Non-Western Populations

Compared with Western nations, the MHL of people in non-Western countries is poorly understood. This is in spite of the fact that in their lifetime, approximately 450 million people suffer from neuropsychiatric disorders (WHO, 2011). Studies carried out in Asia, Africa and Middle Eastern countries have shown that mental health is not well understood amongst these populations (Levav, Shemesh, Grinspoon, Aisenberg, Shershevsky, & Kohn, 2004; Wong, Wong Lam & Poon, 2012). For example, Wong et al. (2012) compared depression literacy among ethnic Chinese in Shanghai, Hong Kong and an English-speaking Chinese Australian population. Only 12.3% correctly identified conditions of major depression in the vignette. This percentage is slightly lower than the percentage found in previous studies of ethnic Chinese in Hong Kong and Australia. Furnham and Hamid (2014) in their research on mental health literacy in non-Western countries reviewed recent literature from January 2000 to January 2014. Researchers in this study looked at the beliefs of three different groups; the general public, students and young people within developed English speaking countries and the second from non-English speaking countries. Their findings suggested that some mental illnesses such as depression and schizophrenia are well researched, whilst others like anxiety or personality disorders are overlooked. They also reported that socio-economic status was a factor in both the recognition of mental illness and treatment practices. Another significant finding was in relation to religious and supernatural causes and treatment of mental illness particularly in developing countries. The authors believed it was equally important to look at the perceived pathways of treatment according to the cultural or religious beliefs held in that society. In Eid and Alzayed’s (2005) Kuwait study of knowledge of symptoms and treatment of schizophrenia and depression, 25.8% of
participants correctly recognised the vignette as depression, 45.4% reported that it was within the mental health sphere and 28.7% did not consider there was a mental health disorder. When they were given the schizophrenia vignette only 3.9% recognised the disorder. Kermode and colleagues undertook a cross-sectional MHL survey in India to examine local knowledge about mental illnesses, including causes and risk factors (Kermode, Bowen, Arole, Pathare and Jorm, 2009). The research was carried out in light of enhancing awareness among communities and provision of mental health training for primary healthcare staff. The questionnaire was applied to 240 systemically sampled community members and 60 Indian village health workers. Participants were presented with two vignettes, one of depression and one of psychosis, and were asked about the causes of the problems and who was most at risk of developing these two disorders. Most participants recognised that the people in the vignette suffered from mental illness and most of them labelled depression correctly. However, when shown the psychosis vignette most people labelled the problem as ‘a mind/brain’ problem. The findings demonstrated that both community members and healthcare workers were able to recognise the presence of mental health illness but their knowledge and responses about the appropriate treatment were limited. The study concluded that in low literacy communities, improving awareness of mental health problems and in turn improving appropriate treatment and care required a whole-of-community approach.

Studies undertaken in developed countries show a marked difference in participants’ abilities to recognise symptoms. For example, Levav et al. (2004) carried out a study in Israel on the mental health–related knowledge, attitudes and practices (KAP) of 196 participants in two kibbutzim (collective villages) that shared many features (e.g., history, origin of the population, community institutions and political affiliation). A brief, self-administered questionnaire exploring KAP within the kibbutz context was completed anonymously by 108 members in one kibbutz and 90 in the other. The data were analysed using univariate and multivariate methods, which showed that MHL was high; 75% endorsed a multifactorial causation of mental disorders, and 79% thought that they were treatable. Understanding of the definition of what constitutes a mental disorder, however, was limited; 43% for psychosis and 10% for depression. A recent study looking at MHL among refugee communities in Australia showed that there were several differences in recognition
of a number of mental health illnesses between the Australian lay public and the Iraqi and Sudanese refugee communities in Sydney (May, Rapee, Coello, Momartin & Aroche, 2014). Ninety-seven participants were given vignettes of characters describing symptoms of major depressive disorder and PTSD. They were required to identify psychological symptoms, beliefs about their causes and helpful treatments for these disorders. The research demonstrated that larger numbers of Australian-born than Iraqi and Sudanese participants recognised the symptoms of major depressive disorders and PTSD described in the vignettes. The Australian-born participants’ beliefs about causes and treatment were more congruent with those of Western medical experts. The Sudanese group endorsed mostly supernatural and religious causal beliefs about depression and PTSD symptoms. However, evidence was also found for pluralistic belief systems and refugees appeared to demonstrate an acceptance of both Western and non-Western models of mental illness and treatment.

A more recent study that surveyed the MHL of 225 resettled Iraqi refugees in Western Sydney investigated knowledge about PTSD and beliefs about the helpfulness of intervention. This study extended the results obtained by May et al. (2014) by utilising a culturally appropriate vignette of a fictional Iraqi refugee who met the diagnostic criteria for PTSD. Additionally, the researchers used the Harvard Trauma Questionnaire (HTQ) parts I & IV and the Kessler Psychological Distress Scale (K10) to measure levels of PTSD symptomology and general psychological distress. Only 14.2% of participants labelled the problem as PTSD and 41.8% recognised the vignette as “fear”. When asked about the helpfulness of treatment and who they would seek help from, 84.9% indicated that seeing a psychiatrist would be helpful, followed by 79.2%, who believed that reading the Koran or Bible would be helpful. There was evidence of low levels of MHL and support for pluralistic belief systems (Slewa-Younan et al., 2014).

This literature review would suggest that that the MHL of non-Western populations and nations maybe even more problematic than that of Western populations and nations. Failures to correctly recognise a mental health disorder is one of the main reasons people do not seek help. In the next section of this chapter, the literature on help-seeking behaviours of the individual from a refugee background is reviewed. It will explore four important matters: individual, formal and informal help-seeking
behaviours; the cultural and religious beliefs that influence the treatment of mental health disorders; stigma in relation mental health; and lack of accessible mental health services.

3.3 Investigation of Mental Health Literacy in Special Populations

One of the advantages of using the MHL method to examine knowledge and beliefs is its wide range of applicability. For example, although the original work was conducted in national surveys of the general public, tailoring surveys to examine MHL for specific disorders within subgroups can and has been done. Such studies will be reviewed next.

This section reviews the MHL for particular illnesses within specific populations. Notably, the illnesses reviewed are depression, schizophrenia, and more relevant to this thesis PTSD within specific populations. In a study that compared the depression MHL of first generation immigrants from former Yugoslavia (n = 54) and Anglo Australians (n = 54), it was noted that participants from the former Yugoslavia scored lower depression literacy and greater depression related stigma than Anglo Australians (Copelj and Kiroopoulos 2011).

Following on from research indicating that depression is a common and serious problem amongst refugees from Southeast Asia, an examination of the MHL of service providers was conducted within the elderly Hmong and Cambodian refugee community (Lee, Lytle, Yang and Lum 2010). Findings indicated that the cultural beliefs of the Southeast Asian elderly impacted their ability to understand, identify and respond to depressive illnesses.

Schizophrenia MHL has been examined in multiple studies, including general populations, using national surveys and smaller specific groups. Furnham and Chan (2004) examined the MHL for schizophrenia in 399 British and Hong Kong Chinese populations. When asked to define schizophrenia, about 28% of participants used the term “split personality‖, 17% were able to describe some of the symptoms of schizophrenia (e.g. hallucination and delusion) and about 7% described the condition as “afraid” or “crazy”. Interestingly, it was noted that half of the participants who described schizophrenia as “afraid” or “crazy” were from a Chinese background.
Most relevant to this thesis is the MHL around PTSD. To date, little work has been done, with the exception that it was recently included in the 2011 National Survey on Mental Health Literacy and Stigma (Reavely, 2011). In this study, 6019 Australians aged between 15 and 25 years were interviewed over the phone. Participants were presented with vignettes of depression, depression with suicidal thoughts, depression with alcohol misuse, psychosis, PTSD and phobia. Questions were asked about what was wrong with the person and the likelihood of treatment. The highest recognition rate was for depression, with approximately 75% of the participants responding correctly. Recognition rates for schizophrenia and PTSD were similar. Around one-third of participants correctly labelled schizophrenia, one-third recognised PTSD and “fear” was the term used most often to describe PTSD. In terms of treatment, participants thought GPs were the most helpful for depression and early schizophrenia, whereas for PTSD, counselling was considered the most helpful interventions method (Reavley & Jorm 2011).

It can be seen from this section that previous MHL research has been conducted using one of two methods, vignette-based survey or qualitative interviews. This study proposes to utilise both methods, administering a vignette-based survey in the first instance, followed by qualitative interviews. An MHL survey was developed for the present study to address specific aspects of MHL along with self-report measures of PTSD, general psychological distress and the collection of socio-demographic information. These latter scales will enable the examination of associations between specific aspects of MHL and individuals’ demographic characteristics and symptom levels. This is important because associations of this kind can improve knowledge about mental health of this particular group as well as promote better health care service programs for this under-studied group of the refugee population.

In conclusion, it can be confidently reported that investigating MHL is an important first step in drawing attention to knowledge or the lack of it, and attitudes, towards mental illness within community groups.

This first step will enable the next step: enhancing MHL. It has already been noted that good MHL can confer a range of benefits, such as prevention, early recognition and intervention, and the reduction of stigma (Jorm et al. 2006). In areas of neglect such as refugee populations, the need for such research cannot be underestimated.
CHAPTER FOUR: STUDY AIMS, OBJECTIVES AND METHODS

4.1 Aims

The overall aim of this thesis was to determine levels of MHL relating to PTSD among resettled Afghan refugees in Adelaide, South Australia.

4.2 Objectives

This research had three objectives:

Firstly, to study MHL relating to PTSD in a group of resettled Afghan refugees pertaining to:

a. problem recognition (including “self-recognition”)
b. beliefs about the severity of the problem described and its prevalence in the target population
c. beliefs about the helpfulness of specific treatments and treatment providers
d. beliefs about likely outcome with and without treatment
e. beliefs about causes and risk factors
f. beliefs about how best to support someone with PTSD
g. attitudes towards someone with PTSD
h. beliefs about possible barriers to treatment.

Secondly, to examine associations between specific aspects of MHL as outlined in the first aim, and individuals’ demographic characteristics (e.g. age, gender, religion, and ethnicity) and symptom levels.

The categories specified in the first objectives were chosen because they were considered to be the aspects of MHL most likely to be of interest in informing the determinants of mental health and quality of life in the proposed refugee population. The second objective, which seeks to examine the associations between specific aspects of MHL and individuals’ demographic characteristics and symptom levels, is important because associations of this kind can indicate specific targets for health promotion programs.
The third objective was the completion of a qualitative study using semi-structured face-to-face interviews in order to explore participant experiences, beliefs and attitudes towards mental illness at a personal level, including the recognition of mental health issues, help-seeking behaviours and barriers to treatment. Probing questions were used to prompt participants to elaborate if needed, in order to obtain richer and more in-depth insights.

4.3 Methods

After obtaining research ethics clearance from Western Sydney University (H10048) (see Appendix 1.1), a mixed-methods approach was undertaken, presenting a survey-based vignette in the first instance, followed by structured interviews and, for those who volunteered, qualitative individual interviews. All qualitative interviews were conducted in the participant’s language, Dari or the Hazaragi dialect of Dari (I, the PhD Candidate conducting the research, am fluent in these languages), using a semi-structured interview guide. Safety protocols were taken into account in case the researcher encountered any trauma related incidences (See appendix 1.2).

4.3.1 Recruitment process

Participants were accessed by promoting the study amongst the South Australian Afghan community through networking opportunities at Afghan cultural, religious and other gatherings and by placing flyers related to the study on the walls of popular Afghan grocery stores frequented by the majority of the Afghan population in Adelaide. Specifically, participation was encouraged from all those born in Afghanistan, aged 18 years and over, of both genders and who had arrived in Australia no earlier than the year 2000. (See Appendix 1.3).

Most of the participants responded to posted recruitment materials, contacted the researcher and volunteered to take part in the study. These participants contacted the researchers using the mobile phone number provided on the flyer. Participants also passed this mobile number onto friends and relatives in their community who then sought to participate in the study. The mobile number and information about the research project were spread across the community by word of mouth. This triggered interest from others who then contacted the researcher. A form of snowball sampling was also used. Snowball sampling is particularly helpful in gaining access to more
vulnerable and hard to reach populations (Sadler, Lee, Lim & Fullerton 2010). Traditionally, snowball sampling involves the participant providing the researcher with another member of the population’s contact details. In this project, a minority of the participants were introduced to the researcher through family or friends.

The researcher initially approached willing participants on the phone to explain the aims of the study and asked about their availability. Interviews were conducted individually, mostly in the homes of the participants. Participants were given the option to select the location of the interview. Most participants selected their family home as they felt comfortable and it meant they were not required to travel to other locations. Younger participants selected university libraries and several interviews were conducted at the University of South Australia and Adelaide University library, as well as, the State Library of South Australia. Two participants wished to be interviewed in the office of the researcher. Prior to each interview participants were provided with a participant information sheet that briefly explained the study and aims of the research. (See Appendix 1.4). Following this they were asked again if they wished to participate in the research project. Written, informed consent was obtained from all participants. In total, 150 participants agreed to take part in the quantitative portion of the study (the vignettes and structured interviews). Out of 150, 24 participants volunteered to participate in the semi-structured qualitative interviews.

At the completion of the vignette and after the interview, participants were given a $25 Woolworths supermarket gift voucher to reimburse them for their time. At the end of each session the participants were asked if they wished to take part in the qualitative part of the research at a later date. Twenty-four participants agreed to take part in qualitative interviews and signed the relevant consent forms before scheduling another time to meet.

4.3.2 Procedures

The process of data collection was undertaken by the primary researcher, a bilingual PhD student fluent in both Dari and the Hazaragi dialect of Dari, as well as English. Sessions ranged from 60 to 90 minutes. Traditional cultural hospitality arrangements,
including participants preparing and offering sweets, tea or coffee, accounted for this variation.

The researcher began the data collection by explaining the aim of the research and assuring confidentiality. All of the questions and information were read out by the researcher in Dari or Hazaragi to overcome possible literacy limitations and an informed written consent was obtained. Demographic information was attained in order to examine the associations between specific aspects of MHL, individuals’ demographic characteristics and symptom levels. Next, a Mental Health Literacy Survey (described in 4.3.3) was administered by researcher, along with the following psychological scales: AWES, Connor Davidson Resilience Scale (CD-RISC 2), Hopkins Symptoms Checklist (HSCL-25), Impact of Event Scale-Revised (IES-R), and WHO DAS II (see Appendix 2). Collectively, these make up the focus of the structured interview. More widely used measures in refugee populations such as Harvard Trauma Questionnaire (HTQ) to measure PTSD and Kessler 10-item Psychological Distress Scale (Andrews & Slade, 2001), would have been more ideal to apply to this population. However these measures were not available in Dari language therefore were not suitable as measurement scales. Assessment of mental health disorders was made using DSM-IV-TR. Partway through the interviewing a new version, DSM-5 was released, but the decision was made to continue using DSM-IV TR for consistency.

4.3.3 Quantitative study: Mental Health Literacy Survey

A modified version of the Mental Health Literacy Survey developed by Jorm and colleagues (Jorm et al., 1997) was used to assess attitudes and beliefs concerning the nature and treatment of PTSD. Specifically, a case vignette of a fictional person suffering from PTSD was read to participants, followed by a series of questions addressing the nature and treatment of the problem described: problem recognition; beliefs about the severity of the problem described and its prevalence in the target population; beliefs about the likely helpfulness of various possible treatments and treatment providers; beliefs about causes and risk factors for the problem described; beliefs about how best to support someone with PTSD, attitudes towards someone with PTSD; and beliefs about likely barriers to treatment among individuals and use of health services for any mental health problems. The mental health literacy survey
used in this study was required to be culturally valid and applicable to the population in an attempt to investigate their attitudes and beliefs towards PTSD. Great care and consideration was undertaken to ensure the vignette describing the fictional character suffering from PTSD was cultural salient to this group. It would have been inappropriate to use a western-based vignette (as is in the 2011 MHL survey) for this group. However, it should be noted that the questions utilised in the thesis MHL survey are derived from 2011 MHL survey with modifications as appropriate. The survey was translated from English into the Dari language and translated back from Dari into English by ONCALL Interpreters & Translators (http://oncallinterpreters.com.au/) of the National Accreditation Authority for Interpreters and Translators (NAATI). Care was taken to address formal (i.e. DSM-IV) diagnostic criteria for PTSD, while avoiding the use of overly medical terminology and providing a culturally valid vignette. All discrepancies were checked and rectified by the translators, the PhD student and supervisory panel following established translation protocols (Bracken & Barona 1991). The survey was piloted prior to commencing the formal interview process with two volunteer participants from the Afghan community. After the pilot study it was found that the survey to be suitable and appropriate for the study purposes therefore no changes were required.

4.3.3.1 Psychological scales
Several quantitative scales were used to examine exposure to trauma events, PTSD symptoms, levels of general psychological distress and depression, functional impairment and resilience. These measures have been utilised with other cross-cultural populations in addition to two recent studies of Afghans and are well-validated for use in Afghan populations (Miller et al., 2006; Mollica, McInnes, Poole & Tor, 1998).

Afghan War Experience Scale (AWES): This study assessed exposure to war-related violence and loss with the AWES, which asks participants to indicate whether they have experienced each of 17 war-related experiences of violence or loss, with answer choices including never (0), once (1), or more that once (2) (Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008). Scores on the 17 items were totalled,
yielding a possible range from 0 to 34, with higher total scores reflecting greater exposure to war-related experiences. (See Appendix 2.3)

**Connor Davidson (CD-RISC 2):** This is a two-item scale that measures resilience and coping abilities. Each item is assessed on a 5-point Likert scale with responses ranging from 0 (not correct at all) to 4 (correct most of the time). The CD-RISC 2 is a well-validated 2-item self-rated instrument that measures perceptions of stress-coping ability, assessing the perceived ability to continue to function effectively in stressful circumstances and the perceived capacity to adapt to change (Stevens et al., 2010). Both items are rated on a 5-point Likert scale ranging from 0 (not true at all) to 4 (true nearly all the time). Based on established norms, in the present study a participant’s summed scores in the range of 7–8 were regarded as representing high resilience, while scores of 0–6 represented low resilience (Vaishnavi, Connor and Davidson 2007). (See Appendix 2.4)

**Hopkins Symptoms Check List (HSCL-25):** The HSCL25 was used to measure symptoms of general anxiety and depression (Mollica, Wyshak, de-Marneffe, Khuon, & Lavelle, 1987). The HSCL-25 consists of 25 items in total, of which 10 items measure anxiety and the remaining 15 items assess for symptoms of depression. Each item is measured on a Likert scale with choices ranging from 1 (not at all) to 4 (extremely). This scale has been used widely in the studies of war-affected displaced refugees, including two recent studies of Afghans (Mollica et al., 1987; Thapa, Van Ommeren, Sharma, de Jong and Hauff, 2003; Cardozo et al., 2004; Scholte et al., 2004). Participants with a mean score greater than 1.75 are considered to be symptomatic for depressive disorder (Mollica et al., 1987). (See Appendix 2.5)

**Impact of Events Scale-Revised (IES-R):** PTSD symptomology was assessed using the 22-item IES-R. This measure has been used widely to examine psychological trauma. The original version of the scale consisted of 22 items, with a Likert scale ranging from 0 (not at all) to 4 (extremely). However, in the Afghan adaptation of the scale, Miller et al. (2002) added a 23rd item to the questionnaire to assess the extent to which participants avoid talking about their symptoms of trauma to avoid upsetting others. However, as this item does not contribute to the final IES-R scores, it was not utilised in this study. The IES-R has demonstrated strong psychometric properties, with internal consistency reported as .96 (Creamer, Bell & Failla, 2003).
Although not originally designed to be used as a diagnostic assessment tool for PTSD, several studies have demonstrated its promise as a brief self-report measure (Creamer, et al., 2003; Morina, Ehring and Priebe, 2013). The largest and most relevant study examining the diagnostic utility of IES-R in two samples of war-affected populations (n = 3313 and n = 854) noted that a cut-off score $\geq 34$ was able to identify individuals with probable PTSD. (See Appendix 2.6)

**World Health Organisation Disability Assessment Scale-II (WHO DAS–II; WHO, 2000):** The DAS II was used to examine functional impairment. This scale has been used widely in cross-cultural mental health research and consists of 12 items on a 1–5 Likert scale, thus generating possible scores of 12–60, with the higher scores indicating greater functional impairment. (See Appendix 2.7)

**4.3.3.2 Sample size and statistical power**

Sample size requirements were based on the need to ensure sufficient completed surveys to permit analysis of associations between specific aspects of MHL, demographic variables and symptom status. In the absence of data on the proportion of participants giving responses to the Mental Health Literacy Survey that could be considered to be indicative of “good MHL”, sample size calculations assumed a 50% proportion, which would give the largest sample size that potentially would be required. To estimate an expected proportion of 50% with a 95% confidence interval of $\pm 8\%$, a minimum of 150 completed interviews were required. With this sample size, the study would also have 80% power to detect a medium effect size from 0.23 to 0.27 using 1–3 degrees of freedom Chi-square test of associations between key demographic variables, symptom levels and specific aspects of MHL.

**4.3.3.3 Statistical analysis**

Statistical analysis was carried out using IBM Statistics version 22.0. Data for continuous variables are presented as means and standard deviations (SD), and categorical variables are presented as frequencies and percentages. Analyses examined the effect of socio-demographic characteristics (age, gender, length of time in Australia, religion, marital status and education) and clinical measures (IES-R, HSCL, AWES, WHO_DAS and Resilience Scale) on responses regarding problem recognition and beliefs about treatments, causes and risk factors. Associations were examined using independent t tests, Mann-Whitney U tests, Chi-square tests and
Spearman’s rank correlations, as appropriate. Pairwise post hoc comparisons with a Bonferroni correction for multiple comparisons were conducted. The missing data rate was very low (< 1%).

4.3.4 Qualitative interview procedure and participants

Participants who agreed to take part in the qualitative interviews and signed the consent forms had also participated in the quantitative part of the research. Twenty-four people (11 males and 13 females) agreed to be interviewed. At this point, saturation was achieved. This is the point at which no new information or themes are observed in the data, or where the same themes recur (Guest, Greg; Bunce, Arwen & Johnson, Laura, 2006). Most female participants were stay-at-home mothers, or English language students, with a minority attending university. The male participants were either looking for work or were at university. A small number (2) of female participants held part-time or full-time jobs. A digital voice recorder (DVR) was used to collect a full account of each interview. The researcher reassured participants that all recorded information would remain confidential and that once the translation and transcription of data were finalised, the recording would be destroyed. Participants were then asked if they wished to proceed or if they preferred not to have the interview recorded. All but four of the qualitative interviews were recorded. The participants who chose not to be recorded stated that they were too shy to speak while being recorded. They were interviewed without recording the session. These interviews took longer to complete as the interviewer took detailed notes in place of using a DVR. On the whole, most qualitative interviews lasted between 20 and 45 minutes.

The majority of the qualitative interviews were conducted in the family home. A few qualitative interviews were conducted at a University or the State Library. All interviews were conducted in the participant's language: Dari or Hazaragi. During interviews as a researcher I was aware of my position within the research process. I understood that when dealing with a highly traumatised population, the qualitative research process can be challenging for both the researcher and participants. It is important that the researcher take steps to critically reflect on their position within the research process; that they examine ‘how the researcher and inter-subjective elements impinge on and even transform, research’ (Finlay, 2002, p. 210). This
process, which involves sustained introspection, is referred to as reflexivity (Guba & Lincoln, 1981). Emotions are important to reflexivity. Emotions are always present in interactions and it is vital to acknowledge the role that emotions play in helping to provide greater understanding of ourselves and others (Elias, 1987; Denzin, 1984). Notably, during several interviews, there were occasions when I – as the researcher – became emotional and shared tears with participants. There were also times when I was so immersed in conversation and deep listening that I felt participants’ sadness after I left their homes – an experience that has been reported by other qualitative researchers working with vulnerable populations (see Fitzpatrick & Olson, 2015). The emotions I experienced were interlinked with my own experiences of the conflict in Afghanistan. While working as a medical doctor in Afghanistan between [1990-1992] I directly experienced the emotional and visceral impact of war. While running group therapy sessions with patients there, I came across people who had experienced the loss of as many as 12-14 members of their families during the war. Hearing patients’ stories and seeing patients’ outbursts helped me to understand the significance of their pain and sadness. As someone who has lived and worked in Afghanistan during the war, I was in an appropriate position to understand – on an emotional and experiential level – and interpret participants’ contributions to the study. Despite being a researcher (in training), I was in many ways an ‘insider’ (see Carroll, 2009), able to interpret participants’ communication in their preferred language (Dari or Hazaragi) and share in understanding some of their experiences of war. However, I was also an outsider as a researcher associated with a university, as a medical professional and (in relation to many participants) as a member of the dominant culture group in Afghanistan. Far from the removed ‘objectivity’ valued in positivist (quantitative research), a researcher’s shared subjectivity with participants is valued in qualitative research; it increases the robustness of interpretations (Lincoln, Lynham, & Guba, 2013).

The following semi-structured interview guide was used in each interview:

- In your opinion, what is good or ideal mental health?
- How would you consider your own mental health?
- What do you do if you have a mental health problem or can’t sleep at night?
- Do/would you feel ashamed if you had a mental health problem?
Probing questions were also used to prompt participants to elaborate as needed. When the interviews were completed the researcher translated and transcribed them from Dari or Hazaragi into English. Then each transcribed text was uploaded into QSR International’s NVivo 8 Software, a qualitative research software program, ready for analysis.

4.3.4.1 Grounded theory and thematic analysis

This study draws on the widely used techniques found in grounded theory to inform its methods of analysis. Grounded theory refers to a method of inquiry and to the product of inquiry. This method offers rich possibilities for advancement of qualitative research (Charmaz, 2008) by continuously checking and refining conclusions based on empirical data collected in the field (Strauss & Corbin, 1998). It is an approach to data collection frequently employed within research on human behaviour to generate theory, which argues that theory should develop from the ‘ground’ – that is using empirical evidence using observations, focus groups and interviews (Pearson, 2004). Leedy and Ormrod (2001) explain that grounded theory research starts with data collection, which later can be developed into a theory. In other words, the theory should emerge from the data collected in the field, not solely deductively from literature, theorists or hypotheses. The aim of grounded theory is to provide a useful conceptual framework to order the data that explains the studied phenomena. The generated theory is derived from data that are systematically gathered and analysed through the research process (Strauss & Corbin, 1998). The standard approach to analysis for grounded theory involves a form of thematic analysis: open coding, axial coding, selective coding and developing a theory (Creswell & Clark, 2007; Leedy & Ormrod, 2001).

While the full grounded theory methodology was not followed in this study, the approach to thematic analysis explicated in grounded theory was used. This conventional practice in qualitative research involves carefully reading data to identify themes, recurrent patterns and overall, to better understand participants’ experiences (Floersch, Longhofer, Kranke, & Townsend, 2010). All qualitative interview data were analysed cyclically using open coding. This involved two steps: initial coding and focused coding (Charmaz, 2000). During initial coding the aim was to produce as many codes as possible by examining each line of the data and
explaining actions within it. Memo writing was also used to elaborate on categories and connections across the transcripts. Finally, all data were pulled together into findings which were subsequently compared with the quantitative data to develop a richer picture of the experiences of this population. To improve the trustworthiness of the coding, 8 interviews were coded by both the primary researcher and a supervisor. This is referred to as inter-coder reliability. It is done to improve the likelihood that conclusions drawn from analysis are robust, as they are drawn from the interpretations of more than one researcher (Tinsley & Weiss, 1975; Wang, Wiley & Zhou, 2007).

4.3.4.2 Mixed Methods

Qualitative research categorise a group of methods or techniques for observing, documenting, analysing and interpreting elements, patterns, characteristics and meanings of specific, events or everyday life (Leininger, 1985). Through observation, interviews and other qualitative data collection methods, qualitative researchers gain an in-depth understanding of participants’ thoughts, perceptions and feelings and the phenomenon of interest (Minichiello, Aroni, Timewell & Alexander, 1995). On the other hand, quantitative research typically involves surveying a random sample of a population or group of populations to come to generalizable conclusions. The results can be analysed statistically and used to further inform an experimental study where a range of problems can be trialled with a larger sample of randomly selected individuals (Woolfall, 2010). Leedy and Ormrod (2001) described three broad classifications of quantitative research: descriptive, experimental and causal comparative. Descriptive research approaches examine the situation as it exists in its current state; experimental research investigates the treatment of an intervention; and causal comparative research serves as a tool for developing classifications of social phenomena and for establishing whether shared phenomena can be explained by the same causes.

As Carter and Little (2007, p. 1316) stated, “methods are the nuts and bolts of research practice”. In quantitative research, rigour is partly dependent on predetermined sampling, data collection, analysis, and reporting that is conducted in a linear fashion. In qualitative research, rigour can be increased if these phases are related. As analysis and early writing reveals unexpected insights, sampling and data
collection can be modified to better support the integrity, focus and explanatory power of the final product. This principle comes originally from grounded theory (Glaser & Strauss, 1967) but can be used in most methodologies; depending on the epistemological position the researcher has adopted (Carter & Little, 2007).

In comparing approaches, qualitative data are seen as richer, having greater depth and being more likely to present a true picture of people’s experiences, beliefs and attitudes (Van Krieken et al. 2006). Qualitative research is also valued because it incorporates social context (Pearson, 2004).

Quantitative and qualitative researchers differ in their approach to appraising data and research. In quantitative research, researchers are generally concerned with reliability and validity. Reliability refers to the consistency of the research findings and a measure is considered reliable if it gives the same result over and over again using the same measurement (Dey, 1993; Kvale, 1996). Validity refers to the degree to which a test measures what it is supposed to measure and subsequently allows appropriate interpretation of scores. The concept of validity is that it is necessary to state what or who the test is valid for because tests are designed for a variety of purposes (Gay, 1996).

Denzin and Lincoln (2000) questioned the interpretation of validity and reliability when designing and appraising qualitative research. Instead of using quantitative definitions for these terms, Dey (1993) argued that the focus should be trustworthiness rather than validity: the extent to which the conclusions are convincingly supported by the data collected. Transferability is often a focus in qualitative research, in place of reliability: the extent to which findings or phenomena are representative of a whole group and not unique to a single participant (Denzin & Lincoln, 1994).

Many authors, including Smith and Hershusius (1986), have summarised the history of the qualitative–quantitative debate as occurring in three stages: conflict, detente and cooperation. Up until 1970, theorists were polarised, believing that qualitative and quantitative techniques differed and must involve specific and separate methods. The two methods were fundamentally different and divided at the core by the notions of objectivity and subjectivity. In the 1970s, detente also featured; situationist
Theorists proposed that the two approaches were parallel research tools. Cooperation then emerged in the 1980s and was characterised by the pragmatist notion of compatibility with the aim of enabling qualitative research as a legitimate tool.

The majority of mental health problems are linked to subjective experiences and cannot be fully appreciated through quantitative analysis alone. This has been explained by Guba (1990), who wrote about the major limitations associated with positivist and quantitative research: it cannot explain social context and the nature of subjectivity related to human behaviour. Denzin and Lincoln (1994) also noted that “Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry”. However, positivists have criticised qualitative research for generating idiosyncratic data that is difficult to reproduce (Miles & Huberman, 1991).

The limitations and advantages of both qualitative and quantitative research led me to use a mixed-methods approach to allow for a better understanding of the roles played by social, cultural, political, and institutional contexts in relation to mental health problems and associated behaviours (Groleau, Pluye & Nadeau, 2007), while still collecting reproducible data.

Mixed-methods research combines the strengths of both qualitative and quantitative methods by combining approaches in a single research study to increase the breadth and depth of understanding (Collins, Onwuegbuzie & Jiao, 2007). The use of mixed methods can be a better approach to research than either method alone. A single data source is not always adequate in gaining understanding of a topic (Creswell & Clark, 2007). For example, Wisdom, Cavaleri, Onwuegbuzie and Green (2012) argued that mixed-methods research can improve understanding of health services by providing a more comprehensive picture than either approach alone. Though it is rare, they argued that mixed-methods studies should be encouraged as they increase the transparency of findings.

In taking a mixed-methods approach, and in line with the interactionist and phenomenological epistemologies described above, I endeavour to be a reflexive and not an objective observer. Emotions play an important role in all dimensions of life.
and influence our interactions with research participants throughout the research process (Hubbard, Backett-Milburn & Kemmer, 2001; Warr, 2004). Many have argued that during the research process it is not possible to eliminate researchers’ emotions and thoughts, nor is it desirable (Perry, Thurston & Green, 2004; Tillmann-Healey & Kiesinger 2001).

A mixed methods – quantitative structured interviews and qualitative semi-structured interviews supported by a grounded theory approach to analysis – best serve this study. By drawing on grounded theory for the analysis of the findings will help me build sound conclusions based on empirical evidence. Integrating qualitative and quantitative approaches will allow findings from each study to be enhanced and explained by the other study.

Integration is the term used to describe the research process when mixing qualitative and quantitative data. Integration of data is a method by which qualitative and quantitative data are collected and analysed separately. Integration occurs during the interpretation of the data. A mixed method research design facilitates this method of data integration and can occur at any point in the research process (Andrew & Halcomb, 2009). Integration of data using this method allows for an identification of common themes which emerge through the data analysis. These are then collected, brought together, compared and contrasted. The integrated approach allows for more detailed and comprehensive analyses of emerging themes. Hence using a mixed method approach produces a better understanding or interpretation of the results than either qualitative or quantitative research method alone.

One of the techniques used for the integrating data in mixed method research is ‘Triangulation’ (O’Cathain, et al. 2010). This involves using a mixed method approach to understand a research question at the interpretation stage after analysing the data separately (O’Cathain et al., 2010).

The key feature of triangulation is that the main findings from each data set are listed and analysed for three components: ‘convergent’ or ‘concurrent’ where the findings of data are in agreement, ‘complementarity’ where the findings from each study complement each other and the data provides complementary information, and ‘dissonance’ where the findings contradict or diverge from each other. There is
another component to these three options; ‘silence’ where one data set produces some findings that are not found in the other data set (Farmer et al., 2006). It is also important to know that the method of triangulation is a process that enables data from qualitative sources to be validated from quantitative sources. This strengthens the validity of the data obtained from both quantitative and qualitative.

The current study incorporates this approach in order to gain a sound understanding of the sets of issues arising as a whole and consequently increasing the validity of the research results.

4.3.4.3 Epistemology

This section provides an overview of the epistemological assumptions underpinning the mixed methods approach to data collection chosen for this study. Researchers must choose a research design and analytic approach appropriate to their research questions and the epistemological traditions underpinning their research question(s) (Grbich, 2007; Thakur, 2010). The term “epistemology” means theory of knowledge (Ganeri, 2010; Thakur, 2010). Epistemologies deal with questions about truth: how people understand something to be true, what they accept as a truth and how this truth has been created or structured. Knowledge about the nature of being and reality, called “ontology”, also questions what people know and how they come to know what is real (Thakur, 2010). There are various epistemologies, with differing assumptions informing quantitative and qualitative research.

Two major, historical and opposing, epistemological traditions are positivism and postmodernism. Positivists believe that “Science can deal only with observable things known directly to experience and are opposed to metaphysical speculation without concrete evidence” (Abercrombie, Hills and Turner 2000, p. 269).

Positivists view reality as being out there to be studied, captured and understood (Guba, 1990). Truths are viewed as absolute and are valued as unique aspects of objective scientific research. Positivism was established in direct opposition to religious ways of knowing, or metaphysical speculation, which dominated Western thought until the period known as The Enlightenment (Woolfall, 2010). Knowledge is viewed by positivists as a careful process involving theory, scientific principles, rationalist thought, universal processes, classification, order and hierarchy.
In the 20th century, other epistemologies emerged: rationalism, idealism, realism, empiricism and materialism (Little, 1995). Questions emerged about what it means to be human and the nature of reality (ontology), about the relationship between the inquirer and the known (epistemology), and about how we gain knowledge about the world (methodology) (Guba & Lincoln 1994). Postmodernists, in contrast to positivists, view the world as complex, disorganised, transitional and made up of multiple “realities”. Thus, postmodernists argue that the social world cannot be explained through objective observation and the scientific method. For postmodernists, intuition and thought are also important ways of knowing. They also question the extent to which observations can be objective (Dalal, 1999).

This thesis draws on a postpositivist tradition (see Lincoln, Lynham & Guba, 2013) that appreciates the value of ordered and objective research to coming to discrete conclusions that are useful for decision-making, while acknowledging many of the limitations of knowledge derived from the scientific method and the limits of truth and objectivity. A postpositivist epistemology informs the quantitative methods employed in this study. Other epistemologies are also drawn on for the qualitative aspects.

Two epistemologies commonly used in research on human behaviour are interactionism and phenomenology. Interactionists believe that subjectivity is very important to understanding the interpretation of motives and actions. They argue that human behaviour is mediated by internal and social processes that people give meaning to their lives through these processes, and that individuals have power over the concept of self, based on their interpretation of other members of society (Van Krieken, Habibis, Smith, Hutchins, Halambos, & Holborn, 2006 p. 607).

Similarly, phenomenologists believe that “human beings make sense of the world by imposing meanings and classifications.” They reject the possibility of “objective measurement and causal explanations of human behaviour” (Van Krieken, et al., 2006 p. 606). Like postmodernists, phenomenologists argue that “objective reality beyond these subjective meanings” does not exist (Van Krieken, et al., 2006). Phenomenology is not interested in empirical facts. Instead, it emphasises the phenomenon. Anything that presents itself to consciousness is of interest in phenomenology, whether the object is real or imaginary, empirically measurable or
subjectively felt (Max Van Manen, 1990). Phenomenology thus attempts to create conditions for the objective study of topics usually regarded as subjective: consciousness and the content of conscious experiences such as judgements, perceptions and emotions (Zahavi, 2003). Furthermore, to gain an in-depth and accurate understanding of the phenomenon of interest, subjectivity is not only inevitable, but also desirable.

Both interactionists and phenomenologists believe that subjectivity is very important to understanding the interpretation of motives and actions. As the majority of mental health problems are linked to subjective experiences, subjectivity is a very important concept in this study. Thus, this study draws on postpostivist, interactionist and phenomenological epistemologies in valuing both structured quantitative and more subjective qualitative data.
CHAPTER FIVE: RESULTS

5.1 Study One: Quantitative Survey and Psychological Scales

5.1.1 Demographic and clinical characteristics

Overall, 164 people contacted the researcher or were referred to the researcher to participate in the structured interviews, but 14 people declined because of either work or family commitments. Most participants were from the Hazara Afghan ethnic group (147), with a few from the Tajic Afghan ethnic group (3). Face-to-face structured interviews were conducted with the final sample of 150 resettled Afghan refugees in South Australia (SA), aged 18–79, who were born in Afghanistan and arrived in Australia no earlier than the year 2000. Employment and gender characteristics have already been described in the previous method chapter. The mean age of participants was 32.8 years (SD = 12.30), and participants had obtained a mean of 6.07 years of education (SD = 5.20). Table 5.1 shows the socio-demographic characteristics of the survey population (n = 150). The majority of participants spoke Dari (98%). The top two countries of transit for participants were Pakistan (45.3%) and Iran (35.3%). Most had arrived in Australia via plane (64.7%) or by (35.3%) by boat. Of these, 51.3% were Australian citizens and 44.0% were permanent residents, followed by 4% with bridging visas. The majority of participants were refugees (42.7%) or asylum seekers (34.7%). Twenty per cent of participants had three-year temporary protection visas (TPV). As for marital status, 62% were married, 25.3% had never been married and 8.7% were widowed.
Table 5.1  Demographic characteristics of the participants (n=150)

<table>
<thead>
<tr>
<th>Socio-demographic Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>74</td>
<td>49.3</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
<td>50.7</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dari</td>
<td>147</td>
<td>98.0</td>
</tr>
<tr>
<td>Hazaragi</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Main country of transit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>68</td>
<td>45.3</td>
</tr>
<tr>
<td>Iran</td>
<td>53</td>
<td>35.3</td>
</tr>
<tr>
<td>Indonesia</td>
<td>24</td>
<td>16.0</td>
</tr>
<tr>
<td>Malaysia</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Mode of transportation to Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plane</td>
<td>97</td>
<td>64.7</td>
</tr>
<tr>
<td>Boat</td>
<td>53</td>
<td>35.3</td>
</tr>
<tr>
<td>Current residency status in Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent resident</td>
<td>66</td>
<td>44.0</td>
</tr>
<tr>
<td>Australian citizen</td>
<td>77</td>
<td>51.3</td>
</tr>
<tr>
<td>Bridging visa</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>Spouse visa</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Arrival status in Australia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td>64</td>
<td>42.7</td>
</tr>
<tr>
<td>Asylum seeker</td>
<td>52</td>
<td>34.7</td>
</tr>
<tr>
<td>Immigrant</td>
<td>34</td>
<td>22.7</td>
</tr>
<tr>
<td>Temporary Protection Visa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never held TPV</td>
<td>113</td>
<td>75.3</td>
</tr>
<tr>
<td>Three-year TPV</td>
<td>30</td>
<td>20.0</td>
</tr>
<tr>
<td>Bridging visa</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Spouse visa</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>38</td>
<td>25.3</td>
</tr>
<tr>
<td>Married</td>
<td>93</td>
<td>62.0</td>
</tr>
<tr>
<td>Fiancé/partner</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>13</td>
<td>8.7</td>
</tr>
</tbody>
</table>
5.1.2 Mental health of respondents

Table 5.2 presents the pre-migration trauma/clinical characteristics of the surveyed population (N=150). Using the cut-off scores for IES-R, 46% of participants had probable PTSD. According to the HSCL-25A, a further 14.7% had symptoms of depression and 21.3% had anxiety symptoms. The mean number of potentially traumatic events experienced by participants was 12.9 (SD = 3.3). In terms of functional impairment, there was a spread of participants across the impairment levels, ranging from 18.7% with no disability through to 46.7% of participants with severe disability, according to the WHO DAS-II. Finally, when examining the results on the CD-RISC-II scale, a majority (88.0%) of participants appeared to have low levels of resilience.

5.1.3 Mental health literacy, attitudes and beliefs

To examine MHL and recognition of mental health disorders in the sample of Australian Afghan refugees, participants were asked what they thought the person in the vignette’s “main problem” was, and what they thought a doctor would consider the main problem to be. Table 5.3 shows the frequency and percentage of respondents mentioning clinical categories to describe the nature of the problem described in the vignette. The most commonly selected response was PTSD (30.7%), followed closely by fear (26.0%), then depression (15.3%), and (4.7%) of respondents reported the person’s main problem was a weak character. Table 5.4 shows the frequency and percentage of respondents mentioning categories to describe a doctor’s diagnosis of the problem in the vignette. The response considered to be the most likely diagnosis by a doctor was depression (30.0%), followed by PTSD (26.7%) and fear (14.7%). Some participants thought the doctor would diagnose the person in the vignette as having stress (13.3%) and a nervous breakdown (10.7%).
Table 5.2  Pre-migration trauma/clinical characteristics of the surveyed population (N=150)

<table>
<thead>
<tr>
<th>Clinical Characteristics</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probable PTSD (IES-R)</td>
<td>69</td>
<td>46</td>
</tr>
<tr>
<td>Probable depression (HSCL-25)</td>
<td>22</td>
<td>14.7</td>
</tr>
<tr>
<td>Probably anxiety disorder (HSCL-25)</td>
<td>32</td>
<td>21.3</td>
</tr>
<tr>
<td>Exposure to traumatic events (AWES)</td>
<td>12.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Level of disability (WHO DAS II)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No disability</td>
<td>28</td>
<td>18.7</td>
</tr>
<tr>
<td>Mild disability</td>
<td>19</td>
<td>12.7</td>
</tr>
<tr>
<td>Moderate disability</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>Severe disability</td>
<td>70</td>
<td>46.7</td>
</tr>
<tr>
<td>Resilience (CD-RISC II)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High resilience</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Low resilience</td>
<td>132</td>
<td>88</td>
</tr>
</tbody>
</table>

Table 5.3  Participants recognition of problem described in the vignette

<table>
<thead>
<tr>
<th>Main Problem</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>46</td>
<td>30.7</td>
</tr>
<tr>
<td>Fear</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>Depression</td>
<td>23</td>
<td>15.3</td>
</tr>
<tr>
<td>Stress</td>
<td>19</td>
<td>12.7</td>
</tr>
<tr>
<td>Nervous breakdown</td>
<td>13</td>
<td>8.7</td>
</tr>
<tr>
<td>Weak character</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Physical condition</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Home sickness</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>
Table 5.4  Frequency and percentage of respondents mentioning each category to describe a doctor’s diagnosis of the problem in the vignette

<table>
<thead>
<tr>
<th>Problem</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>45</td>
<td>30.0</td>
</tr>
<tr>
<td>PTSD</td>
<td>40</td>
<td>26.7</td>
</tr>
<tr>
<td>Fear</td>
<td>22</td>
<td>14.7</td>
</tr>
<tr>
<td>Stress</td>
<td>20</td>
<td>13.3</td>
</tr>
<tr>
<td>Nervous breakdown</td>
<td>16</td>
<td>10.7</td>
</tr>
<tr>
<td>Physical condition</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Weak character</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>No real problem, just a phase</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Homesickness</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

5.1.4  Beliefs about treatment and treatment providers

Participants were asked to select, from a range of 16 response options, what they considered to be the most helpful type of treatment for the person in the vignette. Participants were also asked to rate each treatment option according to how helpful or harmful they believed it to be. Table 5.5 shows participant ratings of helpfulness/harmfulness, and the percentage of respondents that considered each option as “most helpful”. “Finding new hobbies” was considered to be the most helpful treatment (18.0%), followed by “improving diet/exercise” (16.0%) and “psychotherapy focusing on changing thought/behaviours” (14.7%). Admission to psychiatric hospital (2.7%) followed by relaxation (2%) and psychotherapy focusing on relationships with others (1.3%) were considered to be the least helpful treatments. In addition, 62.0% of participants said that reading the Koran is helpful, followed by traditional therapies and prayer sessions (37.3%).
Table 5.5  Frequency and percentage of respondents rating each treatment option as helpful/harmful and ratings of most helpful treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Most Helpful</th>
<th></th>
<th>Helpful</th>
<th></th>
<th>Harmful</th>
<th></th>
<th>Neither</th>
<th></th>
<th>Depends</th>
<th></th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Finding new hobbies</td>
<td>27</td>
<td>(18.0)</td>
<td>129</td>
<td>(86.0)</td>
<td>0</td>
<td>(1.3)</td>
<td>2</td>
<td>(1.3)</td>
<td>19</td>
<td>(12.7)</td>
<td>0</td>
</tr>
<tr>
<td>Improving diet/exercise</td>
<td>24</td>
<td>(16.0)</td>
<td>145</td>
<td>(96.7)</td>
<td>0</td>
<td>(2.0)</td>
<td>3</td>
<td>(2.0)</td>
<td>1</td>
<td>(0.7)</td>
<td>1</td>
</tr>
<tr>
<td>Psychotherapy focusing on changing thoughts/behaviours</td>
<td>22</td>
<td>(14.7)</td>
<td>126</td>
<td>(84.0)</td>
<td>2</td>
<td>(1.3)</td>
<td>0</td>
<td>(1.3)</td>
<td>9</td>
<td>(6.0)</td>
<td>13</td>
</tr>
<tr>
<td>Psychotherapy focusing on past</td>
<td>21</td>
<td>(14.0)</td>
<td>130</td>
<td>(86.7)</td>
<td>5</td>
<td>(3.3)</td>
<td>1</td>
<td>(0.7)</td>
<td>3</td>
<td>(2.0)</td>
<td>11</td>
</tr>
<tr>
<td>Getting information about problem</td>
<td>20</td>
<td>(13.3)</td>
<td>130</td>
<td>(86.7)</td>
<td>2</td>
<td>(1.3)</td>
<td>2</td>
<td>(1.3)</td>
<td>8</td>
<td>(5.3)</td>
<td>8</td>
</tr>
<tr>
<td>Talking about problem</td>
<td>14</td>
<td>(9.3)</td>
<td>85</td>
<td>(56.7)</td>
<td>15</td>
<td>(10.0)</td>
<td>1</td>
<td>(0.7)</td>
<td>46</td>
<td>(30.7)</td>
<td>3</td>
</tr>
<tr>
<td>Reading Koran/Bible</td>
<td>9</td>
<td>(6.0)</td>
<td>93</td>
<td>(62.0)</td>
<td>0</td>
<td>(1.3)</td>
<td>4</td>
<td>(2.7)</td>
<td>43</td>
<td>(28.7)</td>
<td>10</td>
</tr>
<tr>
<td>Admission to a psychiatric hospital</td>
<td>4</td>
<td>(2.7)</td>
<td>57</td>
<td>(38.0)</td>
<td>43</td>
<td>(28.7)</td>
<td>7</td>
<td>(4.7)</td>
<td>40</td>
<td>(26.7)</td>
<td>3</td>
</tr>
<tr>
<td>Relaxation</td>
<td>3</td>
<td>(2.0)</td>
<td>95</td>
<td>(63.3)</td>
<td>3</td>
<td>(2.0)</td>
<td>14</td>
<td>(9.3)</td>
<td>27</td>
<td>(18.0)</td>
<td>11</td>
</tr>
<tr>
<td>Psychotherapy focusing on relationships with others</td>
<td>2</td>
<td>(1.3)</td>
<td>96</td>
<td>(64.0)</td>
<td>4</td>
<td>(2.7)</td>
<td>2</td>
<td>(1.3)</td>
<td>30</td>
<td>(20.0)</td>
<td>18</td>
</tr>
<tr>
<td>Traditional therapies</td>
<td>2</td>
<td>(1.3)</td>
<td>56</td>
<td>(37.3)</td>
<td>27</td>
<td>(18.0)</td>
<td>15</td>
<td>(10.0)</td>
<td>29</td>
<td>(19.3)</td>
<td>23</td>
</tr>
<tr>
<td>Prayer session</td>
<td>2</td>
<td>(1.3)</td>
<td>56</td>
<td>(37.3)</td>
<td>16</td>
<td>(10.7)</td>
<td>12</td>
<td>(8.0)</td>
<td>51</td>
<td>(34.0)</td>
<td>15</td>
</tr>
<tr>
<td>Reading a self-help book</td>
<td>0</td>
<td>(0.0)</td>
<td>49</td>
<td>(32.7)</td>
<td>16</td>
<td>(10.7)</td>
<td>9</td>
<td>(6.0)</td>
<td>60</td>
<td>(40.0)</td>
<td>16</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>0</td>
<td>(0.0)</td>
<td>35</td>
<td>(23.3)</td>
<td>12</td>
<td>(8.0)</td>
<td>7</td>
<td>(4.7)</td>
<td>42</td>
<td>(28.0)</td>
<td>54</td>
</tr>
<tr>
<td>Trying to deal with problem alone</td>
<td>0</td>
<td>(0.0)</td>
<td>11</td>
<td>(7.3)</td>
<td>115</td>
<td>(76.7)</td>
<td>4</td>
<td>(2.7)</td>
<td>17</td>
<td>(11.3)</td>
<td>3</td>
</tr>
<tr>
<td>Drinking alcohol to relax</td>
<td>0</td>
<td>(0.0)</td>
<td>0</td>
<td>(0.0)</td>
<td>131</td>
<td>(87.3)</td>
<td>2</td>
<td>(1.3)</td>
<td>7</td>
<td>(4.7)</td>
<td>10</td>
</tr>
</tbody>
</table>
Participants were asked to consider if medication would be helpful in treating the problem described in the vignette. Table 5.6 presents participants’ ratings of helpfulness/harmfulness, and the percentage of participants who considered each medicine as “most helpful”. An equal number of participants (33.3%) considered vitamins, minerals and herbal medicines to be the most helpful medical intervention.
### Table 5.6 Frequency and percentage of participants rating each medicine as helpful/harmful and ratings of most helpful medicine

<table>
<thead>
<tr>
<th>Medication</th>
<th>Most Helpful</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Vitamins and minerals</td>
<td>50 (33.3)</td>
<td>114 (76.0)</td>
<td>3 (2.0)</td>
<td>7 (4.7)</td>
<td>14 (9.3)</td>
<td>12 (8.0)</td>
</tr>
<tr>
<td>Herbal medicines</td>
<td>50 (33.3)</td>
<td>79 (52.7)</td>
<td>10 (6.7)</td>
<td>13 (8.7)</td>
<td>16 (10.7)</td>
<td>32 (21.3)</td>
</tr>
<tr>
<td>Anti-depressant medicine</td>
<td>30 (20.0)</td>
<td>60 (40.0)</td>
<td>20 (13.3)</td>
<td>0</td>
<td>20 (13.3)</td>
<td>50 (33.3)</td>
</tr>
<tr>
<td>Medicine to help relaxation</td>
<td>20 (13.3)</td>
<td>49 (32.7)</td>
<td>56 (37.7)</td>
<td>2 (1.3)</td>
<td>18 (12.0)</td>
<td>25 (16.7)</td>
</tr>
</tbody>
</table>
Participants were also asked to consider which people or services would be helpful in treating the problem described in the vignette. Table 5.7 presents participant ratings of helpfulness/harmfulness and the percentage of participants who considered each service option as “most helpful”. The person/service rated by the highest percentage of participants as most helpful was a psychiatrist (43.3%), followed by a general practitioner (15.3%), a psychologist (14.7%) and a family member (14.0%). The community religious organisation (1.3%), a close male friend (1.3%) and a telephone counselling line (0%) were considered least helpful.
Table 5.7  Frequency and percentage of participants rating each service as helpful/harmful and ratings of most helpful service

<table>
<thead>
<tr>
<th>Service</th>
<th>Most Helpful</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>65 (43.3)</td>
<td>149 (99.3)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>(0.7)</td>
</tr>
<tr>
<td>GP</td>
<td>23 (15.3)</td>
<td>136 (90.7)</td>
<td>1</td>
<td>(0.7)</td>
<td>5</td>
<td>(3.3)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>22 (14.7)</td>
<td>148 (98.7)</td>
<td>0</td>
<td>(0)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Family member</td>
<td>21 (14.0)</td>
<td>76 (50.7)</td>
<td>6</td>
<td>(4.0)</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Religious leader</td>
<td>6 (4.0)</td>
<td>46 (30.7)</td>
<td>17</td>
<td>(11.3)</td>
<td>15</td>
<td>(10.0)</td>
</tr>
<tr>
<td>Community mental health worker</td>
<td>4 (2.7)</td>
<td>131 (87.3)</td>
<td>1</td>
<td>(0.7)</td>
<td>3</td>
<td>(2.0)</td>
</tr>
<tr>
<td>Close female friend</td>
<td>3 (2.0)</td>
<td>64 (42.7)</td>
<td>6</td>
<td>(4.0)</td>
<td>7</td>
<td>(4.7)</td>
</tr>
<tr>
<td>Afghan social group/club</td>
<td>2 (1.3)</td>
<td>87 (58.0)</td>
<td>8</td>
<td>(5.3)</td>
<td>6</td>
<td>(4.0)</td>
</tr>
<tr>
<td>Community religious organisation</td>
<td>2 (1.3)</td>
<td>62 (41.3)</td>
<td>12</td>
<td>(8.0)</td>
<td>7</td>
<td>(4.7)</td>
</tr>
<tr>
<td>Close male friend</td>
<td>2 (1.3)</td>
<td>62 (41.3)</td>
<td>10</td>
<td>(6.7)</td>
<td>4</td>
<td>(2.7)</td>
</tr>
<tr>
<td>Telephone counselling line</td>
<td>0</td>
<td>37 (24.7)</td>
<td>5</td>
<td>(3.3)</td>
<td>7</td>
<td>(4.7)</td>
</tr>
</tbody>
</table>
5.1.5 Beliefs about causes and risk factors

Participants were asked to consider the likely causes of the problem described in the vignette. Table 5.8 presents the frequency and percentage of participants who endorsed the various causes as “most likely” to have caused the problem described in the vignette, as well as ratings of the likelihood of each cause. The most likely cause of the problem in the vignette was attributed by 31.3% of participants as “coming from war-torn country”, followed by 20.7% who stated “family problems”, 20.7% who selected “experiencing a traumatic event” and 15.3% who said “moving to a new country”. The “very likely” cause of the problem was attributed by 80.0% of participants as “coming from war-torn country”, followed by “family problem” (58.7%), “experiencing a traumatic event” (49.3%), “moving to a new country” (41.3%) and having a bad childhood (49.3%). Participants reported the “likely” cause of the problem can be “poor physical health” (61.3%), “genetic” (44.0%), “destiny” (37.3%) and “punishment from God” (24.7%).
### Table 5.8  Frequency and percentage of participants rating each cause as likely/not likely and ratings of most likely cause

<table>
<thead>
<tr>
<th>Causes</th>
<th>Most Likely</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Not likely</th>
<th>Depends</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Coming from war-torn country</td>
<td>47</td>
<td>(31.3)</td>
<td>120</td>
<td>(80.0)</td>
<td>24</td>
<td>(16.0)</td>
</tr>
<tr>
<td>Family problems</td>
<td>31</td>
<td>(20.7)</td>
<td>88</td>
<td>(58.7)</td>
<td>56</td>
<td>(37.3)</td>
</tr>
<tr>
<td>Experiencing a traumatic event</td>
<td>31</td>
<td>(20.7)</td>
<td>74</td>
<td>(49.3)</td>
<td>72</td>
<td>(48.0)</td>
</tr>
<tr>
<td>Moving to a new country</td>
<td>23</td>
<td>(15.3)</td>
<td>62</td>
<td>(41.3)</td>
<td>75</td>
<td>(50.0)</td>
</tr>
<tr>
<td>Having a bad childhood</td>
<td>10</td>
<td>(6.7)</td>
<td>74</td>
<td>(49.3)</td>
<td>62</td>
<td>(41.3)</td>
</tr>
<tr>
<td>Having weak character</td>
<td>5</td>
<td>(3.3)</td>
<td>14</td>
<td>(9.3)</td>
<td>81</td>
<td>(54.0)</td>
</tr>
<tr>
<td>Having a parent/parents with psychological problems</td>
<td>1</td>
<td>(0.7)</td>
<td>53</td>
<td>(35.3)</td>
<td>65</td>
<td>(43.3)</td>
</tr>
<tr>
<td>Poor physical health</td>
<td>1</td>
<td>(0.7)</td>
<td>11</td>
<td>(7.3)</td>
<td>92</td>
<td>(61.3)</td>
</tr>
<tr>
<td>Punishment from God</td>
<td>1</td>
<td>(0.7)</td>
<td>8</td>
<td>(5.3)</td>
<td>37</td>
<td>(24.7)</td>
</tr>
<tr>
<td>Problem is destiny</td>
<td>0</td>
<td></td>
<td>6</td>
<td>(4.0)</td>
<td>56</td>
<td>(37.3)</td>
</tr>
<tr>
<td>Problem is genetic</td>
<td>0</td>
<td></td>
<td>5</td>
<td>(3.3)</td>
<td>66</td>
<td>(44.0)</td>
</tr>
</tbody>
</table>
Table 5.9 presents the frequency and percentage of participants who endorsed the various risk factors as most likely to have had an influence on the problem described in the vignette, as well as ratings of the likelihood of each risk factor. Having been born in Afghanistan was considered by 48.0% of participants to be the “most likely” risk factor in making a person vulnerable to the problem described in the vignette. The next most likely risk factor was “having left Afghanistan prior to 2001” (22.0%), followed by being “unemployed” (11.3%). An even higher number of participants (80.7%) said “having been born in Afghanistan” was the “very likely” risk factor in making a person vulnerable to the problem described in the vignette, followed by “having left Afghanistan prior 2001” 67.3%, “unemployment” 40.7% and, interestingly, “poor people” 30.0%.
Table 5.9  Frequency and percentage of participants rating each risk factor as likely/not likely and ratings of most likely risk factor

<table>
<thead>
<tr>
<th>Risks</th>
<th>Most Likely</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Not likely</th>
<th>Depends</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Born in war-torn country</td>
<td>72</td>
<td>(48.0)</td>
<td>121</td>
<td>(80.7)</td>
<td>24</td>
<td>(16.0)</td>
</tr>
<tr>
<td>Left Afghanistan prior to 2001</td>
<td>33</td>
<td>(22.0)</td>
<td>101</td>
<td>(67.3)</td>
<td>34</td>
<td>(22.7)</td>
</tr>
<tr>
<td>Unemployed</td>
<td>17</td>
<td>(11.3)</td>
<td>61</td>
<td>(40.7)</td>
<td>81</td>
<td>(54.0)</td>
</tr>
<tr>
<td>Poor people</td>
<td>8</td>
<td>(5.3)</td>
<td>45</td>
<td>(30.0)</td>
<td>90</td>
<td>(60.0)</td>
</tr>
<tr>
<td>Served in army</td>
<td>5</td>
<td>(3.3)</td>
<td>15</td>
<td>(10.0)</td>
<td>116</td>
<td>(77.3)</td>
</tr>
<tr>
<td>Left Afghanistan following 2001</td>
<td>5</td>
<td>(3.3)</td>
<td>78</td>
<td>(52.0)</td>
<td>56</td>
<td>(37.3)</td>
</tr>
<tr>
<td>Single people</td>
<td>4</td>
<td>(2.7)</td>
<td>33</td>
<td>(22.0)</td>
<td>91</td>
<td>(60.7)</td>
</tr>
<tr>
<td>Young people</td>
<td>2</td>
<td>(1.3)</td>
<td>11</td>
<td>(7.3)</td>
<td>87</td>
<td>(58.0)</td>
</tr>
<tr>
<td>Older people</td>
<td>2</td>
<td>(1.3)</td>
<td>21</td>
<td>(14.0)</td>
<td>123</td>
<td>(82.0)</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>(0.7)</td>
<td>15</td>
<td>(10.0)</td>
<td>94</td>
<td>(62.7)</td>
</tr>
<tr>
<td>Very religious people</td>
<td>1</td>
<td>(0.7)</td>
<td>5</td>
<td>(3.3)</td>
<td>64</td>
<td>(42.7)</td>
</tr>
<tr>
<td>Rich people</td>
<td>0</td>
<td></td>
<td>7</td>
<td>(4.7)</td>
<td>54</td>
<td>(36.0)</td>
</tr>
<tr>
<td>Men</td>
<td>0</td>
<td></td>
<td>5</td>
<td>(3.3)</td>
<td>97</td>
<td>(64.7)</td>
</tr>
<tr>
<td>Employed</td>
<td>0</td>
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<td>45</td>
<td>(30.0)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Muslim background</td>
<td>0</td>
<td></td>
<td>2</td>
<td>(1.3)</td>
<td>64</td>
<td>(42.7)</td>
</tr>
<tr>
<td>Not very religious people</td>
<td>0</td>
<td></td>
<td>2</td>
<td>(1.3)</td>
<td>52</td>
<td>(34.7)</td>
</tr>
<tr>
<td>People who have families</td>
<td>0</td>
<td></td>
<td>1</td>
<td>(0.7)</td>
<td>82</td>
<td>(54.7)</td>
</tr>
</tbody>
</table>
5.1.6 Beliefs about mental health problem, severity, prevalence and likely outcomes

Table 5.10 presents the participants’ beliefs about the levels of distress caused by having a problem such as that described in the vignette. The largest number of participants (48.7%) suggested that having this problem would be “very distressing”, 35.3% said having this problem would be “extremely distressing” and only one person said it would be “not distressing at all”.

Table 5.11 presents the participants’ beliefs about the seriousness of having the problem described in the vignette. Of the participants, 59.3% considered the problem to be “very serious”, 24.0% said it was “extremely serious”, 14.7% chose “moderately serious” and only 2.0% said it was “a little serious”.

Table 5.12 presents the participants’ views about the difficulty of treating the problem described in the vignette. Of the participants 46.0% thought that the problem would be “very difficult” to treat followed by 28.7% who thought it would be “moderately difficult” and 21.3% who thought it would be “extremely difficult”.

Table 5.13 presents the participants’ views about the likely result if the person described in the vignette received the help the participant considered to be most appropriate. An equal number of participants (29.3%) endorsed the options of “full recovery with no further problems” and “full recovery but problems re-occur”. Another 14.0% said “partial recovery” and 10.0% said “partial recovery but problem re-occur”.

95
Table 5.10 Perceived levels of distress associated with problem described in the vignette

<table>
<thead>
<tr>
<th>Perceived Distress</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very distressing</td>
<td>73</td>
<td>48.7</td>
</tr>
<tr>
<td>Extremely distressing</td>
<td>53</td>
<td>35.3</td>
</tr>
<tr>
<td>Moderately distressing</td>
<td>18</td>
<td>12.0</td>
</tr>
<tr>
<td>A little distressing</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Not distressing at all</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Table 5.11 Perceived seriousness of the problem described in the vignette

<table>
<thead>
<tr>
<th>Level of seriousness</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very serious</td>
<td>89</td>
<td>59.3</td>
</tr>
<tr>
<td>Extremely serious</td>
<td>36</td>
<td>24.0</td>
</tr>
<tr>
<td>Moderately serious</td>
<td>22</td>
<td>14.7</td>
</tr>
<tr>
<td>A little serious</td>
<td>3</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Table 5.12 Number and percentage of participants mentioning each difficulty category in treating the problem in the vignette

<table>
<thead>
<tr>
<th>Level of difficulty</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very difficult</td>
<td>69</td>
<td>46.0</td>
</tr>
<tr>
<td>Moderately difficult</td>
<td>43</td>
<td>28.7</td>
</tr>
<tr>
<td>Extremely difficult</td>
<td>32</td>
<td>21.3</td>
</tr>
<tr>
<td>A little difficult</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Not difficult at all</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Table 5.13 Number and percentage of participants mentioning each outcome category if appropriate help is obtained by the individual described in the vignette

<table>
<thead>
<tr>
<th>Category response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full recovery but problems re-occur</td>
<td>66</td>
<td>29.3</td>
</tr>
<tr>
<td>Full recovery with no further problems</td>
<td>44</td>
<td>29.3</td>
</tr>
<tr>
<td>Partial recovery</td>
<td>21</td>
<td>14.0</td>
</tr>
<tr>
<td>Partial recovery but problems re-occur</td>
<td>15</td>
<td>10.0</td>
</tr>
<tr>
<td>No improvement</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Get worse</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>
5.1.7 Attitudes to a person experiencing mental health problem

Table 5.14 presents the participants’ reported attitudes to a person experiencing a problem similar to that described in the vignette. Asked how sympathetic they would feel towards this person, 52.7% of participants reported that they would feel “very sympathetic” towards a person experiencing this problem, 24.0% said they would be “extremely sympathetic” and 19.3% said they would be “moderately sympathetic”.

Table 5.14 Level of sympathy expressed towards someone experiencing the problem described in the vignette

<table>
<thead>
<tr>
<th>Level of sympathy</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very sympathetic</td>
<td>79</td>
<td>52.7</td>
</tr>
<tr>
<td>Extremely sympathetic</td>
<td>36</td>
<td>24.0</td>
</tr>
<tr>
<td>Moderately sympathetic</td>
<td>29</td>
<td>19.3</td>
</tr>
<tr>
<td>A little sympathetic</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Not at all sympathetic</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

When asked whether they believed a person experiencing this problem would be discriminated against by others in the community, 38.7% of participants thought that the individual would be discriminated against.

5.1.8 Treatment preferences, causes and risk factors selected by participants who correctly identified PTSD

The responses of participants who had correctly identified PTSD (n = 46) as the problem described in the vignette were analysed. Participants who had correctly recognised PTSD were most likely to select “psychotherapy focusing on the past” as the most helpful treatment (n = 10), both vitamins and minerals and herbal medicines as the equally most helpful medicines (n = 13), and a psychiatrist as the most helpful service (n = 22). Lastly, participants who identified PTSD considered “experiencing a traumatic event” the most likely cause (n = 15) and “being born in a war-torn country like Afghanistan” the most likely risk factor (n = 22).

5.1.9 Personal experiences related to vignette

Participants were asked a number of questions about their own experiences relating to mental health problem recognition and awareness and utilisation of available
treatments. When asked whether they might currently have a problem like the person in the vignette, 74 participants (46.3%) reported that they may have a similar problem, 88 (58.7%) said that they may have had a similar problem in the past, and 62 (41.3%) said that a professional had told them in the past that they may have a similar problem to that described in the vignette. Further, when questioned about help-seeking, 74 (49.3%) indicated that they had sought help, with approximately one third of participants, 47 (31.3%) stating they had sought help more than 12 months ago. Of the participants who reported seeking help, 80 (53.3%) had sought help from their general practitioner. Table 5.15 presents other persons or services that participants reported seeking help from.

**Table 5.15 Sources of help approached by participants who had suffered a mental health problem similar to that in the vignette**

<table>
<thead>
<tr>
<th>Service / People</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>80</td>
<td>53.3</td>
</tr>
<tr>
<td>Psychologist</td>
<td>58</td>
<td>38.7</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>50</td>
<td>33.3</td>
</tr>
<tr>
<td>Community mental health worker/team</td>
<td>14</td>
<td>9.3</td>
</tr>
<tr>
<td>Family member</td>
<td>14</td>
<td>9.3</td>
</tr>
<tr>
<td>STTARS*</td>
<td>7</td>
<td>4.7</td>
</tr>
<tr>
<td>Close male friend</td>
<td>6</td>
<td>4.0</td>
</tr>
<tr>
<td>Close female friend</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Religious leader</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Telephone counselling line</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Afghan social group</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

*Survival of Torture, Trauma and Rehabilitation Services (STTARS)

In response to the question, “Who did you seek or receive services from?”, 80 participants (53.3%) responded that they had sought help from their general practitioner, 58 (38.7%) from a psychologist, 50 (33.3%) from a psychiatrist, 14 (9.3%) from a community mental health worker and 14 (9.3%) from a family member.

Participants were also asked about the prevalence of the problem in their community. One hundred and five participants (70.0%) stated that someone in their family or circle of friends may currently have or previously had a problem like that of the person in the vignette. Table 16 presents participants’ beliefs about the prevalence of
the problem in their own community. The most commonly endorsed estimate, by 31.3% of participants, was that more than 70% and less than 90% of the community experienced it, with 22.0% of participants estimating 90% or more than 90% of the community.

**Table 5.16 Participants’ estimated prevalence rates of problem in their community**

<table>
<thead>
<tr>
<th>Estimated prevalence</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 70%, less than 90%</td>
<td>47</td>
<td>31.3</td>
</tr>
<tr>
<td>90% or more than 90%</td>
<td>33</td>
<td>22.0</td>
</tr>
<tr>
<td>More than 50%, less than 70%</td>
<td>33</td>
<td>22.0</td>
</tr>
<tr>
<td>More than 30%, less than 50%</td>
<td>21</td>
<td>14.0</td>
</tr>
<tr>
<td>More than 10%, less than 30%</td>
<td>14</td>
<td>9.3</td>
</tr>
<tr>
<td>Very few women/men, less than 10%</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

### 5.1.10 Help-seeking behaviours

Participants were asked who they would first seek help from if they were to experience a problem like that described in the vignette. Table 5.17 presents the number and percentage of participants who rated each source of help as the person or service they would approach first for assistance. The persons/services rated most highly as the first person they would approach for help with this problem was a general practitioner (26.7% of participants), followed by psychologist (24.0%), and psychiatrist (23.3%).

**Table 5.17 Number and percentage of participants who rated a particular person/service as the source they would first approach for help**

<table>
<thead>
<tr>
<th>Service/People</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>40</td>
<td>26.7</td>
</tr>
<tr>
<td>Psychologist</td>
<td>36</td>
<td>24.0</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>35</td>
<td>23.3</td>
</tr>
<tr>
<td>Family member</td>
<td>25</td>
<td>16.7</td>
</tr>
<tr>
<td>Religious leader</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>Close female friend</td>
<td>3</td>
<td>2.0</td>
</tr>
<tr>
<td>Close male friend</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Community mental health worker</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Afghan social club</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.7</td>
</tr>
</tbody>
</table>
5.1.11 Examination of associations between MHL and individuals’ demographic and clinical characteristics

Statistical comparisons were used to investigate any associations between participants’ socio-demographic characteristics and specific aspects of MHL (e.g. problem recognition, symptoms levels, beliefs about the helpfulness of specific treatments and treatment providers, perceived barriers to treatment).

The number of years of education a participant had received was found to influence problem recognition ($H = 18.87$, $p = .009$). Participants who selected PTSD as the problem had received more years of education ($M = 8.28$, $SD = 4.91$) compared to participants who selected fear ($M = 4.41$, $SD = 4.96$, $U = -33.15$, $p = .010$). The treatment participants selected as most helpful was influenced by a participant’s age ($H = 25.65$, $p = .007$), however, follow-up analyses were unable to locate the source of this significant result. Furthermore, the number of years of education influenced the participant’s selection of the most helpful treatment ($H = 39.87$, $p < .001$). Participants who had fewer years of education were more likely to consider reading the Koran/Bible ($M = .22$, $SD = .67$) than consider psychotherapy focusing on changing thoughts/behaviours ($M = 10.09$, $SD = 4.84$, $U = -80.99$, $p < .001$). Similarly, participants who had fewer years of education were more likely to consider improving diet and exercise ($M = 3.92$, $SD = 4.71$) than consider psychotherapy focusing on changing thoughts/behaviours ($U = -51.28$, $p = .003$). The number of war events a participant had experienced influenced the selection of the most helpful medicine ($H = 8.45$, $p = .015$); however, follow-up analyses were unable to locate the source of these significant differences with a Bonferroni-adjusted $p$-value of .01. The person or service participants selected as most helpful was influenced by whether or not the participant was likely to have depression ($\chi^2 = 17.06$, $p = .048$). Participants who had depression were more likely to consider a close female friend as the most helpful person (9.1%) than participants who did not have depression (0.8%). The age of a participant also influenced the selection of the most helpful person/service ($H = 19.11$, $p = .024$). Participants who were older were more likely to view a religious leader as the most helpful person or service ($M = 57.50$, $SD = 11.22$) than they would a general practitioner ($M = 29.35$, $SD = 10.80$, $U = 77.21$, $p = .005$). The number of years of education a participant had...
received influenced the selection of a most helpful service, $H = 20.32$, $p = .016$, as
did the number of war events experienced, $H = 22.92$, $p = .006$; however, follow-up
statistical analysis was unable to locate the source of these significant findings.
Participant demographic characteristics did not significantly influence selection of
the most likely causes or risk factors.

5.2 Study Two: Qualitative Interviews:

Findings from the qualitative research raised several issues that revealed deeply held beliefs and perceptions pertaining to mental illness and its treatment. Participants revealed how negative connotations around mentally ill people gave rise to derogative labels such a ‘crazy’ limiting treatment options to non-medical activities and life style changes. Such stereotypes can quickly take hold and curtail help seeking activates that conceal symptoms from others including family. Maintaining the public face of normality and respectable was nominated by participants as critical. The underlying sense of shame and stigma that encircled mental illness was a primary factor motivating the veil of silence and suffering. These overarching themes from the qualitative interviews are considered in the next section and include, shame, gossip, and stigma associated with mental illness as well as barriers to treatment. The following will also discuss what strategies participants utilised when attempting to address their symptoms and how alternatives to medical intervention was pursued that encapsulated participants spiritual beliefs as well as life style changes, all in an effort to avoid public scrutiny.

5.2.1 Barriers to treatment

Analysis of the interview data showed that humiliation, embarrassment and shame associated with mental illness and help-seeking behaviour are constrained by social, cultural and emotional forces, compelling a lot of refugees to hide their mental health issues. Participant SA 3 (female, 41, Afghan/Hazara, married, permanent resident, refugee, education year 0) referred to this as living her life “in a lonely corner”. The stigma of mental illness was clearly recognised by participants as a potent force in setting up barriers to help-seeking. In order to avoid detection it was preferable to conceal symptoms and “behave normally” as “a respectful person” and “successful person as participant SA 82 (female, 43, Afghan/Hazara, married, permanent
Consequently, for those needing help with their mental health, stigma shamed them into silence. Several participants attested to this. For example, participants 44, 1 and 84 reported that because of the anticipated humiliation and shame they would not talk about their mental health issues or seek help.

In this section, I first present the shame associated with mental illness and the tactics participants use to conceal these symptoms. Second, I discuss the prevalence of gossip about mental illness amongst community members, which was said to prevent those who suffer from a mental illness from disclosing it in order to save face and prevent friends from feeling burdened by their problems. Third, I present participants’ perception of health professionals. Although it was not the case for all participants, many described confiding in GPs as a safe means of disclosing their mental illness and seeking help. Finally, I discuss stigma. The stigma associated with a mental illness can lead to isolation, which can exacerbate mental health problems.

5.2.2 Shame

On the whole, participants described a deep sense of shame about experiencing symptoms of mental illness. This prevailing shame threatened the interconnectedness of the individual to their community and in some cases their family. As a consequence of shame there was a persistent pressure to conceal the illness to save face and subsequently those who experienced mental illness attempted to maintain the illusion of “normality”. For those with mental illnesses, this led to avoidance of others and non-disclosure to family members, and ultimately impacted on help-seeking behaviours. For example, Participant SA 76 (male, 31, Afghan/Hazara, single, Australian citizen, refugee, education: university student) said he would be less likely to talk about his mental health problems with certain people.

It depends if I am in the Afghan community. I don’t talk about my emotional health or those people same age like me or close friends because you want to be seen by them as a respectful and successful person and keep that relationship as natural as possible.... You don’t want your friend to see you as an unhappy person and put pressure on them to make you happy or keep you happy.
The social expectation of normality triggered a hyper vigilance amongst participants to ensure they did not reveal their thoughts or symptoms, thus avoiding shame and maintaining a façade of health. One participant explained this concealment, saying:

*I think it is shameful to have a mental illness. I will not go to any community people and say I have a mental illness. I will be so careful to behave normally when I am around Afghan people. Some people [1–2 sec pause] are good but some might say I am crazy, that I can’t cope and I am a weak person. They might laugh at me. These are the reasons I don’t talk to people and try to hide my problems... They can’t help me anyway... it will make my condition worse.*

(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, refugee, education: year 4)

Others also described mental health problems as shameful:

*I do feel ashamed telling others about my mental illness. I don’t like to tell them because some people won’t guide you. Instead they make your condition worse.*

(Participant SA 44, female, 21, Afghan/Hazara, single, Australian citizen, refugee, education: year 12)

(Participant SA 1, female, 30, Afghan/Hazara, recently divorced, Australian citizen, refugee, education: year 3) was similarly hesitant about discussing her mental health problems:

“Sometimes I feel ashamed to talk about it. If I tell them about my illness they will think differently about me.”

Another participant suggested that having an education is important to understanding mental health issues. He reported “Those who [1-2 sec pause] are illiterate, they do not know about mental illness. They may look down on someone who is mentally ill.”

(Participant SA 84, male, 25, Afghan/Hazara, married, permanent resident, refugee, education: year 5). This suggests that the low level of literacy amongst the Afghan...
refugee population may be implicated in the shame and secrecy surrounding mental illness.

5.2.3 Gossip

Contributing to this shame was gossip, which was described as rampant within the Afghan community. Participant SA 125 (male, 20, Afghan/Hazara, single, Australian citizen, refugee, education: year 10) said: “I don’t think there is anything in the world that people don’t gossip about... They say this and that bad thing.” Because of this, participants avoided discussing their mental illness. Participants noted their fear of others knowing their issues with mental illness, because mental illness is a popular topic of gossip, and to be a topic of gossip is intensely shaming. Gossip played a role in maintaining the stigma and the fear that others may talk, encouraging silence and inevitable isolation. A young woman, for example, said:

Yeah when you are mentally ill you feel embarrassed and ashamed. For instance if I talk to people about my illness they look at me in a weird way and if I see them the next time, even if they talk about something else, I feel like they are talking about me and my life.

(Participant SA 1, female, 30, Afghan/Hazara, recently divorced, Australian citizen, refugee, education: year 3)

Gossip was thought to perpetuate the idea that those with mental illnesses are crazy and this fear prompted individuals to conceal or monitor their behaviours, thoughts, words and feelings. In a number of cases this fear warranted a protective response. Participants spoke of protecting friends and loved ones from discussions of their issues. They feared that any talk of mental illness would be a burden to family or friends or could lead to gossip. One young man, for example, was worried about others thinking he was mentally ill and therefore tried to conceal his issues from his friends and did not wish to burden them:

I kind of felt embarrassed to talk about it because I was worried if I talked to someone they will tell me I have a mental illness. When I was calling my family I always told them that I am good, I have no problems because [thinking, 1–2 sec pause] I didn’t want them to worry about me. So I didn’t want my friends to know about me.
Perhaps because of the pervasiveness of gossip, participants described a strong preference for maintaining a clear distinction between their private lives and public presentation. They believed there was a cultural expectation that they keep their mental health issues private:

> We Afghan people, we don’t talk about things. We keep it inside. In our culture it is shameful to talk about your problems. We have a saying, ‘If it gets out of your mouth, it gets into the world’. This person tells the next person and the next so on and so on. After a while the whole world will know about your problem.

A young man warned against talking to others and regretted having done so. However, he recognised the widespread desire to do so:

> You know sometimes you shouldn’t talk about some stuff with others, but you can’t control your mind and you say it. Later I realised and regretted it and I tell myself I shouldn’t have talked about these things. It happens to me a lot. I felt embarrassed later, but these things happen in life. You can’t control it.

Two participants reported avoiding conversations about mental illness at all costs and went so far as reporting that they would not venture out of their home should anyone perceive them to be experiencing a mental illness, such was the stigma attached. Participant SA 121 spoke about the strength of this stigma:

> If they gossip about my illness I would feel really bad and feel embarrassed. I will stay home, not even leave home. I would avoid everyone and stay at home quietly... You can fight it [mental health problem] yourself.
It was considered more acceptable to treat oneself in isolation rather than have the matter disclosed or shamefuly revealed in the public domain. Participant SA 1 described self-imposed isolation in the following way:

*I feel like I want to stay home. I don’t want anyone to be with [me]. I think a lot, I think, ‘What should I do? How should I solve my problems?’ I begin to feel more hopeless. I don’t want to see anyone, don’t want to go anywhere. If people came to my home and want to talk, I did not like it.*

5.2.4 Help-seeking

The shame about seeking help, perpetuated by gossip, posed a significant barrier. Other barriers to treatment were related to finances and mental health symptoms. In this section, financial and mental health barriers to treatment are described first, before a full exploration of the barrier of stigma, described by participants most often and in depth.

Only one participant described their monetary situation as a barrier to seeking medical or psychological care. Participant SA 9 (male, 42, ) said, “I could not afford that.” Two participants described symptoms related to depression as barriers to leaving their homes, which in turn could be a barrier to seeking support for their mental health problems:

*If you are mentally ill you feel like you are different. You want to be left alone. You don’t want to be with people. You prefer to be with yourself no one else.... All I wanted to do was to stay in my room.*

*Participant SA 131, 18, Afghan/Hazara, single, Australian citizen, refugee, education: year 6*)

For one woman the depression was a desire to stay not just at home, but in bed. When her friend asks her to join her to go shopping she:
“… usually refuse[s] and tell[s] her, ‘Let me stay home and sleep.’ I really like to stay in bed... be alone and living my life in “a lonely corner” but I don’t sleep. [Later in the interview] I cover my face with [my] quilt.”

(Participant SA 3, [Participant name redacted])

Most participants, however, said that the stigma related to having a mental health issue had prevented or would prevent them from seeking out professional support. Gossip also prevented many from seeking professional help for their mental health problems, fearing the shame and exposure that would follow if spotted visiting a psychologist’s office. One participant described taking this risk, but did not disclose these visits to his family. He went to see a psychologist, but he stated that no one knew about him seeing a psychologist.

When I came to Australia one and half years ago I wasn’t feeling well and I went to see a psychologist. Because I was over 18 years, nobody including my family knew that I was seeing a psychologist. Nobody knew about this, even my family.

(Participant SA 125, [Participant name redacted])

Others described GPs as a safe means of disclosing their mental illness because of the generality of the profession. If they were seen going into a GP’s office it would not necessarily be perceived to be because of mental health issues. Some participants adopted this strategy to avoid scrutiny from others. It was believed that outsiders were more likely to be trusted than family, friends or community links. This anonymity appeared to protect them from stigma and shame in their communities. For example, Participant SA 120 ([Participant name redacted]) said, “I won’t talk to [a] friend. I will talk to a doctor.” Participant SA 1 ([Participant name redacted]) said she would only talk to her doctor: “I feel comfortable talking to the doctor only.” Participant SA 79 ([Participant name redacted]) said he disclosed the truth about his mental illness to his doctor: “I thought it was my private problem. I was trying to solve it myself. But when I went to my doctor I told him the truth.”
One person described doctors as outsiders and therefore more trustworthy than insiders in relation to mental or other health problems:

*In my opinion the best way is to see your doctor because your doctor is an outsider. They do not know you personally, so you can trust them and tell them everything [later in the interview] you can trust that your doctor will give you proper treatment or advice.*

*(Participant SA 2, female, 31, married, Afghan/Hazara, refugee, Australian citizen, education: year 8)*

Others would not risk seeing even their GP; this left them isolated, with no one with whom they could share their problems. A fear of medical procedures and hospitals led one woman to avoid seeking help from any professionals:

*In general I am scared to seek help from my doctor. For example, even if I injured my leg, I wouldn’t go to the doctor because she or he might operate on me and I hate hospitals and [1–2 sec pause] going to the doctors and operations. ... I do feel ashamed to talk about it like many other people.*

*(Participant SA 44, female, 21, Afghan/Hazara, single, Australian citizen, refugee, education: year 12)*

Some participants described friends as unhelpful to talk to because they could be dismissive, judgemental or overly critically of people with a mental illness, for example:

*Friends are not helpful. They say, ‘you live in such a peaceful place. Enjoy life. Think about yourself. You will die if you think too much.’ ... I especially hate it when they advise me to enjoy my life; I hate that! Then I don’t talk to them because they do not understand me and my problems.*

*(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year 0)*

On the other hand, some participants described limited sources of support, saying they could only trust their mothers or very close friends:
I was comfortable talking with my mother, sometimes with my friends. It was not like I had to tell everyone [laughing], but my mother yes I feel like she is my best friend, I can tell her everything.

(Participant SA 131)

At the beginning I did not have anyone to go to, but slowly I got to know some people and found some friends. So [1-2 second pause] I usually went to my friends and talked to them.

(Participant SA 82)

Confiding in a friend with shared interests meant less isolation to Participant 83, who observed, “As I said, my friends are the same like me. I do talk to them.” Another participant, however, said that there are some people in the community who would understand her and help her, but not all.

Within the Afghan community we have some intelligent people. They will guide and understand you. Those who do not care they would say, ‘You’re crazy.’ They would not listen to you.

(Participant SA 1)

By far the majority of participants described stigma as the most influential factor preventing or determining help-seeking behaviours. This prevailing fear of being misjudged and stigmatised placed intense pressure on individuals to conceal their mental health issues and to speak only to trusted family members or, in some cases, to friends. It was rationalised that seeing a GP was the safest option because GPs were considered nonpartisan “outsiders” and unlikely to disclose the identity of the patient or pass judgement. This helped safeguard against the inevitable stigma and assured anonymity. Nonetheless, for a few participants, the powerful influence of stigma prevented them from seeking help even from their GP, thus leaving them with no treatment options.
5.2.5 Stigma

The stigma associated with mental illness pushed many into isolation, which can exacerbate mental health problems. Mental illness was regarded amongst participants as a problem and deviation from normality, which is stigmatised within the community. The word “crazy” was used by a number of participants when describing someone with a mental illness. It should be noted, however, that there did appear to be a tendency to label both those with mental illness and those with an intellectual disability as crazy. Nonetheless, the stigma associated with mental illness meant that those suffering from the illness experienced social exclusion. For example, Participant SA 9 (male, 42, Afghan/Hazara, married, Australian citizen, refugee, education: year 10) explained that people’s sensitivity towards mental illness is such that if a person in their family had a mental illness they would sever all ties with others for fear of gossip and labelling. He explained:

>If you have a child who has an intellectual or mental disability, the family will cut themselves off from others because they don’t want anyone to know that you have a mentally ill person in your family. They don’t even want to discuss these issues with anyone outside the family… Because they feel if people in the community found out they will talk about it. …. Yeah in Afghanistan it is common for people to call you names. They called me crazy. It is common if someone is limping – they do not call him by his name, they call him ‘limper’. Or, if someone can’t see, they call them ‘blind’ directly to their face.

Two participants reported that, because of the stigma, they would rather not talk about their illness with anyone to maintain their public face. They were concerned because of the size of the community and lack of confidentiality:

>“This woman talks to others about her private stuff. I would rather not tell them about my mental illness.”

(Participant SA 1, female, 30, Afghan/Hazara, recently divorced, Australian citizen, refugee, education: year 3) another participant said,
Even, sometimes rarely, if you find someone you think you can trust and tell them about your problems, even that person will not keep your secrets despite the fact that you asked them 10 times not to disclose that information [laughing].

(Participant SA 2, female, 31, married, Afghan/Hazara, refugee, Australian citizen, education: year 8)

This participant also noted the detrimental impact of keeping a mental illness a secret, which leads to an exacerbating cycle. “So if you can’t talk about it and you hide it from everyone, of course one day you get sick.” Participants feared that others in the community would see them as being “crazy”, reflecting Afghan cultural beliefs about mental illness and their limited understanding of the issues and symptoms. Such beliefs about mental health extended to the world of the supernatural. A number of those interviewed expressed fear that others would equate the symptoms with that of an “evil spirit” taking hold, controlling their behaviours and physical self. Some viewed this as a punishment from God. Such beliefs inevitably discredited individuals as spiritually possessed rather than experiencing a treatable condition. In turn, the attached stigma prevented participants from using conventional methods to seek help, leading to further isolation:

People would make fun of me as they believe [1-2 second pause] – kind of believe that mental health is all about an evil spirit in the person.

(Participant SA 47, male, 23, Afghan/Hazara, married, Australian citizen, refugee, education: university student)

In the Afghan community people who are not very educated, including me, would think you were a bad person sometimes in your life to get ill or they might think it is a punishment from God ... and they judge easily.

(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, refugee, education: year 4)

Several of those interviewed spoke of the stigma attached to their condition. They feared that should they speak or disclose anything about their mental health issues within the Afghan community they would be perceived as crazy, out of their mind or irrational. Many believed it was better to hide their mental health issues and keep their secret for fear of being labelled and even ostracised:
Yes of course you feel ashamed. People think you talk nonsense, you are crazy [laughter].

( bytecode)

They [people] think I lost my mind. Some people will think I am out of my mind, [that I have] lost my mind. Some would think I am having problems and advise me to go see a doctor or go for a holiday.

( bytecode)

Many described this fear of being viewed as crazy as a barrier to discussing mental health symptoms or a cause for regret if they did. Several talked about the shame and stigma associated with talking too much, which people within the Afghan community often perceived as a symptom of craziness, as evidenced in the following statement by a young male refugee:

I won’t talk about my mental illness with my friends. They would call you [me] crazy etc. [smiles slightly]. It is because the concept of mental health is not understood over there [Afghanistan].

( bytecode)

Other participants felt guilty and apologetic after disclosing their worries to others. For example:

When I am anxious and worried I am all over the place. I call my doctor, teacher etc., and then I have to apologise and tell them my thoughts are somewhere else as I say things I shouldn’t be saying.

( bytecode)

Two participants described talking too much as a source of shame. One said, “You feel ashamed. People think… you are crazy” (Participant SA 2, ). Another felt ashamed when liaison workers at the refugee association recommended that she see a
mental health professional. She thought she must have been talking too much, prompting these workers to suggest that she see a health professional:

*People at the refugee association asked me to see a counsellor or psychologist but in my opinion when they said that I felt ashamed because I thought I may look like those who are mentally ill or I may talk too much.*

*(Participant SA 74, female, 29, Afghan/Hazara, married, Australian citizen, refugee, education: year 12)*

A number of participants described a diagnosis of a mental health disorder as quite stigmatising, leading to embarrassment and social exile. A young man, for example, was concerned that disclosing issues related to a mental health problem would be acutely shameful and therefore could not be openly discussed: *“I kind of felt embarrassed to talk about it because I was worried if I talk to someone they will tell me I have a mental illness.”* *(Participant SA 79, male, 22, Afghan/Hazara, single, permanent resident, refugee, education: year 11)*

For others, it was preferable to have an internal dialogue with themselves rather than talk to others. Some even avoided talking to their doctor about mental health issues for fear that someone would hear the conversation with the doctor. A young woman described this fear:

*I’d rather chat to myself, especially when I am by myself... I don’t talk about my problems easily because I think people may react differently or laugh at me. If I were to talk to my doctor and if there are other people around they might find out about my problems and they [people] will think how ridiculous I am.... I do not feel comfortable to talk about my mental illness.*

*(Participant SA 44, female, 21, Afghan/Hazara, single, citizen, refugee, education: year 12)*

Fear of being confined to an institution was another issue. Speaking about her conversation with another refugee, a female participant said:
The first time I spoke with another refugee she said that I was not crazy to see a psychologist. I told her that if you go crazy they will lock you up in a mental ward.

(Participant SA 112. [Redacted])

Participants within the Afghan community consistently reported an overwhelming sense of humiliation, embarrassment and shame associated with mental illness, and this constrained and hampered help-seeking behaviours. In some cases, participants had taken the condition or symptoms into the realm of the supernatural. The resultant fear and misunderstanding produced stigma and affected help-seeking behaviours. These socially and culturally established attitudes, values and sanctions drove individuals with mental health issues to conceal their symptoms, thoughts, emotions or appearance from others, including their family. Such was the power of the stigma and shame that for some, imposed social isolation contributed to an escalation of their mental health issues. It was preferable to maintain a social face of respectability and normality than to reveal deep despair, depression, anxiety or even sleep disturbance. This concealment came at a price, but also avoided a widespread fear of gossip, satisfying a strong desire to be accepted as a useful and “normal” community member. Indeed, there was a clear understanding, but also acceptance, that individuals would keep their mental health problems away from the public domain, thus maintaining the illusion of normality and stability. This did not, however, extend to discrete visits to GPs, who were considered outsiders and therefore more likely to be trusted and less judgemental, protecting patients from community shame and stigma. Doctors were recognised by most participants as the most appropriate source for treatment. Going to a doctor was considered acceptable because they treat all types of illnesses. Seeing a doctor does not imply a mental health issue and ensures that no one is likely to ask questions about the nature of the visit, thus ensuring privacy and avoidance. Yet, for some, the potential shame was so overwhelming that even visiting a GP posed far too great a risk of exposure, thus leaving them with few options but to remain untreated and isolated.

“Living in the corner” would appear to be a relevant metaphor for those living with mental health issues within the Afghan refugee community. It reflects comments from participants who referred to notions of isolation, silence and being set apart,
because their mental health issues meant they did not conform to ideas of what was considered normal, respectful and successful. The respect and esteem of others within the community was highly valued by participants. Mental health issues threatened this esteem. Participants noted adamantly that any slip or disclosure could result in a loss of community standing and reputation. Stigma and shame remain potent barriers to help-seeking, maintaining the overwhelming pressure to cover symptoms, guarding against revealing inner thoughts, and prompting many Afghan refugees to stay silent about concerns or symptoms.

5.2.6 Specific aspects of mental health literacy/beliefs

In this section, participants’ beliefs about the causes of mental illness are presented at three separate levels: global, middle and local. At the global level, wider political unrest was blamed as the first and most important factor. Recurring thoughts of the killings and kidnappings of family members were linked to ongoing mental health issues. At the middle or meso level, most participants talked about vital factors that concerned them critically, primarily their migration to or seeking asylum in Australia. New challenges and gaps helped heighten their alienation and contributed towards loneliness, resulting in adjustment difficulties and emotional instabilities. Lastly, at the local level, participants believed that good mental health is about individuals’ perceptions and actions. Good mental health was reflected in actions and abilities, such as making sound decisions, having the confidence to carry out day-to-day tasks, meeting their responsibilities, and having effective coping strategies.

On the whole, participants reported that the fear of others knowing about their mental illness, the associated stigma and being viewed as crazy were the most powerful influences that created impenetrable barriers to help-seeking. Participants recognised that people with mental illness were often subjects of gossip within the Afghan community. To maintain their self-esteem and standing within the community they felt it was imperative to conceal their symptoms, thus maintaining the respect of others. As part of camouflaging their mental illness participants sought out their GP, because as described above in the previous section the generality of the profession provided a safe way to address their mental health issues. Alternatively, some participants reported that they prayed and read the Koran and this helped them overcome some of their mental health issues. A minority of participants viewed
religion as a source of oppression and rejected all religious interventions, including speaking to religious leaders.

5.2.6.1  Wider political unrest/conflict (global level)
Several participants reported that good mental health comes about if there is an opportunity to live in peace, in an environment that does not expose them to war and they don’t have to witness killings. This extended to describing how the conditions of war impacted on people’s ability to carry out routines necessary for day-to-day living and how it shapes their daily lives. Without the disruptions of bombings participants recognised that they could participate fully in the daily rituals of work, shopping, recreation and family activities – activities that are all linked to mental health. In the following account Participant 3 (female, 41, Afghan/Hazara, married, permanent resident, refugee, education: none) clearly describes the condition of war and its traumatising impact:

Since I was born I have never known peace. All the time I would think, ‘At any moment I will be killed. I will be killed today or tomorrow.’ Sometimes for weeks we didn’t have anything to eat. It wasn’t because we could not afford to buy food, it was because we couldn’t go out as the rockets were exploding everywhere. The roads were blocked by different warring groups and we had to live in the basement for weeks.

There was recognition that good mental health also included an absence of grief and loss and protection from human atrocities. Another participant clearly identified that the memories of war and losing family members had been a source of trauma for him, as well as the impetus to flee his country and leave his family behind:

You know [1-2 sec pause] I myself am a refugee child and have seen many atrocities back in Afghanistan. Losing a family member in the war is something I can never forget. I went through serious trauma in the past [looking upset and looking down for couple of minutes]. Yeah, what can I say further to this? The experience of leaving my own country and loved ones behind has added to my mental illness.

(Participant SA 47, male, 23, Afghan/Hazara, married, Australian citizen, refugee, education: university student)
It was reported that growing up in a war-torn country as a young person was traumatising. “Back home when I was a young man I saw too much. I saw people killing each other, robbing each other,” said Participant 83 (male, 37, Afghan/Hazara, married, bridging visa, refugee, education: year 12). Some said that they had hoped that once they had left their war-torn country they would find peace and be allowed to live a normal life, and their bad memories would therefore eventually fade. However, they soon realised that the memories of the war and atrocities remained in their thoughts for life and in some cases the impact was detrimental, as the following statements testify:

I thought when I come to Australia I would forget about my past and start a new life but it is not easy... for example we all lost a family member in war. [Later in the interview] It is preventing me from having a good sleep and positive thoughts.

(Participants SA 42, female, 19, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

Also when we think about war-torn countries and the situation over there [Afghanistan] that witnessing killing of their family members or witnessing bombing and these kind of impediments can impact on the mental and emotional health.

(Participant SA 76, male, 31, Afghan/Hazara, single, Australian citizen, refugee, education: university student)

Two participants recognised mental illness as the result of unhappy life experiences that can stay forever. They described losing family members during the war and reported that escaping the war is not something people can forget. Memories were said to travel with the person wherever they go. The following reports describe this in detail:

In my opinion if you are not happy about your life you become mentally ill. For instance some of us came from a war-torn country and have lost family members in the war.

[Later in the interview]

We have escaped war; we’ve lost lots of family.
We brought all these problems with us; we cannot get rid of these problems. What happened over there [Afghanistan] is always with you. Once you have been damaged like that it is not easy to be normal again. They bring mental illness with them. This is because during the war they lost members of their family.

One participant described his empathy for those who lived in war-torn countries and lost family members. He considered that people’s coping and functioning abilities can be affected and as a result, they would eventually develop a mental illness later in life:

For example people from [a] third world country, coming from war-torn countries or have lost family member - it would be really hard to cope with problems... in our society these things happen very often. For example someone can have a really tough life and bad experiences or be separated from the family or have been tortured in the past. All these things can have a huge impact on mental health.

A few participants said that when they meet together in community groups they shared stories and their fears amongst themselves. They constantly worried about war and suicide bombers because they still have some family members living in that kind of situation. The following account voiced the thoughts of many:

When I have someone around then [we] talk about our past lives. Then we get upset. But before going to bed I mostly think about my family. I always pray to God to keep them safe from danger and wonder if they are going to school and if suicide bomber explodes a bomb while they [my family] are at school or their way to school.

[Later in the interview]
I worried if they are on their way to school they may be killed.

(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year one)

Witnessing killings and kidnappings was clearly identified as an unforgettable and traumatising event that had a direct impact on mental health:

Those who have seen others killed in front of their eyes. Witnessing others kill each other has a huge impact on your mental health. For example sometimes you sit in a taxi and see the taxi driver is killed. That can have a huge impact on people..... Or they may have relatives kidnapped and be asked for money so these things can affect you badly.

(Participant SA 84, male, 25, Afghan/Hazara, married, permanent resident, refugee, education: year 5)

The genocide of some of the minority ethnics in Afghanistan during Taliban rule was identified as a source of fear and terror. During the Taliban regime family units were dispersed, family members murdered, and family ties and connections irretrievably severed. Because of the patriarchy that exists in Afghan culture, the absence of the male exposes female members to potential threats. Participants who described recurring thoughts and fears that were prevalent in their daily lives referred to such schisms and upheavals. It did not seem to matter that they no longer lived in that kind of situation; they still experienced the terror and lack of security. In addition, the loss of significant family members disrupts the family dynamic, including the role and function of the individuals, as described in the following report:

I lost a family member, a few of them. Some went missing and never came back. Some were killed [pause 1-2 sec]. I think about those days all the time. The war, the Taliban, the killing of Hazara people in the north of Afghanistan.... Four out of five women were widows..... Most of them had small children. Those fears never go away; always there, always there, repeating.

(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, refugee, education: year 4)

Overall, participants reported that thoughts of the past can remain troublesome, causing them to feel concerned for others who still live in war conditions. A young
woman summed this up, saying, “The thought of the past is still with me and there are times it bothers me and I think about those people who still live in war and in that kind of situation” (Participant SA 44, female, 21, Afghan/Hazara, single, Australian citizen, refugee, education: year 12).

In conclusion, a majority of participants described some form of traumatic experience, which led them to develop symptoms of mental illness. These traumatic thoughts were mainly about what happened to them and to their families back in Afghanistan during the war and Taliban rule. These participants talked about recurring thoughts of the killings and kidnappings of family members. They identified specific events and occurrences linked to ongoing issues: preoccupied thoughts and disruptions in their capacity to function. They initially thought that leaving behind the atrocities they witnessed in the past would provide a feeling of peace, allowing them to regain control over their circumstances. However, despite experiencing improved security in their host country, they eventually found that the past experiences remained ever present, limiting self-fulfilment.

5.2.6.2  New context: New challenges

Participants highlighted three critical factors that concerned them greatly and that stemmed primarily from their migration to or seeking asylum in Australia. In this process they left behind their native homeland, cultural familiarities, careers, language, family attachments and community networks. Participants spoke of their lack of English language on arrival, which they believed resulted in problems with finding employment. Cultural differences accentuated their alienation and contributed towards homesickness and loneliness. The most prominent concern expressed was the sadness of missing their families and not having the closeness and security of immediate family to provide guidance and stability.

I first present participants’ stories of difficulties in living in a foreign environment with a different culture and language and the impact of these difficulties on securing employment. I also include concerns expressed for and by those older generation migrants; more specifically, the difficulties that older settlers experienced with learning the English language and how such difficulties can contribute towards mental illness. Then I will present participants’ descriptions of how their separation from family contributed towards poor mental health outcomes and tensions within
the family and their community. Those interviewed repeatedly attested to the difficulties they confronted in adapting to a new environment, which hampered their ability to participate fully as a member of the broader Australian community. While there was a strong desire to belong, this was difficult to achieve and is reflected in the following quotes:

Also moving from one country to another and facing a culture clash. No matter how strong you are and how good life you have I don’t think you have the ability to function like once you did in your previous life. This can cause lots of problems within the family and with children.

(Participant SA 79, male, 22, Afghan/Hazara, single, permanent resident, refugee, education: year 11)

When I just arrived to Australia I couldn’t solve my problems on my own. I was dependent on others. That bothered me a lot because I couldn’t speak the language. I was away from my family and I missed them. I was missing my community, my culture, my family and my friends. [Later in the interview]

I was worried about how to learn English language, I had lots of thoughts [pause 1-2 sec] when there is no plan or program everything gets mixed up and it doesn’t work.

(Participant SA 112, female, 39, Afghan/Hazara, married, permanent resident, asylum seeker, education: Year 12)

Language difficulties were a common experience for new arrivals; however, this difficulty was far more challenging for the older generation. Their difficulties in adopting the language of Australia (English) were also reflected in their abilities to adapt to the new culture. This affected them emotionally and psychologically, adding to their isolation. Illustrative examples of these concerns are provided below:

Older people can’t learn the language and it is harder for them. ... Older people always have difficulties and these can stay for a very long time or only go away after a very long time.

(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year n one)
Mostly our parents can’t speak the language and it is difficult for them to learn. They are not able to do their job or carry out their duties. For instance if they want to go to the doctor they can’t go by themselves and sometimes their children won’t help them. [This] creates more problems because when they go to the doctor they cannot talk to their doctor about their symptoms or even their feelings. So their mental health can deteriorate and this has a huge impact on them.

(Participant SA132, female, 20, single, Afghan/Hazara, permanent resident, refugee, education: year 11)

Another participant was also concerned about the older generation’s past trauma and present experiences as refugees.

Older generation migrating from their own country, 100% are having issues brought from their past life. On the top of that they have problems living here [Australia] so it makes their situation worse .... They do not have their family with them; they do not have friends or acquaintance[s]. They are in a foreign country with [a] different language ....We have shops, we have mosque[s], we have schools, we have community events and gatherings. These activities are crucial in someone’s settlement.”

(Participant SA 9, male, 42, Afghan/Hazara, married, Australian citizen, refugee, education: year 10)

One participant found it particularly stressful knowing that in order to get employment she would need to be proficient in English as well as have an understanding of the systems within the employment domain:

It [has been] causing me stress for a few years now, since we came to Australia. Maybe it is because I would love to study - not really study but learn the language and then get a job. I am constantly thinking that I won’t be able to do it because the English language is difficult to learn. But if I can learn the language I will be able to work then I will have better future. .... It may not happen or it may happen after many years. That is why I am stressing a lot.

(Participant SA 82, female, 43, Afghan/Hazara, married, permanent resident, refugee, education: year 2)
Unemployment and the search for meaningful jobs formed a large part of participants’ anxieties. Experiencing unemployment for any length of time, but more so if for extended periods, impacted significantly on participants’ self-esteem, identity and financial security, and could lead to negative mental health outcomes. This was clearly identified by a few participants. One said, for example,

I think unemployment is another reason you can get mental illness, because you feel embarrassed all the time in front of your family because you can’t get a job.

(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, refugee, education: year 4)

Another emphasised that having a job with responsibilities, time lines and tasks that provide pride and purpose is vital for self-esteem and emotional wellbeing:

I feel really happy at work. I feel like I have a job and also supporting other people around me. That is why I think if you keep yourself busy and have a job is good for you.

(Participant SA 74, female, 29, Afghan/Hazara, married, Australian citizen, refugee, education: year 12)

Yet another woman reported that she migrated to a new country in the hope her children would have secure lives, a better future and good jobs:

I was thinking about the future and hoping my children would grow up in a secure environment and have a better life. They will have a good job and look after me.

(Participant SA 82, female, 43, Afghan/Hazara, married, permanent resident, refugee, education: year 2)

There was also another point of view: work could be both a mental health facilitator and a hindrance:

It was good that I quickly found a job and I worked for two years at MRC. This helped me and I really became busy at work and at the same time I studied. I feel much better now, it doesn’t mean though I am 100% well emotionally.... Sometimes I feel a need to change my job because
when my refugee clients talk to me it affects me but then I think I can help people in this job and help them solve their problems.

(Participant, SA 112, female, 39, Afghan Hazara, married, permanent resident, asylum seeker, education: Year 12)

Living in a foreign environment, learning a new language and finding employment or searching for meaningful jobs formed a large part of participants’ anxieties, as did living apart from family members.

Some participants reported that having to live away from their immediate family had caused them substantial loss and grief. The memories of leaving home, knowing that they may never see their loved ones again, were particularly distressing. Arriving in Australia without the support of family was said to foster a sense of disconnectedness and isolation. Many relied on parental guidance in their home countries for advice and nurturing, even into their adult years; however, leaving Afghanistan and family behind meant that these important elements were missing during their settlement, leaving them vulnerable to depression and other mental illnesses. They reported that connection to the family gave them a sense of belonging, grounding them securely in their identity, culture and heritage. If participants migrated with family they did not feel as isolated because they had access to extended family networks, thus substantially reducing isolation. Those who had left families behind described this as a constant worry. They feared for their loved ones’ safety and wellbeing, and this was described as a contributor in the deterioration of their mental illness and exacerbation of mental illness. The following quotation represents the voice of many, describing deep grief and sadness about family separation:

*In my opinion those who immigrate from Iran or Pakistan and start a new life here in Australia, their mental health changes because of the migration. When they lived in Iran or Afghanistan they were much happier in my opinion. Even myself and my family when we were in Iran we were much happier. In Iran it is true people had lots of problems but they are not so isolated there because they live close together in community and spend their days together…. In Australia people have a good life but are isolated….Those happy days in Afghanistan or Iran are lost to us.*
(Participant SA 131, female, 18, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

Living without her family around her led to feelings of isolation, lack of connection, and feeling foreign in one young woman:

_Ummm if for instance Afghans move to a new place like Australia there are so many problems which can affect them emotionally. Some of them live far from their family. They can feel like foreigners here in Australia._

(Participant SA 132, female, 20, single, Afghan/Hazara, permanent resident, refugee, education: year 11)

Some participants described a sense of powerless or guilt for not being able to reunite with or support their family. For instance,

_"I am thinking about what my mother said that I can’t bring her here [Australia]. My nephew and nieces ask me to send them this and that but I can’t financially afford to do this and it bothers me a lot."_

(Participants SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year n)

A young male university student stated:

_"I should be happy here in Australia because I have access to basic services, there is no war here and there is freedom of speech but it is the opposite because I miss them, I miss my family, my old friends. I am looking to find a part-time job to support my family but it is hard to find one and this bothers me a lot. (Thinking) I am hoping when I finish my university degree things will change for [the] better and I will be able to support my family and myself._

(Participant SA 47, male, 23, Afghan/Hazara, married, Australian citizen, refugee, education: university student)

Later in the interview, the same participant also talked about how happiness eluded him. Even though he is not living in an oppressed environment or an environment where basic human rights are lacking, he said he still could not find happiness because of other settlement issues and because of his distance from his family. A young woman also reported the impact of loneliness and isolation on mental health:
I also think not having anyone in Australia and feeling lonely can affect your mental health. I think most Afghans left family behind and they constantly worry about them.

(Participant SA 132, female, 20, single, Afghan/Hazara, permanent resident, refugee, education: year 11)

Another young woman confirmed the need for family support, stressing its importance; that if she had not received that support she would have taken her own life:

_A few times because of my personal problems I did not want to live and wanted to kill myself. At that age you need a strong family or community around you where you can get help. If I had not got that help, I would not have been here._

(Participant SA 117, female, 21, married, Afghan/Hazara, permanent resident, refugee, education: Year 7)

Sadness from losing family members in the war and the orphaned children left behind with little support was the main concern of one young man. During the interview, he appeared concerned and reported that he himself had lost a few family members during the war, including his brother. He also talked about his concern for his orphaned niece and nephews living in an insecure condition in Afghanistan, describing this as a source of stress and the impetus behind his, at times, short temper:

_Because I myself had a really harsh life so I always think about them. Their past is gone now. I worry that they [niece and nephews] have lost their father and worry what will happen in the future, what kind of life they will have in such a harsh situation over there [Afghanistan]….I sit down and think about his [niece] and his brothers [nephews] and I become stressed and agitated._

( Participant SA 124, male, 24, Afghan/Hazara, single, permanent resident, refugee, education: Adult language school).

In conclusion, most of the participants described some form of difficulty adapting to a new country, which led them to develop symptoms of mental illness. The difficulties they reported following their migration to a new environment included
concerns about leaving behind their native homeland, their cultural familiarities, careers, language, family attachments and community networks. These losses and gaps helped accentuate their alienation and contributed towards loneliness, resulting in adjustment difficulties and emotional instabilities.

5.2.6.3 Individual perceptions and actions (local level)

At the local level, most participants believed that good mental health was reflected in actions and abilities, such as making sound decisions, having the confidence to carry out day-to-day tasks and meeting their responsibilities, as well as resilience and effective coping strategies to solve problems and tackle day-to-day issues. At the local level, I will discuss beliefs about mental illness under three subheadings. I will first present participants’ perceptions of what mental health is, followed by the links between physical health and mental health, and finally, strategies participants used to deal with the symptoms of mental illness in particular, insomnia.

What is mental health?

Participants placed emphasis on mental health being the foundations of self-determination, having the ability to be goal-oriented, make good life decisions, and possess high self-esteem. This, in turn, was said to allow people to be confident and successful. These attributes were associated with good mental health as well as wellbeing. The following participants all spoke confidently about the links between mental health, wellness and functioning:

*People with good mental health are determined. They can make wise decisions no matter what kind of situation they are in. I mean it doesn’t matter if the person is angry or frustrated, they are still capable of making good decisions.*

*(Participant SA 125, male, 20, Afghan/Hazara, single, Australian citizen, refugee, education: year 10)*

*From my point of view good mental health is something that [is] related to wellbeing, happiness, confidence, positive thinking and allows you to reach the goals you set for yourself in life.*

*(Participant SA, 42)*
In my opinion ummm [1-2 Sec pause] good mental health is to have a good sense of wellbeing.... Those people with good mental health usually have lots of confidence, high self-esteem and are very positive by nature.... These kind of people are capable of building good relationship with others, with their families and with the wider community.

(Participant SA 47, [Participant SA 47])

Many participants repeatedly used the word “happy” or “happiness” when describing a person with mental health and they associated mental health with a “happy life”. Participants took this further and concluded that if someone is happy, they will not develop mental illness and this will inevitably lead to a successful life. The opposite, sadness, was said to lead to poor mental health. The following statement expresses the sentiments of many of the participants:

Good mental health means you are happy. You see your life and live your life happily. These kind of people are successful in their study.... It is because they have good mental health so if you have a good mental health you have a good and happy life.

(Participant SA 9, [Participant SA 9])

One young refugee believed that mental health is important for sustaining mind and thoughts. She reported that a healthy mind and positive thinking can give a person the ability to deal with the demands of daily life and life’s challenges:

Mental health is the way we feel and think. It impacts on your ability to deal with the good and bad events in our life.... Are about controlling your emotions and behaviours. It is also about ability to handle our life challenges at home, work and school... having good communication with friends and relatives and being positive, happy and content.

(Participant SA 44, [Participant SA 44])

Mental health, physical health and sleep

Some participants said that in order to have good mental health it is necessary to have good physical health and sufficient sleep. In the following extracts, participants
highlighted this aspect of wellbeing and its impact on the mental and emotional health of others. The following participants, for example, specifically linked physical health with mental health:

*Good mental health depends on few things... good physical health, eating good food and getting a good sleep.... I think if one of the above is not followed through or there is shortage of either it will lead to dysfunction of the body system and deterioration of health, leading to illness.*

(Participant SA 79, male, 22, Afghan/Hazara, single, permanent resident, refugee, education: year 11)

*Some have health issues that make them worry and they think about whether they will get better or not recover from physical illness... this can affect you mentally.*

(Participant SA 82, female, 43, Afghan/Hazara, married, permanent resident, refugee, education: year 2)

Others described sleep as essential for emotional and psychological health. When participants were asked about their sleep patterns most reported that they experienced some form of sleep disturbance or difficulty with getting to sleep, frequently resulting in sleep deprivation. Sleep issues centred primarily on three reported experiences. First, some participants reported they had difficulty falling asleep as they were preoccupied with anxious thoughts, which prevented them from falling asleep:

“I woke up early in the morning and could not get back to sleep again.”

(Participant SA 82, female,)

Second, some participants reported that although they could fall asleep, they woke during the night and were not able to return to sleep because of intrusive thoughts:

*Oh don’t talk about my sleep, it is really bad. I can’t sleep until 2–3am. I wake up early in the morning then I can’t go back to sleep.... Four to five days a week I have this problem. Then I get so tired that I want to sleep during the day and on weekends it gets worse.*

(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, Refugee, education: year 4)
Sometimes I can’t fall asleep at all and sometimes I sleep for 1–2 hrs. After that I wake up. I can’t sleep all night and then I sleep in the morning.

[Later in the interview]
I feel very tired and yawn all day in the classroom. I can’t concentrate in the classroom.

(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year n)

I could not sleep sometimes for 4–5 nights or for one week. I wanted to sleep but I couldn’t because those memories were playing out in my head like a film. I was trying to forget but I couldn’t.

(Participant SA 2, female, 31, married Afghan/Hazara, Australian citizen, refugee, education: year 8)

Third, many participants talked about being woken by nightmares, their physical responses to them, and finding it difficult to get back to sleep:

I can’t fall asleep, for [a] few hours I am thinking and thinking all the time.

(Participant SA 74, female, 29, Afghan/Hazara, married, Australian citizen, refugee, education: year 12)

I was shouting, things were chasing me, I was running. I dreamt about my mother becoming a ghost or a spider - big ones. I saw my mother turn into a ghost and run after me. I shouted and woke my husband. He asked me “what is wrong.” I was telling him big spider take it off me. I was numb for about 2 or 3 minutes.

(Participant SA 79, male, 22, Afghan/Hazara, single, permanent resident, refugee, education: year 11)

Participants described symptoms of moderate depression and anxiety, which contributed to sleep problems and were most probably related to past trauma. One woman described feeling anxious and lacking energy when she was in a detention centre. She spoke about her symptoms:
All I want to do is to stay in bed under the quilt. My face is uncovered but the rest of my body under the quilt that is what I like to do, think and think.

[Later in the interview]
I was feeling anxious all the time last year. I was in community detention and all I did was sleep.

(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year 1)

In addition, traumatic memories could be triggered by some form of media presentation, such as the news on TV or movies, interrupting their sleep:

It depends on the news or if I see an accident for example if I hear really bad news such as someone was killed [thinking 1-2 sec] my heart aches. This makes me think about a lot of negative thoughts and this affects my sleep. ... I dream about my past life. By past life I mean what we went through in my own country. The war, the gunshots, and the blast I saw just in front of my eyes.

(Participant SA 42, female, 19, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

Yeah I think coming from war and growing in war can affect you [me] badly. I have so much fear and sometimes when I am alone I think about those problems [past trauma] all the time... this affects my sleep.

(Participant SA 132, female, 20, single, Afghan/Hazara, permanent resident, refugee, education: year 11)

In conclusion, the participants highlighted that good mental health depends on an opportunity to live in peace, without exposure to war or witnessing killings; the ability to make good decisions; and having the confidence to carry out day-to-day tasks. Disruption of any of these functions will affect wellbeing. In addition post-displacement issues such as living in a foreign culture or environment, learning a new language, finding employment and worrying about family members left behind contributed towards a large part of participants’ anxieties and poor sleep. As a result, many participants reported that these intrusive thoughts prevented them from falling asleep, resulting in sleep deprivation. In the next section, strategies for coping with sleep problems will be discussed.


Strategies for coping with sleep problems

Several participants had learned how to deal with symptoms of mental illness, in particular insomnia. They listed strategies for coping with sleep problems: physical activities, exercise before bed or during the day, reading books, and the use of technology and meditation. The following accounts describe these strategies:

But when I can’t go to sleep at night I read a book or listen to soft and relaxing music. Sometimes I meditate which calms me down and I feel relaxed.... I do exercise in my room and play soft music while doing exercise.

(Participant SA 44, [female], 21, Afghan/Hazara, single, Australian citizen, refugee, education: year 12)

I have experienced that if I walked a bit or if I did physical activities I slept better and also thought less about my past life.

(Participant SA 2, [female], 31, M, Afghan/Hazara, Australian citizen, refugee, education: year 8)

If during the day I did a lot of physical activity and felt tired, when it is time for bed I sleep better because I am tired. [Later in the interview] There was time I used to go to the gym. Before joining the gym I felt very depressed. I asked my friend, ‘What should I do?’ She advised me to join in and take part in some regular activities.”

(Participant SA 131, [female], 18, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

Sometimes I do exercise or go out for a long walk in the sun or take deep breaths and that helps me to sleep better at night.

(Participant SA 132, [female], 20, single, Afghan/ Hazara, permanent resident, refugee, education: year 11)

I do go to yoga classes every Sunday but every morning I try yoga or skip rope 100–200 times every morning. That helps too.

(Participant SA 112, [female], 39, Afghan/Hazara, married, permanent resident, Asylum seeker, education: Year 12)

Other participants used technology to get to sleep, such as You Tube and Facebook, but acknowledged that experts advise against watching a computer screen before
bed. One participant noted that he found watching You-Tube and movies helped his insomnia:

*In the past three years these technologies like touch screen mobile[s] etc. became available and when I can’t sleep I go on the Net, Face Book or go on different sites I like, sometimes watch a film, it takes four hours until I go to sleep.*

(Participant SA 76, male, 31, single, Afghan/Hazara, Australian citizen, refugee, education: year 12)

Another used his computer for relaxation:

*Sometimes when I can’t sleep I listen to hypnosis on You Tube. That helps me to go to sleep. But I worry if I use it too much, I will become addicted to it.*

(Participant SA 126, male, 21, single, Afghan/Hazara, Australian citizen, refugee, education: year 11)

Several sought medical and professional advice and were guided accordingly:

*Here in Australia I did go to see my GP especially about my sleeping problems. My GP thinks it is a normal reaction because of what I have gone through as a little girl.*

(Participant SA 42, female, 19, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

*I went to my doctor, he told me there was no specific medication for it. He advised me to try to organise my sleep... and that it is normal for my situation."

(Participant SA 79, male, 22, Afghan/Hazara, single, permanent resident, refugee, education: year 11)

Some were prescribed medication:

*I couldn’t sleep and I went to the doctor. I got sleeping tablets. When I took them I had some problems because the pills affected me during the day and I slept more... I went back to my doctor she told me to try to take the pills in the afternoon, to allow some time to take effect by bed time.*

(Participant SA 1, female, 30, Afghan/Hazara, recently divorced, Australian citizen, refugee, education: year 3)
One young woman reported that it was easier for her to talk with her GP about her sleep problems than her mental illness:

*I do not feel comfortable to talk about my mental illness, I did talk about my sleeping problems because I think many people are having this problem... mental illness is a sensitive issue.*

(Participant SA 44, female, 21, Afghan/Hazara, single, Australian citizen, refugee, education: year 12)

In conclusion, at the local level participants described mental health as sound decision making, self-determination, resilience, flexibility and functioning; as necessary to success, happiness, self-determination, confidence and problem-solving. They also highlighted a link between physical and mental health that resulted in insomnia. Participants described various techniques to help with insomnia: exercise, technology and medication. Sleep disorders or disturbances featured highly as an issue related to mental illness. Sleeping soundly was described as a feature of mental health, and poor sleep was associated with mental illness. However, participants predominantly addressed the symptoms of mental illness and not the cause. As we have seen, Participant 44 preferred to discuss her insomnia rather than her illness with her GP. Overall, participants recognised that mental illness could manifest itself physically and emotionally and referred to past trauma. This is why most participants prayed for peace and harmony and put faith in a greater power, “God”, to intervene and protect them and their loved ones in Afghanistan. It is important, then, to discuss religion and spiritually. This includes participants’ views and perceptions of religion, spirituality and faith in God, as well as their contrasting views and perceptions about the role of religion in addressing the experiences of trauma and mental health disorders.

5.2.7 Religion and spirituality

In this section I provide an overview of participants’ perceptions of religion, spirituality and faith. The majority of participants believed in the power of God to protect them emotionally and physically. Other participants described religion as a source of struggle and stress, as well as a source of liberty. Younger participants in particular described their feelings of being restricted by religious norms and beliefs, which could impact on their mental health.
I first describe the group of participants who recognised their experiences of war and unrest as contributors to mental illness. These participants discussed prayer and faith, concluding that their mental health could be restored or stabilised through religious means. Second, I examine the participants with the opposing views who presented religion as a tool of oppression rather than an agent of goodwill, peace and harmony.

For the following two participants prayer was seen as vital to helping bring about peace in Afghanistan. Their faith gave them an avenue to contribute in some way towards helping their country and its people. Having made the connection between war and mental illness, the participants were aware that stopping the war would help minimise mental illness. For those residing outside of Afghanistan the power of prayer remained influential and possibly the only means they had to intercede and try to protect their fellow country people. Because the unrest in Afghanistan affected them emotionally and psychologically, these participants showed empathy by praying to God to bring peace, which provided them with some comfort.

\[\text{I always pray to God to bring peace to Afghanistan so that my people have a good life like people here. Peace can make people calm and stress-free.} \]

\[\text{(Participant SA 119, male, 18, Afghan/Hazara, single, permanent resident, refugee, education: year 4)}\]

\[\text{I always pray to bring peace to my country and to bring peace for the people so that they can have a good life like I have here. Because all this [referencing the unrest in Afghanistan] will affect them emotionally and mentally. We do not want mental illness to take over and to make them crazy [pause 1-2 sec. Participant smiles sadly.]}\]

\[\text{(Participant SA 116, male, 48, Afghan/Hazara, married, permanent resident, migrant Spouse Visa, education: year none)}\]

Another participant talked about how she felt guilty that she lived in a peaceful country and how she constantly worried about the rest of her family, who remained in Afghanistan living with the unrest. She prayed for peace so her family could be safe, but these prayers did not bring her any comfort. Rather, she was so deeply affected by her own memories of the war that instead of focusing on her prayers, she was distracted by past images of war and killing and she became disoriented. For this
participant prayer did not bring comfort, but instead contributed to her anxiety, as she could not complete the ritual without intrusive thoughts.

*I see myself as living in peace here but it makes me worry more, because there is peace but there is no peace over there.*

[Later in the interview]

*I pray, I don’t know what I am praying.... I am anxious even when I am praying to God, thinking constantly about the war, how to escape the war, the killing of people, and the terrorising of people.*

(Participant SA 3, female, 41, Afghan/Hazara, married, permanent resident, refugee, education: year n one)

Many participants disclosed mental illness symptoms such as insomnia. They described how they were not able to sleep because as soon as they went to bed they were preoccupied with worries. Reading the Koran helped to ease their symptoms, as described in the following reports:

*There are many reasons for me to have impact on my sleep for instance my mother, my mother [is] in Iran and I am here, when we can reunite, my sister in Iran etc. ... When I can’t sleep I think about the reasons causing me sleeplessness. Then I think about how I can find the way to solve it. For instance sometimes I take all my worries to bed and these problems preoccupy my thoughts and it causes sleeplessness. I can’t control my sleep, but if I read a verse from the Koran before I go to bed... this helps me.*

(Participant SA 132, female, 20, single, Afghan/Hazara, permanent resident, refugee, education: year 11)

*I go out for a walk with my son, go to the park with other female friends. They talk most of the time. I do not sit with them; I just go for a walk. Then I come home. It is prayer time so I do my prayers... I think a lot.*

[Later in the interview]

*Some nights when I can’t sleep I pray or read the Koran.*

(Participant SA 1, female, 30, Afghan/Hazara, recently divorced, Australian citizen, refugee, education: year 3)
Whereas some participants sought relief for their issues through spiritual activities and rituals, others viewed religion as the source of conflict and tension. Religious rituals, rules and sectarian divides added to their sense of oppression and pressure, exacerbating their mental illness. One young man described religious tensions as a source of “pressure”:

*I was very young but I heard there were lots of problems - for example war - between the Sunni and Shia; religious issues. Yes, I think these differences in religion cause lots of conflict... then these matters affect you mentally as you are under pressure constantly.*  
(Participant SA 125, male, 20, Afghan/Hazara, single, Australian citizen, refugee, education: year 10)

Confining religious rules that dictate the norms and beliefs, especially about behaviours, public appearance and gender roles, could be a source of conflict rather than comfort:

*Wearing a scarf is something really different. One day when I was in the shopping centre a lady passing by asked me ‘why do you girls wear scarves when men don’t in your religion?’ I couldn’t really answer her because I didn’t know the answer. I didn’t really understand why. I talked to my friends about it and they made fun of me. I couldn’t sleep because I was thinking about it all the time and then I realised that wearing a scarf really makes us different from Australian people. These thoughts come into my mind every day. These may be simple issues to some people but it can have a huge impact on me and my mental health. So just a question like ‘Why do women wear scarves and men don’t?’ keeps me awake at night and causes me to have many negative thoughts. I couldn’t sleep for days and I don’t know what to do.*  
(Participant SA 42, female, 19, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

It bothered [me] mentally and emotionally when we had to go out, we had to cover ourselves from top to bottom so nobody else looked at us. They say that is what the Koran says which is totally wrong. In Islam the
face and the hands of women and men should not be covered it is enough if you dress modestly [pause 2-3 sec appeared very upset].

(Participant SA 44, [participant information]

A young man referred to the difficulties of adhering to or following religious expectations. His interest in a girl was curtailed because of religion and this left him feeling distressed. In this case the extract suggests that there is no individual freedom to choose or engage in relationships with others without strict protocols or approval from elders. This limits choice for young adolescents, which could add to confusion and potentially contribute towards mental illness.

I have not discussed this with anyone else [pause 1 to 2 secs]. Well, towards the end of my uni semester I started talking to a girl who I knew for about three years. I really like her. I have not spoken to her since the university summer holiday break [laughing].

[Later in the interview]

I have tried to get in touch with her but she is very religious and she would not give me her phone number.... I even went to the mosque because her family goes there all the time. I wanted to get close to the Mullah. I wanted to ask for his help to ask him to approach her dad... but it’s impossible because she is very religious.”

[Later in the interview]

I wish girls and boys in our community had the freedom to talk with the one they love but it’s very unlikely because families are very religious.

(Participant SA 126, [participant information]

For some participants, it was important to incorporate religious practice and faith as coping strategies. Using prayers and reading the Koran gave them some relief and helped them to establish or restore mental health. However, others saw the very nature of religion as a negative intrusion that impacted adversely on the wellbeing of individuals. Interestingly, despite expressing this world view about religion, they did not necessary negate their own spirituality; rather, spirituality still held some
relevance and formed part of their personal expression of life. Notably, religion as an institution was viewed negatively. The following interview extract explains this point of view, which was held by a number of participants. He explained that he had doubts about his faith, and using a prison metaphor, surmised that those following a religion are trapped in their own circle of rules, rituals and norms. The rules confine them to a strict set of behaviours and norms. He described religion as another form of oppression adding to life’s difficulties, rather than as a liberating force:

_I myself as a person do not believe in religion. I have some doubt about religious matters. It doesn’t mean I am a non-believer, but I have my own doubts. This is my ideology.... I realised everything is meaningless... in reality we are in a small circle, despite the fact we feel this circle is very big... it is small and we all prisoners in this circle._

(Participant SA 76, male, 31, Afghan/Hazara, single, Australian citizen, refugee, education: university student)

Identity and belonging can be intertwined with religious and cultural beliefs. For those arriving in Australia from Afghanistan, the various symbols and identifiers of culture and religion take on a different meaning and can have an isolating and alienating effect. Expressions of faith and culture that were previously found in the local community in Afghanistan are absent in the Australian suburbs. In addition, special yearly festivals or significant events such as Ramadan or Eid lack the same significance, as they are not celebrated by the entire community. The events are significant for only a small part of the population. This strengthens the emphasis on difference and in turn impacts on a sense of belonging and identity. Belonging was subsequently questioned and for some, sentimental thoughts of home grew strong. This is reflected in the following description of the isolation and feelings about living in an alien cultural and religious environment:

_Here is isolated and those happy days in Afghanistan or Iran were lost to us. I don’t know but I think the reason behind it can be that we feel like foreigners. It’s not our country, that everyone is the same, have the same culture and speak the same language... our culture and religion is different. Maybe that is why they are not happy. These things can have an impact._
[Later in the interview]

I think I told you the difference between the cultures and religions has affected me emotionally. Yeah I think this is the reason I feel a bit isolated.

(Participant SA 131, female, 18, Afghan/Hazara, single, Australian citizen, refugee, education: year 6)

In conclusion, several participants described war and unrest as contributing towards their mental illnesses. Prayer and faith were said to ease their problems. Most participants prayed for peace and harmony and put faith in a greater power, “God”, to intercede and protect their loved ones in Afghanistan. Some prayed to God, some read verses from the Koran and some just meditated in quiet prayer at home. Other participants described religion as a source of conflict and tension as well as a source of oppression. Young participants in particular described their feelings of being confined by religious rules, norms and beliefs, which could impact on their mental health. These included expectations on how one needed to behave and how to appear in public, and the strictly determined gender roles. These young people considered such rules and expectations to be causes of conflict rather than order and peace. For others, the differences between the dominant Australian culture and the Afghan culture were a point of tension and loss, particularly during religious and cultural events, which were not as vibrant as when celebrated in their homeland. The cultural and religious differences were experienced as a source of grief, leading to further isolation. This finding is relevant to understanding mental illness amongst refugees from Afghanistan, particularly for those who sought relief and support from their spiritual beliefs and practices. Their ties to cultural and religious tradition remains a key factor in how Afghan participants determined how best to respond to mental health issues. Participants who were older and less educated consistently reported seeking help from non-medical sources and this may reflect the ease of accessibility to such interventions and a sense of familiarity and security. Both quantitative and qualitative findings will be discussed in the next chapter with consideration of attitudes, beliefs, problem recognition, help-seeking behaviours and the impact of trauma and displacement.
CHAPTER SIX: DISCUSSION

6.1 Discussion of Study One

6.1.1 Mental health literacy survey: Problem recognition, beliefs about the severity of problem, treatment and prevalence, causes and risk factors, perceived stigma and help-seeking behaviours

6.1.1.1 Problem recognition

Problem recognition and beliefs about the helpfulness of activities, treatments and treatment providers will be considered in this section within the parameters of MHL. To summarise, close to one-third (30.7%) of the participants identified the problem described in the vignette as PTSD, followed closely by fear (26%) and then depression (15.3%). This suggests a reasonably low rate of problem recognition and correlates with known gaps in the MHL of various populations. As for remedies, participants reported that improving diet or exercise, finding new hobbies, getting information about the problem and specific psychotherapy were the treatments most likely to be considered helpful for the problem described, whereas psychiatrists, psychologists and GPs were the treatment providers most likely to be considered helpful. Taking vitamins and minerals was also highly regarded, whereas the use of psychotropic medication was viewed less favourably.

Participants with lower levels of education were less likely to identify the problem described as PTSD, whereas participants with lower levels of education and older participants were more likely to consider religious worship to be helpful, whereas participants with higher levels of education and younger participants did not. There were no associations between participants’ levels of PTSD and depressive symptomatology and the aspects of MHL addressed.

The Afghan participants in the current study were able to identify PTSD at slightly lower rates than that of the general Australian population (30.7% versus 34.3%) (Reavley & Jorm, 2011). A smaller number (15.3%) of the current study’s population thought it was depression. In comparison, results from a similar Iraqi study of MHL found very low rates of identification of PTSD, with only 14.2% of Iraqis identifying the problem described in the vignette as PTSD (Slewa-Youan et al., 2014). Although the result of the current study of the Afghan population is encouraging, it is
still far from ideal. Further, almost half (46%) of participants in the current study had clinically significant levels of PTSD. Even when PTSD is deemed to be a serious and disabling problem, help-seeking may be hindered by perceived stigma associated with disclosure. If less than one-third of individuals with clinically significant symptoms of PTSD recognise that they have this problem, then it is not surprising to find a low uptake of mental health intervention in this subgroup (Jorm et al., 1997).

Afghans recognised PTSD at the same rate as Australians but twice the rate of Iraqis. This difference could be related to the fact that there were a higher number of students and younger Afghan participants in the current study. It may also be possible that these participants have been exposed to information about general and mental health at Australian educational institutions allowing for greater knowledge of symptoms. Furthermore, as the majority of Afghan participants have been in Australia for a long period of time, arriving since the start of the millennium, allowed for greater levels of exposure to information about mental health in media, school and social groups. Despite recognition rate, exposure to mental health information and education Afghans continue to record low levels of help-seeking uptake compared to main stream Australian population. In many cultures, mental health is closely associated with religious or spiritual life which will be discussed later. However how we understand our own mental health, and any problems we experience, will be personal to us and be influenced by internalised taboos, values and beliefs. Therefore, there is nothing simple about the relationship between health and country of origin, ethnicity, education and understanding of mental health issues. Mental health promotions need to take into account not only country of origin of refugees, ethnicity of refugees but also the length of their stay in western countries and their level of exposure to western health provisions. As important as country of origin is, campaigns will need to incorporate a strategy that addresses and challenges the stigma often associated with mental illness, while remaining culturally sensitive.

The finding that participants with higher levels of education were more likely to identify the problem described as PTSD than those with lower levels of education may reflect an association between higher levels of education and greater exposure – and receptiveness – to Western biomedical models of mental health problems and their treatment. In fact those with higher education naturally have better
understanding of the language in the adapted country. This also can be a powerful tool in terms of recognising the illness and how to go about treatment. It may be also possible that despite their limited education, individuals could be influenced by external agents such as media or adult children who can bring and inform parents about mental health issues. Hence with one or two members of the family attending schools or higher education also can influence the way other family members think about mental health issues. Education system has important role to play in educating and informing families and individuals regardless of the level of education.

Education was also found to be related to levels of satisfaction with mental health treatment in a study of Vietnamese patients. Eighty-six Vietnamese patients and family members were asked to rate their satisfaction with refugee and mainstream mental health services. The result of the study indicated that patients’ fluency in English and their relative’s level of education were associated with inverse satisfaction scores, tentatively suggesting that the greater the ability of patients and their families to evaluate services, the less likely they were to express satisfaction with treatment (Silove, Manicavasagar, Beltran, Le, Nguyen, Phan, Blaszczynski, 1997).

6.1.1.2 Beliefs about the mental health problem’s severity, prevalence and treatment

When examining the beliefs about the prevalence and severity of the mental health problem described in the vignette, 35.3% of the Afghan participants in the current study considered having such a problem to be “extremely distressing”, with 48.7% believing it would be “very distressing”. Comparatively, only 27.1% of the Iraqi participants in the study by Slewa-Younan, et al. (2014) reported that having this problem would be very distressing, followed by 32.9% who noted that the problem would be moderately distressing. Additionally 59.3% of the participants considered the problem to be “very serious”, 14.7% selected “moderately serious” and only 2.0% selected “a little serious”. In comparison, of the participants in the Iraqi study (Slewa-Younan et al., 2014) 25.8% rated the problem described in the vignette as “very serious”, 36% described it as “moderately serious” and 15.1% described it as “a little serious”. The majority of Afghan participants found mental health problems as extremely or very distressing. Over 50% of the participants thought that the
problem in the vignette was very serious compared to Iraqi refugees where only a just over a quarter considered 27.1% the problem in the vignette as very serious. Therefore, the Afghan participants were able to recognise the seriousness of the problem as twice the rate of Iraqis despite both groups arriving to Australia as refugees. The reason for this disparity could be a consequence of the detention of Afghans and contact with mental health professionals within these institutions. It is also possible that majority of Afghans lived in neighbouring countries prior to coming to Australia and they perhaps sought help from mental health institutions as refugees in those countries. This suggests that mental health promotions as mentioned above needs to take into consideration the refugee population country of origin, exposure to Western mental health system, mental health promotion messages as well as their length stay in Australia. Understanding beliefs about the perceived seriousness and distress caused by the problem described in the vignette is important, as it can reflect ambivalence towards help-seeking and maybe the consequence of the stigma associated with mental illness.

This tendency towards ambivalence and help-seeking was articulated by Mond, Robertson-Smith and Vetere (2006) in a study of stigma and eating disorders. Participants were given a vignette describing a fictional 15-year-old female meeting diagnostic criteria for anorexia nervosa, followed by a series of questions designed to assess perceptions of severity, self-centredness, contribution to society, social distance and desirability. When asked how distressing the problem would be, 45.6% said it would be “very distressing” and 37.6% said it would be “extremely distressing”. These results suggest that significant numbers of participants thought that the problem was distressing, but because of the stigma towards individuals it was perceived that this disorder is mild, hence not deserving of serious attention. The fact that on the one hand many participants understood the severity of the condition, and yet on the other hand they did not seek help, denotes the ambivalence towards eating-disorder behaviour that exists among women in the community.

In summary, there was a consistency between the beliefs of the Afghan and the Iraqi participants about how distressing the problem described in the vignette was, but a higher proportion of the Afghan participants considered the problem to be very serious.
As part of the current Afghan study, when participants were asked about the prevalence rate of the problem described in the vignette within their own community, 31.3% reported that 70%–90% of the Afghan community may have similar problems. This reported figure was higher than in the Iraqi study (Slewa-Younan et al., 2014), in which only 17.8% noted a prevalence rate of between 70% and 90% of people in their Iraqi community who may have similar problems. Afghan participants thought that the prevalence rate of the problem was higher in their community which may be due to their community demographic. Critically, the majority of Afghan community has tended to congregate in one or two suburbs in Adelaide. This has meant greater levels of intense interaction and community inter-connectedness. This would suggest that the information about individuals could be disseminated more effectively. Specifically, community members had regular contact with others and could share and pass on information about the well-being of others. In contrast it may be the case that because the Iraqi community is dispersed across multiple suburbs interactions amongst its members is more limited than the Afghan. The discrepancies in the prevalence of mental illness may be influenced by the demographic of the two communities. Gender and age may also have influenced these results particularly as Afghan men and younger people spend a great deal of time at community meetings and events. Hence they are more likely to be exposed to the knowledge of others having mental health problems. The prevalence rate as perceived by these two communities may not necessarily reflect the true prevalence of the illness. Reporting the prevalence rate is important strong close knit communities can be useful when sending out information to educate but at the mean time can facilitate avenues for gossip and stigmatisation of members. This important community aspect will need to be taken into consideration when formulating education programs or mental health promotions.

When the Afghan participants in this study were asked about the degree of difficulty of treating the problem described in the vignette, 21.3% of participants reported it would be “extremely difficult” to treat the problem and 46.0% said it would be “very difficult” to treat. In contrast, Iraqi participants rated the degree of difficulty of treating the problem presented to them as much lower than Afghan participants, with 16% stating it would be “extremely difficult” and 26.2% selecting “very difficult” (Slewa-Younan et al., 2014). The majority of Afghan participants thought the
problem in the vignette would be very difficult to treat. This may have an influence on their help-seeking behaviours because there could be some hesitation when there is this belief that the problem would be hard to treat. The Iraqi participants were more optimistic about treatment than Afghans. The statistical differences require further research that considers age, gender, length of time in Australia and education levels as well as country of origin and their traumatic backgrounds. The historical duration of the war in Afghanistan could also have influenced on these results.

Next, the current study’s participants were asked about their views on the likely recovery outcomes if the fictional character in the vignette were to obtain appropriate help. The findings indicated that Afghan participants responded along similar lines to those in the Iraqi study, with 29.3% of Afghan participants selecting a “full recovery with no further problems”, another 14.0% selecting “partial recovery” and 10.0% selecting “partial recovery but the problem could re-occur”. In comparison, 31.6% of Iraqi participants reported that after appropriate treatment, a full recovery would be likely if the individual received appropriate help (Slewa-Younan et al., 2014). Caldwell and Jorm (2011) examined nurses’ beliefs versus those of the Australian public about prognosis, long-term outcomes and discrimination, in response to vignettes describing a person with either schizophrenia or depression. Their study used a self-completion postal survey. Their findings suggest that nurses tend to be more negative than the general community but more positive than the other professional groups (particularly the medical professions) about long-term outcomes and prognosis of mental illnesses. Only 8.8% of nurses reported full recovery with no further problems and 61.4% reported full recovery with the problem likely to re-occur, whereas 29.8% of the general Australian population reported full recovery with no further problems with professional help and 44.4% reported full recovery but the problem may re-occur. Overall, these findings suggest that the refugee population are less optimistic about mental health outcomes and recovery than the general Australian population. Both countries and even studies within Australian professionals were not very optimistic about the outcome of the treatment which may influence people’s decision to pursue treatment. It may also suggest that mental health as perceived as not treatable. Unless there is confidence in the success of treatment or with the mental health service it is unlikely individuals would take appropriate treatment options. Without a reasonable belief in the chance of recovery
people may also avoid appropriate treatment or turn to more traditional method of treatment. It is important that promotion programs tailored to the need of these communities in order to support these vulnerable groups. This can be done through giving clear messages that treatment options can be tailored for specific mental health problems and have a reasonable chance of allowing the person to live an active and normal life.

6.1.1.3 Beliefs about causes and risk factors of mental illness

The belief of participants about vulnerability to the problem in the vignette was also assessed in the survey. Almost a third of the Afghan participants (31.3%) considered that the most likely factor to have caused the problem was “coming from war-torn country”, which was the majority view. This was followed by “family problems” (20.7%) and “experiencing a traumatic event” (20.7%). In comparison, 96.5% of the general Australian population assessed by the NSMHLs considered a traumatic event to be a likely or very likely cause of the problem described in the PTSD vignette (Reavley & Jorm, 2011). However, in the Iraqi study the majority of participants (52.9%) reported that the “experience of a traumatic event” was the most likely cause for the problem described in the vignette, followed by a belief that “coming from a war torn country” (16.0%) was the most likely cause (Slewa-Younan et al., 2014). Afghans were more likely to select war over other option as the cause of PTSD. Whereas Australian and Iraqi participants choose a traumatic event and did not view war as the most critical factor in the cause of PTSD. This would imply that Afghans may have experienced significant differences in either their pre arrival or their experiences of the war. With regard to the Australian population it is unlikely that war would feature in their PTSD due to Australia’s long history of non-invasion and peace. Traumatic events would most likely involve non-war activities. While the Iraqi population have experienced war this was not as historically as long as that in Afghanistan and this could be why they choose traumatic events. Traumatic events may also be seen as a war related activity therefore for example watching a bomb explode is an event rather than seen as war related. Hence the protracted conflict in Afghanistan resulted in the deterioration of security in the country, loss of family members, kidnapping and the genocide of minority groups. This triggered significant migration and asylum seeking by Afghans to other countries. This migration escalated during the Taliban rule in Afghanistan and after the fall of the Taliban in
December 2001. The significant exposure to long term war and persecution may be an influential factor in the choice of war as the primary cause of PTSD for Afghans.

These discrepancies within communities with regard to causes of PTSD may enable mental health professionals and researchers to formulate targeted and appropriate programs to cater for the needs of these refugee populations. This can be done by ascertaining the length of time people have been exposed to ongoing conflict in the past.

The second option for the cause of PTSD Afghan selected by a quarter of participants was family problem. This could be due to the inter-familial conflicts that arose during the Taliban era. Shiite/ Sunni couples who were married before the Taliban faced significant persecution once the Taliban took power and after they left. The conflict between Shiite and Sunni population in Afghanistan escalated during the Taliban regime. Prior to that Afghans did not have these inter religious problems and families with both Shiite and Sunni members lived peacefully. The Taliban persecution of Shiite meant that families were split apart, marriages ended and families traumatised. In addition, many male bread winners were killed during the war resulting in a significant rise in single headed female households with large families without the protection of adult males.

**6.1.1.4 Perceived Sympathy and Discrimination**

When participants in the Afghan study were asked how sympathetic they would feel towards the person with the problem described in the vignette, 24.0% said they would be “extremely sympathetic”, 52.7% of participants reported that they would feel “very sympathetic” and 19.3% said they would be “moderately sympathetic”. These finding are very similar to those of the Iraqi refugee study by Slewa-Younan et al. (2014), in which 37.8% participants reported that they would feel “extremely sympathetic”, and another 32.4% said they would feel “very sympathetic” towards a person experiencing this problem. When asked if they believed a person experiencing this problem would be discriminated against by others in the community, 38.7% of participants in the Afghan study reported that the individual would be discriminated against. Surprisingly, only 20.4% of participants in the Iraqi study believed that the individual would be discriminated against, with a larger number (78.7%) stating that they did not believe that the individual would be
discriminated against. Reavley et al. (2014) undertook a survey to measure and compare attitudes towards people with mental health disorders, comparing the attitudes of Australian health professionals, including psychiatrists, psychologists and GPs, with attitudes of the general community. A postal survey was undertaken of 518 GPs, 506 psychiatrists and 498 clinical psychologists, and 6019 members of the general Australian community were sampled using a telephone survey. Data analysis was undertaken using exploratory structural equation modelling in order to establish the dimensions of stigma and compare patterns of association according to gender, age, clinical vignette and professional grouping. Participants were given a case vignette describing a person with either depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, PTSD or social phobia, and two questionnaires assessing stigmatising attitudes (the Depression Stigma Scale and the Social Distance Scale). Findings suggested that mental health professionals had less stigmatising attitudes than the general public. Medical and mental health professionals were found to be comparable to those members of the general community in social distance and also in personal and perceived attitude stigma.

These findings suggest a high level of stigma related to mental illness in the public Australian community, so it is not surprising that it remains high within the refugee communities as shown in both the current study of Afghans and the study of Iraqis by Slewa-Younan et al. (2014). The current research noted that the majority of Afghans reported that they would be very sympathetic towards people with mental illness with over 70% reporting high levels of sympathy towards someone with mental illness. This was also the case in the Iraqi study in which over 60% of participants also expressed high levels of sympathy. However, when asked about the level of discrimination about mental illness of people in their individual communities there was a significant difference in responses between Afghan and Iraqi studies. Just over a third of Afghans believed that people with mental illness would be discriminated against. The Iraqi study recorded much lower levels with 5th of participants stating that they would discriminate against. There was a reasonable amount of empathy for those in the vignette but Afghans considered much higher level discrimination towards those with mental illness than the Iraqis. This does correlate with other statistics that confirm stigmatising nature of mental illness within the Afghan community (de Anstiss, Ziaian, Procter, Warland and Baghurst (2009).
While people may perceive themselves as sympathetic, when faced with a situation in which for example, hosting someone in their home with schizophrenia may challenge their notion of empathy. Stigma still remains an influential factor in people perception as well as help-seeking behaviours. Therefore health professionals need to be aware of these challenges within the minority refugee populations.

6.1.1.5 Help-seeking behaviours
Help-seeking behaviours can be defined as two distinct activities, formal and informal. In the qualitative part of this study I discussed in detail both types of help-seeking-behaviours of the Afghan participants. In the quantitative section of this research, participants were asked who they would first seek help from if they (the participants themselves) were to experience a problem such as that described in the vignette (formal help-seeking). A GP was rated by 26.7% of participants as the first person participants would approach for help with this problem, followed by a psychologist (24.0%) and psychiatrist (23.3%). In contrast to our results, the Iraqi study by Slewa-Younan and colleagues (2014) found that seeking help from a psychiatrist rated most highly at 24.0% and was the first person participants would approach for help with this problem, followed by family members (21.8%) and psychologists (19.1%). Other research supports variation in help-seeking patterns among different ethnic groups. Black Caribbeans used their friends more than family members and used formal help quite frequently, Asians were more likely to use their family, but not use formal help and Black Africans were more likely to seek help from a religious leader and less likely to seek formal help (Brown et al., 2014).

6.1.1.6 Professional treatment providers
Clearly, different cultures vary in their perceptions of mental illness (Karno & Edgerton, 1969), which in turn can influence the utilisation of traditional psychiatric services (Stanley, 1977). More importantly, culture can influence mental illness by defining the normal and abnormal, by influencing aetiological factors and clinical presentation, and by influencing help-seeking behaviour (Bhugra & Bhui, 1997). In refugee communities culture can determine values and give credence to informal or spiritual sources, but some go beyond the spiritual to choose professional treatments. Of interest is the finding that participants in the current study considered psychiatrists, along with psychologists and general practitioners, to be the treatment
providers most likely to be helpful. This was comparable with participants in the Iraqi refugee study, where 84.5% selected seeking help from a psychiatrist as most helpful (Slewa-Younan et al., 2014). Both the Iraqi and Afghan studies showed variations from the preferred treatment providers noted in the NSMHLs, where counsellors, followed by GPs, were considered the most helpful in treating PTSD (Reavley & Jorm, 2011). In comparison, other studies found that asylum seekers and refugees used GP services more often than they used psychiatrists and psychologists. In the cross-sectional study conducted in Ireland, which used validated self-reported health status questionnaires of adult asylum seekers (n = 60) and refugees (n = 28) from 30 different countries of origin living in Ireland, the two groups were compared for utilisation of the health care system and the use of over-the-counter medications, asylum seekers were found to use GP services more often than refugees (Toar, O’Brien & Fahey, 2009). The reasons for these differences warrant further examination, as there may be social or cultural elements surrounding the role of psychiatrists that are particular to the Iraqi and Afghan populations. It also is possible that PTSD is perceived among individuals in these cultures as being a more severe “brain-based” illness than certain other mental health problems. Believing that, treatment from a mental health professional who is also a physician is warranted. Finally, another reason for the higher endorsement of psychiatrists among participants in the current study may not only resonate from the trust they place in the biomedical community, but it may also be possible that this endorsement is, in part, an artefact of social desirability in responses. It is therefore not surprising that majority of participants in the current study (76.7%) believed that “dealing with the problem alone” would be harmful, with only 7.3% reporting it would be helpful. This is reassuringly better than the Iraqi study conducted by Slewa-Younan and colleagues (2014), where more than half of the participants believed “trying to deal with the problem alone” would be helpful. This response is very concerning and it is interesting to note that most of the Iraqi participants who selected this option were more likely to have been in Australia for a short period of time. Research articulating particular characteristics of individuals who prefer to deal with mental health problems alone have identified that at least in the case of depression, these individuals tend to be male and to hold the belief that mental illness is self-limiting and due to personal weakness (Jorm et al., 2006). Although such a detailed analysis
was not conducted in the Iraqi study, it is important to note that the desire to deal with mental health problems in isolation may be considered to be beneficial or harmful across differing refugee populations. For researchers and mental health professionals it is important to note the diversity in treatment options and preferences of individual ethnic communities.

6.1.1.7 Beliefs about the role of medication and religion as treatment
In terms of using medication, the current Afghan study participants preferred using vitamins and minerals and herbal medicine rather than prescription antidepressants and/or anxiolytic medication for the treatment of PTSD. These treatment options are consistent with findings from other studies of MHL across a number of mental health problems in differing populations (Jorm, 2012). However, it should be noted that when participants in the Australian NSMHLS were asked for the most helpful medication to treat PTSD most regarded the use of anti-depressant medication more favourably, indicating greater similarity with treatment guidelines (ABS, 2007) than participants in this current study.

Evidence suggests that in cross-cultural communities, interventions and ceremonial rituals, such as consulting spiritual leaders, reading the Koran or praying with the person who is unwell, are readily accessed and considered acceptable, whereas medication such as antidepressants can sometimes be thought to worsen the symptoms of mental illness, as suggested a study of Somali refugees (Bentley & Owens, 2008). In the current study, 62% of participants reported that reading the Koran would be helpful for the problem described and 37.3% believed that prayer would be helpful. Consistent with this finding, Miller and colleagues (2009) noted that faith in God and prayer is among the ways Afghans report coping with mental illness. For the Afghan participants, non-pharmaceutical interventions were preferable than antidepressant and anxiolytic medication. Religion also plays a significant role and acts as a coping mechanism and companion to traditional forms of herbal medicine. These are familial traditional practices that allow them to feel comfortable and safe to utilise. This is particularly important for the newly arrived refugees who are separated from culture and traditional healers. By combining traditional forms of healing with western medical model allows for greater sense of familiarity and respect for tradition.
6.1.1.8 **Beliefs about usefulness of self-help activities**

In the current study activities regarded generally as self-help interventions, such as improving diet and exercise, finding new hobbies, and getting information about the problem, were highly endorsed by participants as treatments for PTSD. These findings are consistent with findings from other studies of MHL relating to a broad range of mental health problems across different populations, including the Australian National Survey of Mental Health Literacy and Stigma (NSMHLS) (Reavley & Jorm, 2011). In the current study, this finding may reflect not just a universal preference for the use of less confronting and less potentially stigmatising interventions, but also an expression of the perceived importance of “keeping oneself busy”, a coping mechanism known historically to be favoured in Afghan populations (Lipson & Omidian, 1997). At the same time, participants in the current study also viewed favourably the use of specific psychotherapy in the treatment of PTSD, the vast majority considering both “psychotherapy focusing on changing thoughts and behaviours” (84%) and “psychotherapy focusing on the past” (86.7%) to be helpful. In this respect the participants’ views in the current study are consistent with “evidence-based practice”, in which the use of specific psychotherapy, along with anti-depressant medication, is advocated in the treatment of PTSD (New Zealand Guidelines Group, 2001). Our findings also correlated with Morgan, Reavley and Jorm (2014) study in which beliefs of health professionals where compared with those of the Australian public in two consecutive years, 2011 and 2012. In 2011, surveys of a nationally representative sample of the Australian public (n = 6019) were carried out using a number of clinical vignettes, and then in the following year a sample of Australian general practitioners, psychiatrists, and psychologists (n = 1536) were also surveyed. Participants were asked to rate the helpfulness of a range of interventions and the likely outcome with or without appropriate professional treatment. The findings revealed that the Australian public relied more on close family or friends, a counsellor, vitamins and minerals, a special diet or avoiding certain foods, and having an occasional alcoholic drink to relax. In contrast, professionals reported a greater belief in psychotherapy and cognitive behavioural therapy for depression and anxiety. Comparatively, Afghan participants also endorsed the importance of diet and exercise, viewing these activities as a helpful source of distraction. However, the vast majority of Afghan participants considered
both “psychotherapy focusing on changing thoughts and behaviours” (84%) and “psychotherapy focusing on the past” (86.7%) to also be helpful. Notably these findings suggest that those Afghan participants with higher levels of education endorsed professional interventions, as do professionally trained Australians. This would suggest that educational levels influence decisions with regard to usefulness of mental health interventions, regardless of culture or ethnicity. This distinction between may assist future research or mental health promotions.

6.1.1.9 The role of religion in beliefs about vulnerability to development of PTSD

Various studies have reported the existence of a view amongst non-Western populations and followers of a diverse range of religious doctrines that illness or bad experiences are viewed as God’s punishment (Adshead, 2008). Nonetheless, only 25% of the Afghan study participants believed that mental illness was a “punishment from God”. Even within Christian belief systems there is a belief amongst some of the faithful that illness is more likely to be God's punishment for sin (Adshead, 2008). This punitive belief system was also noted in a study of Somali refugees, where half of the participants attributed causes of mental illness to God (Bentley & Owens, 2008). They described that both the good and the bad experiences of life derived from God, including illness of any kind. Similar results were found in the study of ethnic differences in the knowledge, attitude and beliefs towards mental illness in the traditional but fast-developing country of Qatar (Bener & Ghuloum, 2011). Using a cross-sectional study method, the authors surveyed patients accessing primary health care centres in Qatar in 2009. In this study, a representative sample of 3000 Qatari and non-Qatari Arabs aged 20 years and older were approached, with 2514 subjects (83.8%) responding. Findings indicated that a significant proportion of Qataris (50.6%) thought that mental illness can be a punishment from God, compared to non-Qatars (44.5%), and that 45.1% of Qataris thought that people with mental illness are mentally retarded compared to only 35.1% of non-Qataris (35.1%). This highlights the role that religion is thought to play in the beliefs of some non-Western populations regarding vulnerability to and development of mental illnesses. Findings in the current study differ somewhat to the Qatar results, as only a minority of Afghan participants (25%) perceived that mental illness was punishment from God. This differentiation could be due to the age and levels of education of
participants in the Afghan study, who tended to be students and members of younger
generation of community. However, the tendency to assume that mental health is due
to God’s will remains of concern because 25% of Afghans with this ideology are
unlikely to seek help. Therefore, it is recommended that researchers take into
consideration the influence of religion on the values and judgments with regard to
mental illness. To ensure treatment, promotions and education programs are
inclusive and reach all community members.

The Afghan participants in the current study were also asked to consider the likely
risk factors associated with vulnerability to the type of problem described in the
vignette. In response to risk factors and what was “most likely” to make a person
vulnerable, 48.0% of participants reported that having been born in Afghanistan was
the most likely risk factor in making a person vulnerable to the problem described.
The next “most likely” risk factor was “having left Afghanistan prior to 2001”
(22.0%), followed by “being unemployed” (11.3%). Afghanistan experienced
significant internal conflict amongst different ethnic groups, power struggles and an
unstable government prior to 2001 when the Taliban took power across the country.
It was this ongoing conflict and persecution that forced large numbers of the Afghan
Hazara population to seek sanctuary outside Afghanistan. These findings were
similar to the Iraqi study, in which one-third (33.3%) of participants reported that
having been born in Iraq was the most likely risk factor in making a person
vulnerable to the problem described in the vignette (Slewa-Younan et al., 2014). The
relationship between being born in a war-torn country and the development of PTSD
is clear. The association that participants assigned to the conflicts that displaced them
from their home country and vulnerability to PTSD is not surprising and follows a
pattern of events in which exposure to war, persecution and conflict contributes
toward incidents of PTSD. Of concern is the low number of participants who were
able to make the link between conflicts with PTSD. Awareness of the link is critical
because early intervention and treatment programs are key recovery.

Afghan participates also chose unemployment as a risk factor for the vulnerability to
PTSD. This would suggest that employment is rated highly by Afghans. Conversely
unemployment would be considered detrimental. This was the subject of Pharr,
Moonie, and Timothy’s study in which the researchers investigated the role
unemployment plays in mental health outcomes. The purpose of their study was to examine the impact of employment status and duration of unemployment on perceived health, access to health care, and health risk behaviours. The researchers analysed data from Nevada’s 2009 Behavioural Risk Factor Surveillance System (BRFSS), comparing participants who were unemployed (greater than and less than one year) with those who were employed and those who were voluntarily out of the labour force. The perceived mental health profiles of unemployed participants were significantly worse; they were more likely to delay healthcare services owing to cost, and were less likely to have access to health care than employed participants and those voluntarily out of the labour force (Pharr, Moonie, and Timothy, 2012). Dean and Wilson (2009) also reported that the unemployed tend to have higher levels of impaired mental health, including depression, anxiety and stress, as well as higher levels of mental health hospital admissions, chronic disease (cardiovascular disease, hypertension and musculoskeletal disorders), and premature mortality. The crucial role that employments play in mental health outcomes was also recognised by Afghan participants. Providing meaningful activities in the form of employment meets several needs including an income to support family, as well as employment bringing attributes of independence, identity and dignity. Unemployment on the other hand contributes to higher levels of impaired mental health, and intensifies vulnerability to mental illness. A reduction in vulnerability would require the attention of policy makers and educational facilities to strengthen and pave the way for participants’ entry into paid employment. This would also include access to training and vocational pathways.

6.1.2 Clinical characteristics of the surveyed population

6.1.2.1 Post-traumatic stress disorders

Although this thesis sought to determine MHL of Afghan refugees, it was also important to consider and discuss the levels of psychological distress and symptoms in the study population. In this study, levels of PTSD symptoms were examined using the Impact of Event Scale—Revised (IES-R). It was noted that 46% of participants had probable PTSD. By comparison, in the Australian National Survey of Mental Health and Well-Being, the rates of PTSD ranged from 6.4% for 12 months’ prevalence to 12.2% for lifetime presence, which are between three to five
times less than current Afghan study sample. In a systematic review of resettled Iraqi refugees, rates of PTSD were ranged from 8% to 37.2% (Slewa-Younan, Uribe et al., 2015). Furthermore, the National Trauma Survey (NTS) interviewed two groups of Rwandans aged from eight to 19 residing in the community and others institutionalised in unaccompanied children’s centres to measure traumatic exposures. Researchers used an inventory of possible war-time experiences and post-traumatic stress reactions with the Posttraumatic Stress Disorder Checklist. The survey found that the overall rate of “probable PTSD” in these two groups of Rwandan participants was 62% and 54%, which was slightly higher than that of the current Afghan study (Neugebauer, Fisher, Turner, Yamabe, Sarsfield, & Stehling-Ariza, 2009). In another study of Afghan refugees residing in refugee camps in Pakistan, the percentage of probable PTSD was significantly higher than in the Rwandan and current study. Researchers measured morbidity in the Afghan camp residents who had been attending the hospital. The data suggested that nearly 80% of this population had been diagnosed with PTSD using the Mini International Neuropsychiatry Interview Schedule (MINI) (Naeem, Mufti, Ayub, Haroon, Saifi, Qureshi, Ihsan, Chaudry, Dagarwal, 2005). In a further study of 300 various newly arrived refugees in Western Australia it was reported that 17% of this population had probable PTSD. Interestingly, it was noted that the PTSD rates varied with the region of origin, with refugees from the Middle East / Western Asia having significantly higher levels of psychopathology than those from Africa or Southeast Asia (Laugharne, 2012).

6.1.2.2 Exposure to traumatic events

In the current Afghan study we also examined participants’ exposure to traumatic events using the AWES. The mean number of potentially traumatic events experienced by participants was 12.9 and ranged from one participant who had not been exposed to any PTEs through to 14 participants reporting exposure to 17 traumatic events. Given that, on average, participants reported being exposed to at least 12.9 PTEs, far greater than the one traumatic event required to fulfil criterion A of PTSD diagnosis in the DSM-IV-TR (American Psychiatric Association, 2002), it is not surprising that 46% of the current study sample had probable PTSD. Pre-arrival exposure to traumatic events was also the subject of a study of asylum seekers and refugees in the Netherlands. The study found a link between the number of pre-
migration traumatic events and increased post-migration stressors (Gerritsen, et al., 2006).

1.1.2.3 Functional impairment

The current Afghan study measured functional impairment of participants. A variation was noted, ranging from 46.7% of participants who reported severe disability to nearly 35% of participants who showed mild to moderate disability and 18.7% participants who reported no disability. These results were determined using the World Health Organisation Disability Assessment Scale-II (WHO DAS-II). Disability can be described in a number of ways, including impairment in body structure or function; a limitation or lack of ability to perform an activity in the manner considered normal for a human being, and restriction in participation is social interaction and work (Cordozo, Bilukha, Crawford, Shaikh, Wolfe, Gerber & Anderson, 2004). Disability can exist in varying degrees and combinations. It can be because of a long-term physical or mental health condition that limits or restricts one’s everyday activities and lasts for six months or more (Australian Institute of Health and Wellbeing, 2016). A study to measure the prevalence of mental distress in a group of “at risk” Afghans in Afghanistan was undertaken in 2013. A cross-sectional disability survey was carried out of 5130 households in 171 clusters throughout the 34 provinces. The sample included 838 non-disabled control participants aged above 14 and 675 disabled participants. Results showed that various vulnerable groups (disabled people, the unemployed, the elderly, minority ethnic groups, as well as widowed, divorced or separated women) were at higher risk of experiencing mild to severe mental health problems. The adjusted odds ratio for war-related disability compared to non-disability was 4.09 (95% confidence interval 2.09–2.99) for mild mental distress disorders and 7.10 (3.45–14.5) and 14.14 (3.38–59.00) for moderate or severe mental distress disorders (Trani & Bakhshi, 2013). According to the National Survey of Mental Health and Well-Being (Australian Bureau of Statistics [ABS], 2007), of the 8841 people who had a profound or severe core-activity limitation, 43% had a 12-month mental disorder. Interestingly, it was noted that those same people had almost three times the prevalence of 12-month anxiety disorders (14.4%) (the most common mental health disorders), followed by affective disorders (6.2%), confirming the coexistence between mental illness and functional impairment.
6.1.2.4 Depression

In the current Afghan study, not only were participants presenting with high rates of PTSD but also depression, with 14.7% of participants scoring above the cut-off suggestive of probable depression. Depression is problematic because it is often associated with high levels of co-morbidity, including conditions such as substance abuse and eating disorders. In comparison, the National Survey of Mental Health and Well-Being noted that rates of depression in the general Australian population were reported to be 6.3% for 12-month prevalence and 15.0% for lifetime prevalence, which are significantly lower than in the Afghan study (ABS, 2007). When we compared the prevalence rate of PTSD with the Iraqi population, the Afghan population study showed much higher rates, but in the systemic review, Iraqi refugees showed significantly higher rates of depression with wider variation (28.3% to 75%) (Slewa-Younan, Uribe, et al., 2015). Similarly, higher rates of depression (57%) were reported in the study of 55 Afghan households in Drenthe in the Netherlands than in the general population in the Netherlands (Gernaat, et al., 2002). Another population-based study of adult refugees and asylum seekers from Afghanistan, Iran and Somalia was conducted in the Netherlands from June 2003 to April 2004. In this study, a random sample of refugees was obtained from the population registers of three municipalities (Gerritsen, et al. 2006). A total of 178 refugees and 232 asylum seekers participated (response rates of 59% and 89%, respectively). Symptoms of PTSD, depression and anxiety were measured with the HTQ and the HSC-25. The results showed that more asylum seekers than refugees had symptoms of PTSD (28.1% and 10.6%, respectively). As for the subscales, 29.3% of the refugees and 61.5% of the asylum seekers reported symptoms on the depression scale, and 27.7% and 41.2%, respectively, on the anxiety scale. Results also showed that participants from Afghanistan and Iran had a higher risk for PTSD and depression/anxiety (Gerritsen, et al., 2006). Overall, our results seem generally consistent with previous studies of Afghan refugees and point to the substantially higher levels of PTSD, depression and general anxiety than in the general community.

6.1.2.5 Anxiety disorders

In DSM-IV-TR, anxiety disorders are defined as the outcome of unconscious conflicts in the patient’s mind. Anxiety disorders generally involve feelings of
tension, distress or nervousness. A person may avoid, or endure with fear, situations that cause these types of feelings (ABS, 2007). It is important to note that anxiety symptoms can be conceptually and categorically variable in relation to cultural viewpoints and this suggests that anxiety disorders cannot have a uniform definition. In the current Afghan study anxiety levels were examined using the anxiety subscale of the HSCL-25, with the finding that 21.3% of participants showed anxiety symptoms. According to the National Survey of Mental Health and Well-Being (ABS, 2007), the rate of anxiety in the general population is reported as 14% for 12-months prevalence, which is much lower than the Afghan sample. However, the results of the current study were similar to that of Tibetan refugees residing in rural North India. In that study, which utilised the Beck Anxiety Inventory (BAI), a survey of 300 participant Tibetan refugees was conducted to determine the prevalence of anxiety in this community. The results revealed that 21% of the study population had significant levels of anxiety that were classed as moderate or severe, with older adolescent participants registering even higher levels of anxiety disorders (Alexander, David & Grills, 2013).

6.1.2.6 Resilience

Resilience refers to an individual’s or community’s ability to positively cope with life’s hardships, and includes relationships between the individual, his or her family and the community (Omidian & Papadopoulos, 2003). It also includes making sense of one’s life in the middle of uncertainty (Eggerman & Panter-Brick, 2010). Resilience plays an important role within recovery, adaptation and coping with expected and unexpected adversity. Developing and utilising effective coping skills helps build resilience, which in turn helps facilitate ways to adjust to the pressures and challenges that are brought about by stresses (Wind & Marshall, 2008). Resilience was measured in the current Afghan study using the CD-RISC II and 88% of the study population showed very low levels of resilience, with only 12% showing a high level of resilience. These figures suggest a high percentage of participants with probable PTSD and low levels of resilience, leaving them vulnerable to experiencing stress symptoms and with strained coping abilities. It is therefore not surprising that almost half of the participants reported severe disability. People deal with mental health issues in different ways and have different coping abilities.
Following this theme, Omidian (2012) examined the concept of resilience in a study where culturally relevant psycho-social training was developed for Afghan teachers. Resilience was defined using Dari words that fitted the participants’ understanding of the concept through the use of the metaphor of two sticks, one green and pliant, the other dry and brittle. Someone without resilience would be like the dry stick that breaks under pressure, while the person who is resilient will be more like the pliant stick that returns to its original form after being bent, being almost impossible to break. The group also determined that faith played a role in maintaining hope, a factor thought to be related to resilience. They surmised that everyone has problems and difficulties in life, but if you believe in God and think positively, stress will not overcome them. Furthermore, participants believed that if all doors are closed, God’s door is always open and therefore hope is ever present. Finally, the group warned that if they think negatively and are pessimistic for the future, then stress will increase. This suggests a strong correlation between resilience and coping abilities through religious beliefs. Some studies have shown that the more exposure to catastrophic events a person experiences, the more likely they are to have higher resilience. This was examined in the Iraqi study that looked at a population of 298 Iraqis arriving in the US (Ssenyonga, Owens, & Olema, 2013). The group was assessed on their arrival and reassessed one year later. Those who were kidnapped while in Iraq had higher levels of resilience and lower rates of PTSD than those who were not kidnapped (Wright, Talia, Aldhalimi, Broadbridge, Jamil, Lumley, Pole, Arnetz, 2016). The researchers concluded that the kidnapped victims had developed greater levels of resilience and were therefore able to cope better than non-kidnapped participants. Other studies, however, have shown that there are no significant differences in the resilience and post-traumatic disorders of refugees with and without PTSD.

Overall, this study’s findings indicated that participants had significantly higher levels of probable PTSD, depression and anxiety symptoms, low levels of resilience and high ratings of functional disability. With such problematic clinical presentations, it is important that participants access and seek timely mental health care. However as has been stated previously, problematic levels of MHL can impact significantly on treatment-seeking.
6.1.3 Conclusion

In conclusion, there was a slightly lower rate of recognition of PTSD amongst Afghan participants than amongst members of the Australian population. Of those who identified PTSD, there was a higher proportion of participants with higher levels of education than the proportion of participants with lower levels of education. This may reflect an association between higher levels of education and greater exposure – and receptiveness – to Western, biomedical models of mental health problems and their treatment. Treatment options sought by the Afghans tended to be non-invasive, with Afghan participants nominating self-help interventions, such as improving diet and exercise, and finding new hobbies. These activities suggest methods or forms of distraction, perhaps to help individuals redirect their thoughts and energies. In addition, participants believed that getting information about the problem was highly useful. The use of such non-comforting, confronting and potentially least stigmatising interventions may also be an expression of the perceived importance of “keeping oneself busy”, a coping mechanism known historically to be favoured in Afghan populations (Lipson & Omidian, 1997). In contrast, those participants with higher levels of education viewed the use of specific psychotherapy in the treatment of PTSD favourably. On the use of pharmaceuticals in the treatment of PTSD, Afghan participants preferred using “vitamins and minerals” and “herbal medicine” rather than prescription “anti-depressant” and/or “anxiolytic medication”, following a similar theme in which non-invasive and non-medical treatments take precedent. In terms of informal help-seeking, participants believed consulting spiritual leaders, reading the Koran or praying with the person who is unwell to be appropriate helping practices. In combination with this, the majority of participants reported that reading the Koran helped, while slightly over a third reported that prayer would be helpful. As part of finding support, Afghans also believed that dealing with the problem alone would be harmful, therefore seeking comfort from trusted others was helpful, unlike in the study of Iraqi refugees by Slewa-Younan and colleagues (2014), in which more than half of participants preferred to deal with the problem alone.

Therapeutic approaches considered useful by Afghan participants presented some interesting results, with the majority choosing to see a GP rather than a therapist or counsellor. By visiting a GP there was less likelihood of psychological or in-depth
discussion of the problem, it was less likely to be confronting and there was certainly less requirement for verbalising.

Afghan participants considered the three primary factors that contributed to the problem described in the vignette were “coming from war-torn country”, followed by “family problems” and “experiencing a traumatic event”. In both the general Australian population and the Iraqi population experiencing traumatic events was the main reason behind the problem described in the vignette. In terms of risk factors, Afghan and Iraqi participants had similar responses to the problem described in the vignette (PTSD). Afghan participants considered the problem more distressing, of more serious consequence and of greater prevalence in their community, than did participants in the Iraqi sample (Slewa-Younan et al., 2014), and yet, the number of Afghan participants who expressed beliefs that a person described in the vignette would be stigmatised and discriminated was higher than in the Iraqi study. Such differences and similarities are important to note as they suggest a level of diversity of opinion about mental illness and treatment pathways for resettling refugee communities in Australia.

The current study suggests Afghan refugees resettled in Australia are likely to have very high levels of distress and PTSD symptomology. Of greater concern, the study revealed a poor understanding of mental health symptoms, with large numbers of participants not seeking treatment deemed appropriate for their mental illness. The results of this study demonstrate differences in terms of MHL and treatment practices between the Afghan population and both mainstream and Iraqi populations. This indicates the need for specific and targeted mental health services and treatment plans that recognise cultural differences and values in order to bridge the gap between Western medical models for treatment and Afghan refugee treatment preferences. Working with refugee populations falls under a larger obligation to understand culture and belief. Stanley et al. (2009) highlighted that for professionals to treat refugees effectively, they should consider first understanding their own cultural beliefs and values. Therefore, education and training must go in both directions: education of refugee communities about mental health services as well as education of service providers working with refugee communities (Collinetti & Murgia, 2008). These differences and similarities provide useful insights for treating
professionals, particularly in the delivery of mental health education and promotion, and highlight the need for further studies of MHL, which will be discussed further in the final chapter of this thesis.

6.2 Discussion of Study Two

6.2.1 Belonging

Belonging has been found to be central to inclusion and identity and underpins good health (Egan, Tannahill, Petticrew, & Thomas, 2008). Thus, in the current study, reflecting on belonging in interviews was given a high degree of importance. Belonging is understood here to be a prerequisite to full participation in a community regardless of ethnicity or religion. The need to belong and loneliness are two subjective states that, on the basis of prior research and theory, would appear to be related both to one another and to well-being (Mellor, Stokes, Firth, Hayashi, & Cummins, 2008).

In the present study of Afghan refugees, disconnectedness was found to hinder settlement or distract refugees from seeking help. Participants described feeling disconnected from others and avoiding social gatherings. In one instance, a participant remained in his room away from family and friends. Before reflecting on the findings relating to participants’ challenges with belonging, it is important to place these findings into their context.

The present study is of a refugee population that has experienced trauma resulting from ethnic persecution that was sanctioned by the majority government rule. The current study group consists mostly of Hazara Afghans, a minority Shiite population who have experienced historical persecution from the dominant Sunni Pashtuns within Afghanistan. This persecution manifested over the centuries in episodes of ethnic cleansing, escalating significantly during the Taliban regime. In fleeing Afghanistan, Afghan Hazaras share similarities with other refugee groups who have sought asylum in Australia, notably those arriving from post-war Europe and more recently from Cambodia and Vietnam, as well as Africa. This study reveals how the Afghan Hazara refugee population not only holds a strong identity as refugees fleeing war, but also identify as a distinct ethnic minority who have experienced historic persecution within their ancestral homelands. Distinctively, this group not
only faces the immediate consequences of war and trauma, they also bring with them the collective memory of their ethnic persecution. There are some parallels with Muslim Chinese, who have also sought asylum in Australia as a result of religious and ethnic persecution (Crane, 2014). Participants of the current study provided details of the persecution and atrocities endured by this minority group during the Taliban regime, including beatings and killing of family members in front of children, the taking of young boys and girls as captives and setting fire to homes and properties. The memories of these events stay with them and manifest in dreams and thoughts. Afghan participants described their past trauma as an ongoing issue embedded within their everyday tasks and challenges. They talked about missing their family, worrying about their safety and the difficulties they face when having to make decisions alone without their families’ guidance and support. Culturally, it is common for Afghan women to refer to their mothers, especially when faced with marital problems. The loss of family connection, tradition and trauma impacted on participants’ abilities to adapt to a new environment, learn a new language and find employment. All of these resettlement matters play an important role in facilitating a sense of belonging that could help counter the effects of past trauma.

In this section, findings related to participants’ challenges with belonging are reflected upon in the context of the literature. First, I will discuss the sense of “otherness” described by participants. Second, I will reflect on the nexus between belonging and employment. Last, I will move on to language, culture and the safety of families left behind facing persecution and loss and grief. Overall, these findings suggest that belonging is a critical part of settlement outcomes and that factors which impede belonging contribute to a sense of otherness or outsider status, leaving individuals marginalised.

### 6.2.2 Sense of otherness

This sense of otherness was described clearly by a few participants in the current study. Participants reported feeling different at school because they looked different and, for the girls specifically, because they wore a hejab (head scarf). This sense of

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1 For example, one participant who had marriage issues regretted that she could not consult her mother for guidance on what steps she should take.
difference discouraged feelings of connectedness to the broader school community. This was also the case in a study of refugees from West Papua living in North Queensland, Australia. Their sense of disconnectedness, coupled with key challenges caused by trauma, persecution, flight and asylum seeking, destabilised their settlement progress (Rees, Silove, Tay, & Kareth, 2013). Despite their somewhat unique characteristic as a minority refugee population that historically has been subjected to ongoing persecution, the participants’ feelings of difference are not unique to this study. Being “visibly different” to the Anglo-Australian norm is a factor that has been found to disrupt a sense of belonging (Inglis, 2010). This notion of otherness, marginalisation or limbo was well-documented in a study of young Congolese refugees in Kampala in which participants said that they felt like the people of Israel fleeing Egypt, unable to go back and unable to see ahead or see where they were going. They identified with the Israelites because of the disconnection they felt between people and place (Den Boer et al., 2015). For Muslim Australians in particular, challenges with feeling connected to Australia may be even more complex and conflicted in the current post-September 11 socio-political climate (Dunn, 2001; Dunn, Klocker & Salabay, 2007; Human Rights and Equal Opportunities Commission, 2004). The physical nature of ethnic appearances, religious and cultural differences, language, what is worn, and stereotypes (particularly with regard to young Muslims in the current climate) can so easily act to isolate ethnic groups and those most vulnerable within those communities from the mainstream. In the current study participants described feeling distinctly different, which created a sense of separation, and contributed towards further isolation. The participants in the current study also recognised that a sense of belonging was central to their future in the host country. However, inclusiveness was impeded by the social, economic and cultural factors that impacted on their settlement process as new arrivals. By drawing on the participants’ views as expressed in their interviews, the following four resettlement challenges were identified and discussed.

6.2.3 Employment

Participants in the current study suggested employment as one way to belong to a new environment. However, despite the strong desire to secure employment expressed by most participants, employment was rarely achieved because of the
multiple barriers that participants faced, most notably language skills. One participant stressed that to be able to get employment she would need to be proficient in English as well as have an understanding of the systems within the employment domain. Findings from the RCOA reported by Oliff (2010) support this conclusion. The RCOA report also noted that other factors can contribute towards poor employment outcomes for refugees, including the lack of Australian work experience, limited access to transport, lack of knowledge about Australian workplaces, discrimination in employment, difficulties with recognition of qualifications and skills, and visa restrictions for asylum seekers (Oliff, 2010).

For some participants in the current study, the barriers to finding work were so overwhelming that they believed it might never happen. This was also the case for Sudanese refugees in Australia who attended AMEPs. A study by Hatoss (2014) found that the level of English Sudanese refugees developed was not sufficient for them to find employment. The few participants in the current study who were employed reported that they felt like useful members of the community, able to contribute by helping others. They specifically noted that employment made them feel content, even though they did not feel entirely emotionally stable. It was not clear if these participants had secured full-time or part-time employment; nonetheless, they attested that being part of the general workforce and contributing to their family’s security gave them some satisfaction and inevitably led to a greater sense of belonging. Participants in the current study faced all the obstacles reported by the RCOA. However, those participants on a Bridging Visa who were living under uncertain conditions and did not have free access to government-sponsored job networks and income support were even more vulnerable. Those on a Bridging Visa were not permitted to work to support themselves and their families and were not able to attend free English language classes. Denial of these basic human rights accentuates their otherness and separates them from the mainstream. Davidson et al. (2004) supported this conclusion by emphasising that asylum seekers with no work rights, English language tuition and income support are at the highest risk of isolation.
6.2.4 Language

Language skills are not only imperative to securing employment, but also to seeking other community-based services. Language is critical to communication; thus, it inevitability influences settlement progress and belonging in a myriad of ways. The participants’ lack of English language skills, for instance, posed a challenge in seeking support from health professionals. The current study showed that lack of English language proficiency posed a far greater challenge for older generations in the Afghan community. Younger participants reported that their parents’ poor English skills meant that they consistently relied on their children when interacting with support agencies and medical services. Participants described adults becoming dependent of their children to act as interpreters and primary contacts with professionals. This disrupted the hierarchy in families, with children taking on adult roles, further disempowering adults. Rosenberg, Seller & Leanza, (2008) noted the importance of professional interpreters in her study ―Through interpreters’ eyes: Comparing roles of professional and family interpreters‖. The author reported that to ensure accurate transfer of information physicians should always use a professional interpreter when meeting with patients. A family member should often be included in encounters to serve primarily as a valuable patient advocate.

Studies of Afghan refugees’ experiences related to language skill challenges are few to non-existent. However, studies of refugees more broadly have suggested that English fluency greatly facilitates social adjustment and acculturation (Williams & Berry, 1991). Lack of English language, on the other hand, creates further isolation and can exacerbate mental illness (Dandy & Pe Pua, 2013). This dilemma was highlighted by Casado and Leung (2002) in their study of elderly Chinese American immigrants, where it was found that participants with a lower English proficiency score were more likely to feel depressed. In the current study male participants highlighted that their main obstacle to learning English was the desire and the immediate need to make a living and earn an income to support the family members in Australia as well as those left behind in Afghanistan. This was also the case for Sudanese refugees who attended AMEP classes (Hatoss, 2014). A survey of this student group showed a high dropout rate. The primary reasons for this were students obtaining low-paid physical labour, either in the local farms or at the abattoir. Taking
these jobs meant that participants were not able to attend the classes offered during the day. In the same study, dropout rates amongst female students showed that women faced different challenges to male students. Typically, when women gave birth to a child, they dropped out of the AMEP program and often did not continue with their studies afterwards (Hatoss, 2014). Although this issue was not explored in the current study, it is well-documented that Afghan women traditionally take on the primary responsibilities for child care, while men are traditionally responsible for providing the income for the family (Ayoub, 2002). It may be that these traditional expectations would define and determine educational or language outcomes for both genders (Hatoss, 2014). There are services funded by state and federal governments to support refugees with English language proficiency, including English as a second language classes run by TAFE and AMEP. However, the responses of the current study participants suggest that these services are either insufficient or not suitably tailored to meet the needs of the Afghan refugees in this study. Further research is required to explore what English language initiatives could result in more effective outcomes with increased capacity and more accessible classes, for example after-hours classes, home tutoring programs and weekend classes. Additionally, community consultation research could be undertaken with new-arrival communities on what language services would meet their specific needs, including suitable ages, level of English proficiency, gender and schedules. In sum, the current research identifies that language acquisition is critical to establishing a sense of belonging through employment and is necessary to accessing services.

Language and culturally appropriate communication between health professionals and Afghan refugees are critical elements and affect help-seeking. The consequences of misunderstandings or miscommunications may be detrimental to health outcomes. In the current study, several younger participants noted how they worried about their parents’ health because they were not able to communicate their symptoms in greater detail to medical professionals. Contributing to this was a reluctance to make their wishes known, because of either cultural differences in perception of mental health, gender-specific sensitivities, the lack of English language, or being unfamiliar with the Australian healthcare system as new arrivals. These factors can reduce treatment concordance, discourage further visits, or even worsen health outcomes. This is consistent with the literature and findings from a study of older Iranian immigrants
who were reluctant to seek mental healthcare services in the United States (Martin, 2009). This resistance was attributed largely to the cultural differences in mental health conceptualisations exemplified in the confronting and direct use of language, definition and terminology. Sonderegger and Barrett (2004) also emphasised that for many people from non–English-speaking backgrounds, their cultural norms make them less likely to ask questions of medical professionals who are held in positions of high authority. Factors impacting the success of a smooth transition for refugees are numerous and each community’s unique demography, history of immigration, attitudes and acculturation strategies can play a part in effective resettlement. It is essential, therefore, for further research to be undertaken to explore the linguistic, social and cultural determinants of successful resettlement and educate health professionals on the specific dynamics that inform communication and interpersonal exchange in health settings.

Language plays a crucial role in a variety of transactions and is a key factor in settlement outcomes and community engagement. The current research found that not learning the language further isolated participants and led to further exclusion from the mainstream. Isolation, however, can be exacerbated by self-imposed behaviours and lead to further complexities in mental health. In the current study, participants described behaviours characteristic of isolation: staying home for days or weeks at a time; having no communication with anyone, including family, acquaintances and friends; and wilfully avoiding contact with others. One participant described refusing invitations from friends to go shopping because she wanted her friends to let her stay home and sleep. But, rather than sleeping, she would cover her face with her quilt. The repeated examples of behaviours characteristic of isolation found in the interviews is concerning, especially as the literature suggests that isolation not only impairs cognitive functioning such as problem-solving abilities, planning and verbal reasoning, but can lead to negative mood, anxiety, anger and depression symptomatology (Cacioppo et al., 2006. If not addressed it could lead to a complete or near-complete lack of contact with people and society. The urge to restrict contact with others and the outside world reported by several participants in the current study, would inevitably infer consequences for their sense of belonging and indeed have a substantial impact on relationships with others, precluding any sense of belonging. Inevitably self-imposed seclusion would have a detrimental
impact on finding employment, learning the language and adjusting to the new social environment. This disconnectedness can be further exacerbated with news and stories of conflict in their homeland, where family and loved ones reside.

6.2.5  Fear of safety of family

Fear for the safety of family and loved ones can cause increased and ongoing anxiety, which can pervade daily life and undermine psychological functioning. The loss of homeland and of loved ones during the war, the ongoing persecution of ethnic minorities, the conflict between Sunni and Shiite and loss of identity were all clearly voiced by many participants in the current study, resulting in participants feeling unable to develop connections to their new environment. This conclusion is also consistent with findings from a study of Kurdish refugees and Iraqi refugees, which found that fear for the safety of family members back home and escaping war without any hope of returning home left them with an intense sense of loss and grief (Nickerson, Bryant, Brooks, Steel, & Silove, 2009). This loss is not necessarily “related to something concrete, to a point on the map or a moment in time but to the world as whole with which a person no longer feels connected” (Pourto, 2013, p. 40). When this state is combined with the stressors associated with learning a new language and a new way of life, the burden of adjustment is increased (Nickerson et al., 2009).

6.2.6  Loss and grief

Linked to loss, PTSD was found to be an important impetus behind isolation for several participants. For instance, in the current study a young participant who grew up during the war years, despite having migrated to Australia, described how he experienced the constant fear that any day he might be killed. This had paralysed him emotionally and limited his ability to fully engage with those around him. This participant’s ongoing sense of vulnerability and isolation could be understood as a result of PTSD. As described in chapter two is a psychiatric disorder that can result from the experience or witnessing traumatic or life-threatening events such as terrorist attacks, violent crimes and abuse, military combat, natural disasters, serious accidents or violent personal assaults (DSM-4). Subjects with PTSD often relive the experience repeatedly through nightmares and flashbacks, and report difficulty
sleeping. Their behaviour can become increasingly detached and lead to emotional changes that can impact on social functioning and family life. The disorder is often severe and long-lasting and can impair daily life; in some cases it can lead to suicidal thoughts and behaviours (Prolo, Chaipelli, Iribarren, & Neagos, 2005).

In the current study, most participants articulated their hope that migration to a new environment without war, killing and violence would help them forget about the past and allow them to live without fear and anxiety. Escaping, it was thought, would resolve their problems and bring stability back into their lives. However, for many participants this aspiration did not eventuate, with many participants reporting that the effect of their trauma would be with them as long as they lived. Findings from the current study are in agreement with findings from a study of 124 Middle Eastern refugees in Sweden, in which the consequence of historical experiences of trauma were found to have had a significant impact on mental health and settlement outcomes (Lindencrona, Ekblad, & Hauff, 2008). This would suggest that safety alone is not able to bring resolution to mental health issues. In their study of Cambodian refugees in Thailand, Mollica and colleagues (1998) also reported that cumulative trauma continued to affect psychiatric symptom levels a decade after the original trauma events. Wilson, Pence, and Conradi (2013) argued that trauma does not affect everyone in the same way. Some people experience a terrible event but suffer no long-term adverse emotional effects, whereas the same event can have a devastating impact on the individual standing next to them. Traumatic response is highly individualised and shaped by a wide range of factors, from genetics, to previous life experiences, to support systems available in the aftermath of the event (Wilson et al., 2013). This was evident in the current study, with some – a minority of participants – believing that the past bore no relationship to their future, and they were not encumbered by the past war years.

With this difference in participants’ PTSD in mind, isolation and mental health requires closer examination of the PTSD literature. Bremner, Vermetten, Vythilingam, Afzal, Schmahl, Elzinga & Charnney (2004), in their study targeting women with early childhood abuse-related PTSD, depicted PTSD as an issue mediated by the central nervous system. The authors compared non-PTSD subjects with those with PTSD by asking participants to complete a neuropsychological test.
The Stroop test, which is often used to illustrate the nature of automatic processing versus conscious visual control, was administered to participants while undergoing positron emission tomography (PET) scanning. Images of the anterior cingulate and medial prefrontal cortex were taken because of their known role in stress response and emotional regulation. Scans showed significantly decreased blood flow in the anterior cingulate in PTSD subjects and correlated well with emotional arousal. Furthermore, trauma and stress brings about acute and chronic changes in the neurochemical systems and specific brain regions, resulting in long-term changes in brain “circuits” involved in the stress response (Vermetten & Bremner, 2002). Anything that affects the function of these systems can result in long-term manifestation of stress-induced behavioural changes (Durston et al., 2001). The brain regions that play an important role in PTSD are the hippocampus, amygdala, and medial prefrontal cortex. The two neurochemical systems, cortisol and norepinephrine, are critical in the stress response (Yehuda, 2006). As an example, combat veterans with PTSD demonstrated decreases in cortisol concentrations, as detected in urine or blood, compared with healthy controls and other comparison groups (Yehuda, 2006). Bremner and Vermetten’s findings (2004) indicate that PTSD may have a neural component. Although they have been repeated in PTSD patients from other populations, including Holocaust survivors, refugees, and abused persons, the findings are not consistent across all studies (Yehuda, 2006). Other studies have depicted the relationship between trauma, PTSD and individual risk factors (including biological factors) as interrelated, because not all trauma survivors develop a permanent disorder; in fact, many recover (Halligan & Yehuda, 2000; Sherin & Nemeroff, 2011). However, responses to trauma can be mediated by a number of factors including prior exposure to trauma or environmental factors, leading to chronic stress; and the age at which trauma was experienced (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Davidson, Hughes, Blazer, & George, 1991). The varied psychological outcomes of participants reported in the current study support a nuanced and multifactorial understanding of PTSD.

6.2.7 Conclusion

Trauma as a consequence of pre-arrival exposure to war and persecution, loss of homeland and loved ones, ongoing persecution as an ethnic minority and loss of
identity were experiences voiced clearly by many participants. In the current research, trauma was a persistent issue embedded within the everyday tasks and challenges participants faced at the personal and societal levels. These difficulties were further complicated by post-arrival challenges associated with learning a new language, finding employment, completing education and overcoming isolation. While the Afghan study participants strongly identified with their ethnic community, they also recognised that successful resettlement requires refugees to engage effectively with the broader Australian society through employment and educational activities. In the current study, those participants who did secure employment reported that they felt they were useful members of the community and they could contribute by helping others. Therefore, further research should explore how best to tailor and develop educational and health/psycho-social intervention programs. For some participants, belonging was enhanced through language acquisition, employment and educational opportunities. All these activities can play an important role in building a sense of belonging, which could help to counter the negative effects of migration.

Australia provides some services for refugees, including work and education opportunities, encouraging family reunion and the provision of physical and mental health services for those in need (Department of Immigration and Border Protection, 2014). However, there is still much work to be done in addressing and understanding the main reasons behind why some refugees find it difficult to resettle, how these issues can be resolved, and the need for targeted English language and mental health intervention programs. The findings of the current study provide useful information for those designing services and for treating professionals, particularly in the delivery of culturally sensitive mental health services. This could include specific training of interpreters who are assigned to the hospitals and GPs, to relieve children from this role. Furthermore, gender roles are critical. Medical professionals need to use female interpreters to pave the way for women to discuss confidential issues that may be taboo for them to raise in the presence of male interpreters or children. Although appropriate psycho-educational programs for refugee communities are important (Jorm, 2011), other research explores strategies and preventative programs, looking specifically at educational and health/psycho-social interventions to alleviate psycho-social adjustment problems during resettlement in order to eliminate the negative consequences of these barriers and stressors (Mace, Mulheron, Jones, & Cherian, 2014).
Further research is needed to explore targeted and tailored programs to address the impact of language skill deficiencies on Afghan refugees’ abilities to secure employment, access health services, and foster a sense of belonging in their new communities. This will be elaborated in the conclusion to the thesis in this chapter.

6.2.7.1 *Stigma as a barrier to help-seeking*

Help-seeking behaviours associated with mental health problems are hindered by social, cultural and emotional forces, forcing many refugees to hide their symptoms. In the current study, shame and stigma associated with mental illness were clearly identified by the majority of participants as powerful forces presenting barriers to seeking help.

In this section, I first discuss stigma as a barrier to help-seeking. This is followed by discussion of the perception of mental illness, the role of religion and the use of the Western medical model. The discussion then focuses on shame and gossip and how these are entwined with mental illness. This is followed by informal and formal help-seeking.

Depression is classified as an affective disorder that is characterised by significantly lowered mood, a loss of interest or pleasure in activities that are normally enjoyable, and changes in sleep patterns (American Psychiatric Association, 2002). A number of participants in the current study complained about loss of interest or pleasure in activities. They preferred to stay at home and refused any contact with friends. A majority of participants reported experiencing some form of sleep disturbance or difficulty with getting to sleep. The participants were aware that sleep was essential for good emotional and psychological health, but sleep did not eventuate. In the current study, sleep issues centred primarily on three reported experiences: some had difficulty falling asleep, as they were preoccupied with anxious thoughts that prevented them from falling asleep; some reported that they could fall asleep, but woke during the night and were not able to return to sleep because of intrusive thoughts; and the remaining participants reported that they were woken by nightmares and intrusive thoughts and found it difficult to get back to sleep. Several participants talked about nightmares and their physical responses to these nightmares included night sweats, tremors and heart palpitations. Correlations between
nightmares and anxiety, depression, and PTSD have been reported in other research (Berquier & Ashton, 1992; Zadra & Dondri, 2000).

In the current study, insomnia had become part of the lives of many participants and they tried to find strategies to cope with this problem. Coping strategies included various physical activities such as exercising before bed or during the day, reading books, the use of technology and meditation. Others read the Koran and prayed for their own peace of mind, and for their family. They placed their faith in a greater power – “God” - to intervene and calm their minds so that sleep would eventuate. Only a few sought medical and professional advice and were prescribed medication. These findings raised important questions for the researcher: Why did so few seek help from health professionals for their insomnia? What role does religion play in Afghan refugees’ experiences of mental illness? Where do Afghan refugees go for support? With these questions in mind, further examination of the findings revealed that stigma plays an important role in shaping Afghan refugees’ help-seeking behaviours. For some, a diagnosis with a mental illness was equivalent to a punishment from God; for many, having a mental illness was thought to be deeply discrediting within their community and fodder for malicious gossip. The stigma associated with a mental illness and the gossip that supports its discrediting effects prevented many participants from seeking formal support, limiting their help-seeking options to very close family, friends and religious rituals. For a concerning minority, the fear of stigma was so severe that it enforced self-isolation and withdrawal.

6.2.7.2 Conceptualisation of mental illnesses: The role of religion and the use of the Western medical model

A few participants in the current study viewed mental illness as a punishment from God or an “evil spirit”. This meant that rather than viewing their experience as a treatable condition, these participants viewed mental illness as a spiritual affliction, which therefore required treatment by spiritual intervention. This finding is not unique to Afghan refugees. In their research into MHL in developing countries, Mubbashar and Farooq (2001) examined the beliefs of 60 patients who had experienced traditional treatment. Amongst these participants, more than half attributed their illness directly or indirectly to jinns (roughly equivalent to demons).
The most common consequences of mental illness were that it is discrediting and a source of discrimination. Participants in the current study suggested that mental illness was regarded as a deviation from “normality” and a number of participants used the word “crazy” when describing someone with a mental illness. Others depicted it as a hereditary condition or a result of brain damage and untreatable. As noted in the previous chapter there was a tendency to label both those with mental illness and those with an intellectual disability as crazy. Interestingly, other studies of specific mental health disorders, for example schizophrenia in Hong Kong, have noted that participants viewed those with schizophrenia as crazy and were fearful of them (Chan & Yu, 2004). A few participants even described their fear that should their mental illness became public they would be “locked up” in a “mental ward” and this would curtail any future career options. This was critically important for them because as refugees they were working hard to re-establish their economic independence and careers.

Overall, in the current study it was implied that having a mental illness meant that sufferers would be viewed as “not coping” or as having a “weak personality”. Participants suggested that if even one person in the family had a mental health issue, this would lead to labelling the entire family as having a child or family member with an intellectual disability. Consequently, the community would look down on them. Feeling discredited due to mental illness within one’s own ethnic community is not unique to the participants in this study. A study of African American mothers in the rural state of Georgia in the USA assessed their perceptions of the mental health service system, help-seeking processes, and service experiences and found that community stigma and experiences of shame and humiliation associated with mental health problems in one’s child or self were widespread (McBride, Hefling, Suiter, & Brody, 2011).

This phenomenon of shame associated with mental illness has been conceptualised theoretically by Goffman (1963), who defined stigma as the internalised social response to a discrediting attribute, such as a disfiguring birthmark or diagnosis of a mental illness. “Courtesy stigma” a phrase offered to encompass that stigma may also affect people who are closely associated with a person who has been shamed, such as immediate family and friends, who may be considered responsible for the
condition of their relative and feel guilty for their relative’s condition (Muhlbauer, 2002). Corrigan and Miller (2004) referred to this as family stigma, where the discrediting of a person with a mental illness is extended to the whole family by association. Therefore it is important to recognise the effects of acknowledging a mental illness in certain cultures, such as shame, humiliation and fear of stigma (Fessler, 2007), and its commonality amongst traumatised people and those who were born outside Australia (Budden, 2009).

In addition to being discrediting for the individual and their family, participants described mental illnesses as a source of discrimination. Discriminatory attitudes towards those with a mental illness are widely recognised in the literature (Blignault, Woodland, Ponzio, Ristevski, & Kirov, 2009). Research has shown that people with mental health problems are discriminated against within the broader community and they find it hard to get jobs and maintain friendships and relationships. In the current study a female participant referred to such discrimination. She was concerned that if her husband’s mental health issues were disclosed he would not be seen as a competent person or he would have a hard time getting a job at a time when employment was especially important. Griffiths, Carron-Arthur and Parsons (2014), in their Australian national study of predictors of personal stigma, reported that people who were born outside Australia and older generations experienced a higher level of personal stigma than those born in Australia and younger generations.

### 6.2.7.3 Shame

It is important to note that the effects of stigma, discrimination and stereotyping can be internalised by those with a mental illness. Consequently, those with a mental health problem may assume they will be rejected socially and so believe they are not valued (Livingston & Boyd, 2010). This phenomenon is captured in the concept ‘labelling theory’. Thoits (2010), discussing Becker’s labelling theory, stated:

> Because the former mental patients expect rejection and discrimination from other people and they try to find coping strategies either by avoiding people, concealing information about their past psychiatric illnesses or attempting to educate others about mental illness to combat their stereotypes. In general these stereotypes tend to backfire, leaving former patients isolated, demoralised and distressed and with fewer
employment opportunities. Thus expectations of rejection are sufficient to start a negative self-fulfilling process, regardless of the actual reactive behaviours of other people. (p. 122)

Thus, the stigma and shame associated with a mental illness label can generate poor self-esteem, low self-confidence and reduced motivation resulting in isolation of the individual with the mental illness (Hippel & Trivers, 2011).

At its core, shame is a feeling associated with being negatively evaluated either by oneself or others because one has failed to meet standards and norms for what is appropriate. For this reason, shame is often referred to as a moral emotion (Tangney & Stuewig, 2004). There is agreement in the literature that the experience of moral emotions such as shame appears to be universal, but varies across different cultures and individually (Furukawa, 2005; Wallbott & Scherer, 1995). Participants in the current study described the feelings of shame associated with their mental health problems. A desire to save face prompted them to hide their mental health problems and maintain an illusion of normality so as to be seen by the rest of the community as a respected and successful person. Goffman (1963) explained the idea of “saving face” by referring to the notion that face or public persona may be defined as the positive social value a person effectively claims for himself or herself and others assume when he or she presents during a particular contact. Face is a self-delineated image in terms of approved social attributes. Qi (2011) explained this concept further:

The idea that a person’s having face is associated with that person’s “positive” self-evaluation can be understood not normatively but quantitatively in the sense that a loss of face would amount to a subtraction from an existing stock of face. (p. 286)

In the current study, such was the fear of stigma and shame that some participants chose to minimise or avoid all social contact. This isolation contributed to an escalation of their mental health issues. Minimising social contact maintained a social face of respectability and normality and hid the deep despair, depression and anxiety, safeguarding a positive social value. This concealment came at a price, but avoided the primary fear of widespread gossip. Concealment of mental illness was
deemed necessary not only as protection against gossip but also as to satisfy the need to be accepted as a useful, financially secure and self-reliant community member.

6.2.7.4 Gossip

As mental health problems were a source of discrimination and internal shame, it is not surprising that they were a popular topic of gossip in the Afghan refugee communities. Participants in the current study described gossip as widespread within the Afghan community. Participants noted their fear of others knowing their issues with mental illness, because mental illness is a popular topic of gossip, and to be a topic of gossip was intensely shaming and stigmatising. Gossip plays a role in maintaining the stigma; and the fear that others may talk provoked silence and the avoidance of others. For example, one participant was reluctant to talk about her mental health problems and took steps to monitor her behaviours. Her mantra became one of self-censorship because she believed that “If it gets out of your mouth, it gets into the world” and becomes the subject of gossip. The fear of being the subject of gossip drove individuals to conceal their behaviours, thoughts, words and feelings. In a number of cases this resulted in ongoing monitoring of the individual’s own behaviour, creating a state of hyper-vigilance to ensure controlled interactions. On a broader level, participants believed that should their mental health issue become public it could tarnish the entire family.

Participants reported that because of the occurrence of gossip, there was a strong inclination to maintain a clear distinction between their private and public lives. This practice was informed by an assumed cultural expectation that they could (and perhaps should) keep their mental health issues private and within the trusted circle of the family. This was also reported in a study of Laotian Americans who reported that in that Southeast Asian culture, mental health problems are regarded as hereditary, so admission of a problem would be damaging to the family’s reputation within its own community (Gordon, 2011). Some of the participants in the current study were so fearful of being the subject of gossip that they used extreme tactics to minimise the risk of being stigmatised. Such was the stigma attached to mental illness, they reported that they avoided all conversations about mental illness symptoms and would not venture out of their home in case anyone perceived them as mentally ill or not normal. The cultural expectations and assumptions of normality as
prescribed by the ethnic community appeared to exert considerable influence on the stigma associated with mental illness and exacerbate the isolation of those experiencing it. In the current study, seen through the eyes of participants, the stigma of mental illness is more confining than the illness itself.

6.2.7.5 Informal and formal help-seeking

From the discussion thus far, the findings imply that help-seeking behaviour in Afghan refugee participants was strongly influenced by the stigma associated with a diagnosis of a mental illness. Public understanding of mental illnesses and attitudes towards people with mental illnesses play a paramount role in prevention, treatment and rehabilitation (Jorm & Kitchener, 2011). Help-seeking can be both informal and formal and each plays an important role in treatment and recovery. Informal help-seeking is defined as assistance from informal social networks, including immediate family members or friends (Rickwood, Thomas, & Bradford, 2012).

In the current study there was mixed opinion about seeking support from family members and friends. Some believed that they could trust only their mothers and so made overseas phone calls to seek advice or support from their mothers. Others wanted to talk to a close relative or their mothers about their illnesses, but did not because they did not want to burden them. This left them feeling isolated. Some participants turned to close friends and felt safe talking about their mental illness within this close friendship circle. This finding is not unique to this study. In their study of help-seeking for mental health problems in young refugees from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan, De Anstiss, Ziaian, Procter, Warland, and Baghurst (2009) similarly noted that most participants in her research project were very reluctant to venture away from their close friendship networks for help with their psycho-social problems, owing to a range of individual, cultural and service-related barriers. They concluded that the emotional and psychological aspects of mental illness make supportive friends and family even more important to a person’s recovery. This was also the case in a study of Iraqi refugees, in which the majority of participants reported seeking support from family members (Slewa-Younan, Mond et al., 2014). However in the current study, not all participants were able to talk about their mental illnesses with family members or friends. This contributed to avoidance of family members and exacerbated their
isolation. Their preference was to seek help outside the family because, as they articulated, outsiders were more likely to be trusted than family, friends or community links. This anonymity appeared to protect them from stigma and shame in their communities. Dinos, Stevens, Serfaty, Weich, S., and King, (2004) supported this conclusion in their research of stigma, in which they examined the feelings and experiences of 46 patients recruited from community and day mental health services in North London. These participants reported that they were concerned about the demeaning attitudes of family, friends and work colleagues if they were to seek support from them.

A few participants ventured outside of their family or close circle of friends for support. Regardless of their level of education these participants sought help from others whom they knew had a better education and whom were considered more knowledgeable and less judgmental. These participants considered that those with an education were more likely to possess a better understanding and were more sympathetic towards mentally ill people. Conversely, participants suggested that illiterate people had a poor understanding of mental illness and therefore were more likely to judge and stigmatise a person for being mentally ill. Findings from the current study, particularly about knowledge and empathy, contribute to the debate on the relationship between education and stigma. Previous research findings provide a diversity of conclusions. In contrast to the present study of Afghan refugees, other studies, such as that by Song and Chang (2005), suggest that highly educated people have higher expectations of self-control, leading to less tolerance of mentally ill people. However, it should be noted that Song and Chan’s study did not consider ethnic or cultural aspects of the study population; their study was undertaken in a general population and was not specific to an ethnic population, as is the case with the current Afghan study. Nevertheless, when it comes to confiding in others, attitudes towards mental illness and perceptions of its shamefulness, level of education appears to be a strong consideration.

Those participants who sought help from their GP described visiting their GP clinic as a safe means of disclosing their mental illness because of the general nature of the profession. To be seen going into a mental health service would risk the proliferation of stigmatising gossip, whereas to be seen going into a GP’s office would not
necessarily be perceived by others in that way. This strategy was adopted by some participants as a means of avoiding the scrutiny of others. However, as already noted, other participants of the current study would not risk seeing even their GP, leaving them isolated with no professional source of support. Nadeem, Lange, Edge, Fongwa, Belin and Miranda, (2007) also noted that the embarrassment and shame associated with using a mental health service can contribute to the many barriers to help-seeking that prevent refugees from getting treatment for their mental illness symptoms.

It is concerning that a minority of participants felt so fearful and depressed that they were unable to leave the family home to seek treatment or support, as this could lead to the development of other serious physical and mental health conditions. Chapman and Perry (2008) also noted a similar concern. Their study emphasised the importance of understanding that depressive disorders can often lead to chronic illness because they tend to obscure the course and treatment of chronic non-communicable diseases, leading to the worsening of cancers, diabetes and other significant medical conditions. Chapman and Perry also highlighted that non-communicable chronic disease and depressive disorder are increasingly recognised as contributing to the challenges of providing quality health care. Thus, understanding the connection between the two becomes vital.

A significant influence in the lives of Afghan refugees is religion. Regardless of the level of belief or commitment, participants referred to religion as either a source of informal help or a hindrance. Participants in the current study had divided opinions about the role of religion and religious leaders in experiences of and responses to mental illness. Some participants identified religion as a source of conflict rather than comfort. They thought that being confined by religious rules that dictate norms and beliefs, especially about behaviours, public appearance and gender roles, can be a source of oppression and conflict. Religious rituals, rules and sectarian divides added to their sense of oppression and pressure and this in turn was said to intensify their mental illness. Other participants believed in the power of God to protect them emotionally and physically. A few participants noted the importance of using their religious practices and faith as coping strategies. Prayer and reading a verse of Koran gave them some respite and helped to restore their mental health. This finding is
similar to findings in a study of Somalian refugees in which interventions and ceremonial rituals, such as spiritual leaders reading the Koran or praying with the person who is unwell, were used readily (Bentley & Owens, 2008). Similarly, Slewa-Younan, Mond (2014), who studied the MHL of Iraqi refugees, highlighted that reading the Koran was highly endorsed as type of helpful treatment activity. Miller and colleagues (2009) also noted that faith in God and prayer were ways in which Afghans’ coped with mental illness, and that having hope or faith was important in helping them to deal with problems. Other studies support these conclusions, suggesting that traditional sources of help, spiritual healers, supernatural and religious methods are more commonly used as a source of treatment in developing countries, in cross-cultural communities and in communities more generally (Mubbashar & Farooq, 2001; May et al., 2014; Pearce, Medoff, Lawrence, & Dixon, 2016).

Religion may serve as a protective factor again more detrimental coping strategies. The psychological literature reports that when stigma prevents people from seeking professional treatment or support, people have been found to self-medicate through the use of alcohol, tobacco and/or illegal substances. Self-medication is a common behaviour among people with PTSD, depression and anxiety disorders and has potentially harmful consequences (Crum et al. 2013; Leeies, Pagura, Sareen, & Bolton, 2010).

They are likely to adopt less healthy behaviours to help them cope with their distress, behaviours which can increase their risk for developing chronic diseases and worsening their overall health over time (Colton & Manderscheid, 2006). Such behaviours were not reported by the Afghan participants in this study. Cultural taboos and Islamic beliefs within the Afghan community make smoking and drinking culturally and socially unacceptable. This study demonstrated that participants’ preferred coping strategies were to isolate themselves from others, further distancing themselves from help or potential treatment options, rather than self-medicating.

6.2.7.6 Conclusion

A majority of the participants in the current study confirmed the presence of shame, humiliation and stigma related to mental illness within their community. Participants
described their dread of being the subject of gossip and how this fear acts a barrier to treatment. Because of the role it plays in hindering individuals from seeking help, and compelling people to be complicit in their self-imposed isolation and segregation from family, their community and professional help, the relationship between stigma and help-seeking cannot be overlooked. The resultant powerlessness this creates can further exacerbate the mental illness. The isolation can also lead to non-communicable illness, further complicating individuals’ physical and mental health. The level of self-restraint practised by some was intended to avoid the shame and stigma from others, but rendered them powerless to seek help. As an alternative to seeking professional help, a substantial portion of participants in the current study described religion as central to their responses to mental illness. Further research is needed on the role spiritual leaders can play in treating and altering communities’ perception of mental illness, and the value of meditation and prayers in complementing more formal treatment plans. Other researchers agree that devotion to religion has been found to be an effective coping mechanism, and that faith in God and prayer are among the reported methods Afghans have used to cope with mental illness (Kanagaratnam, Raundalen, & Asbjørnsen, 2005; Miller et al., 2009). In the current study, religion played a dual role; for some it was a source of concern and stigmatising, but for others it was a source of comfort. If taken holistically, help-seeking options would include diverse measures that are inclusive of belief systems, alternative medicines and meditation as well as professional medical intervention. This would be supplemented with targeted educational programs for those within the community who have had limited education or who are illiterate. The next chapter will aim at integrating the findings of both the quantitative study and qualitative interviews by examining in depth the divergent and similar themes with regards to perceptions of about mental illness, stigma, shame, and help-seeking.
CHAPTER SEVEN: INTEGRATED DISCUSSION

Integration is the term used to describe the points during the research process at which mixing of qualitative and quantitative data occurs, and it can occur at multiple points throughout the data collection and analysis process (Andrew & Halcomb, 2006). This chapter begins with a discussion of common themes emanating from quantitative and qualitative studies thus far discussed. A dominant perception was that people with a mental illness were “crazy” and therefore this attracted shame and stigma. Stigmatising attitudes towards someone with mental illness ensured that the shame and fear that this created built barriers to treatment. On a more formal basis, the majority of participants chose to see a GP rather than a specific mental health professional or counsellor. It was reported that by visiting a GP there was less likelihood of psychological or in-depth discussions of the problem. This also helped to avoid possible confrontation of the issues or discussing these in any detail. As an alternative, a substantial portion of participants in the current study described religion as central to helping them tackle their mental illness. In the current study, religion played a dual role, for some a source of concern and stigma but for others a source of comfort. Beliefs about the causes and risk factors of mental illness included trauma caused by coming from a war-torn country. Adding to their anxiety and impacting on their coping abilities and wellbeing was the additional burden of post-migration issues, including dealing with leaving family members behind in conflict situations, the loss of identity and culture, learning a new language and securing employment.

Next, I will discuss the themes that compare and contrast findings from participants in the quantitative and qualitative studies. It should be highlighted from the outset that the qualitative study involved 24 participants from the 150 participants in the quantitative study who volunteered to participate in the semi-structured face-to-face interviews. The participants in the qualitative study diverged in their recognition of mental health and how it was perceived. Participants completing the qualitative study labelled those with mental health issues as someone who was “weak”, “crazy”, “disabled”, or “not normal”. This labelling revealed a tendency to personalise the issues by allocating the cause of mental illness to the flawed individual. In contrast, in the quantitative study, when asked to respond to the vignette, participants
recognised PTSD but also that factors external to the individual were most likely the cause; thus, they de-personalised the issue of PTSD. Comparing the results of the quantitative survey with the qualitative individual interviews provided a useful understanding of these conceptual differences amongst the current Afghan participants. In this section I will also discuss common themes about help-seeking behaviours and the helpfulness of treatments, including non-pharmaceutical and prescribed medication and treatment providers. The final theme that emerged from the study was the influence of stigma and its association with mental illness. Throughout the qualitative study stigma emerged as a significant factor as it dictated how people responded to the disclosure of mental illness, its treatment, self-assessment and self-management. This differed to the findings of the quantitative study and will be discussed.

7.1 Lasting Effects of Trauma and War

There was a consensus among the participants in the two studies that war was the genesis for much of their mental health issues. Directly, war impacted on every level of their lives, straining coping abilities and causing them to flee their communities and cultures and reside outside their traditional support networks. Regardless of migration or relocation to a safe environment, war was an ever-present memory. For this reason they equated being born in Afghanistan as negative because it meant that they had endured a constant struggle to stay alive, with no certainty or predictability in daily life. As one participant highlighted this theme by lamenting on his childhood being taken from him, all he could remember was war and seeing the perpetration of atrocities. Participants linked experiences of traumatic events and recurring thoughts of the killing and the kidnapping of family members to their ongoing mental health issues. It is therefore not surprising that almost half of the participants met the threshold for clinically significant PTSD symptomatology and also described their past trauma as an ongoing issue. The disorder was also found to be an important impetus behind self-imposed isolation for several participants. In one example provided during a qualitative interview a participant described his constant fear of being killed, which limited his ability to engage fully with those around him.
7.2 Post-migration Factors

Participants also noted that post-migration factors added additional strains to their coping abilities. These included adapting to a new culture, learning a new language, enduring the loss of familial supports and securing employment. Such demands heightened anxieties, resulting in adjustment difficulties and emotional instabilities that were reported in both the qualitative and quantitative studies. Specifically, a significant number of male participants identified unemployment as a huge problem for them. They described how being unemployed impacted on their self-esteem and made them feel dejected. Employment is closely related to identity, self-esteem and economic sustainability for the family. Those participants who obtained employment, related that being employed gave them satisfaction, pride and a sense of belonging.

The Afghan participants also viewed intergenerational conflict as a destabilising factor. The relative speed with which children and young people resettle and adapt to the new country leaves older adults fixed psychologically in the old country. Most children become acculturated far more quickly and extensively than their parents, leaving adult caregivers disempowered and reliant on their children to interface with institutions by acting as interpreters for them. This has important implications for family relationships. It often confuses children and leads to intergenerational conflict, with children expecting more independence than would be culturally acceptable. A keystone for participants’ mental health status was their loss and grief related to losing family members in the war and leaving close family members behind. It was reported that this intensified their mental health issues.

7.3 Disability Associated with Mental Illness and Resilience

Disability and resilience in psycho-social functioning emerged as important elements in the survey and during qualitative interviews. A large number of participants reported high levels of impairment in psycho-social functioning. More generally, some participants described locking themselves in the house and avoiding any social contact. This was further supported in the qualitative study, in which participants reported that having a mental illness is like having a disability or a child with intellectual disability. The quantitative study also found that a majority of participants who reported high levels of disability had low levels of resilience, hence
leaving participants vulnerable to experiencing stress symptoms. Participants in both the survey and face-to-face interviews identified clearly that they cannot cope with their day-to-day activities because their mental health is not stable.

7.4 Recognition of Mental Health Issues and Help-seeking Behaviours

In this section, differences of opinion in the findings of both studies are compared and contrasted. As part of the quantitative arm of the research, when participants were presented with a clinical vignette, one-third of them successfully recognised the condition as PTSD, with only a small number of participants stating it displayed weak character. The researcher also found that those participants who recognised PTSD in the survey also had higher levels of education, resulting in an association between PTSD recognition and educational levels. Participants with higher levels of education also knew how to access treatment by seeking support from medical practitioners. They determined “psychotherapy focusing on changing thoughts and behaviours” and “psychotherapy focusing on the past” to be helpful. Conversely, participants with lower levels of education were less likely to identify the problem described as PTSD and more likely to seek relief through religious activities, which will be explored further later in this chapter.

Regardless of educational levels, both quantitative and qualitative participants nominated modifications to lifestyle as a way to treat mental illness and preferred over-the-counter vitamins and herbal medicine rather than prescribed medication antidepressants and/or anxiolytics. These findings are far from confined to refugees. The preference for self-help interventions over medication remains a feature of MHL in all populations and for all mental health problems. For the treating professional it would be important to note that although patients may be seeking help with mental illness, they may be reluctant to accept medications as treatment.

Greater attention to providing information and education on the purpose and effectiveness of taking these medications, in conjunction with lifestyle initiatives, could lead to more effective outcomes. It would be ideal content for educational programs that seek to improve MHL and provide information on mental illness, symptoms and treatment options. Such programs would need to explore in greater detail the need for prescriptions medicines in severe cases. Although lifestyle choices
are an important factor, when used alone they will not treat mental illness in all cases.

Whereas the quantitative aspect of the research asked participants to assess the mental illness through a hypothetical example, the vignette, the qualitative study asked participants to reference responses from their personal experience and perceptions. The researcher asked questions that measured MHL with questions akin to those asked previously in the quantitative survey. The majority of participants reported that they viewed those people affected by mental illness to be of weak personality or “not normal” (see discussion in 7.5). Some also said that mental illness is a punishment from God or evil spirits or that the person must have done something bad. Some also said that having a mental illness in the family was similar to having a disabled family member. Others equated having a mental illness as being “crazy”. Good mental health, on the other hand, was referred to as the foundation of self-determination, the ability to be goal-oriented and make good life decisions, possessing high self-esteem and having the confidence to carry out day-to-day tasks to meet their responsibilities and be respected in their own community.

7.5 Perception of Their own Mental Health

Comparatively, it would appear that even with a good education the majority of participants in the qualitative and some participants in the quantitative study deferred to perceptions of mental illness as a personal weakness or disability. In other words, although those who had received higher education considered themselves able to respond to mental illness without labelling, the qualitative results suggest that the influence of community perception is great and hence opinions are subject to cultural, social and/or religious dictates. When presented with information about a hypothetical situation, participants who correctly selected PTSD and suggested professional help was needed did not apply this rationale consistently when asked about examples from their personal experiences. The juxtaposition of the theoretical and personal reveals interesting contradictions. This would suggest that even if participants possessed knowledge of mental health issues, they did not apply it when dealing with them in their personal lives. This is not an unusual situation; people often know what they should do, but do not follow through; nevertheless, further in-depth research could probe the reasons behind the above discrepancy. Again this
would suggest that community, cultural and religious paradigms play a significant role in the lives of the Afghan participants despite their level of education.

7.6 Helpfulness of Treatment and Treatment Providers

Participants’ perspectives of the helpfulness of treatment and treatment providers differed in both the quantitative and qualitative studies. It needs to be reiterated that beliefs about help-seeking may not translate into actual help-seeking, therefore beliefs may not predict behaviour. Participants in the quantitative part of the research reported that psychiatrists, psychologists and GPs were the treatment providers most likely to be considered helpful. The reason for the higher endorsement of psychiatrists observed among participants in the current study may resonate from the trust they place in the biomedical community, but it is also possible that this endorsement reflects, in part, an artefact of social desirability in responses.

Those with lower levels of education and older participants were more likely to consider religious worship to be helpful. However, a majority of participants in the qualitative interviews preferred to visit their GP. They described visiting their GP clinic as a safe means of treatment as the generalist nature of the profession would cloak the actual purpose of their visit. Some also sought support from reading verses from the Koran or prayers. Overall, participants had mixed opinions on seeking informal support from friends and family members or from religious leaders. Some believed that they could only trust their mothers and so made overseas phone calls to seek advice or support from them. Others, especially female participants, wanted to talk to a close relative or their mothers about their illnesses but did not, because they did not want to burden them. This left them feeling isolated. Some participants turned to close friends to talk about their mental illness, trusting their close friendship circle. In the quantitative part of the research, the MHL survey, 76% of participants found it helpful to seek support from friends because friends were less likely to be judgemental and were trustworthy. A majority of participants in both studies reported that reading the Koran, prayers and faith in God would protect them emotionally and physically. However, a minority of participants, especially younger participants, opposed religion as a remedy because they believed religion to be a source of oppression and feared that any disclosures to a religious leader could result in mischievous gossip. Again, these findings suggest that it is important for the treating
professional, in considering treatment options specifically for the Afghan population, to take into consideration social, cultural and religious concepts.

7.7 Stigma Associated with Mental Illness

According to the findings from the quantitative MHL survey, participants did not associate mental illness with stigma. In the survey, 76% of participants said they would be very sympathetic towards a person experiencing the mental health problem described in the vignette and only a third of participants thought a person with the problem would be discriminated against by others in the community. This may not necessarily be a discrepancy. It is quite reasonable for people in general to feel sympathetic to friends or relatives with a problem and not see how or why discrimination would be an issue; nevertheless, people who are experiencing a mental illness themselves may feel stigmatised and possibly discriminated against. However, amongst those 24 participants who were interviewed, stigma was a significant factor and one of the most consistent themes to emerge from that arm of the study. Stigma influenced how participants perceived treatment and constructed coping responses. Participants reported that they feared they would be discriminated against, that they would be viewed as being crazy and lose the respect of their own community and friends. For this reason, they described how they felt pressured to appear normal by concealing their symptoms. In the qualitative study, shame, gossip and stigma associated with mental illness were clearly identified by the majority of participants as highly influential and powerful barriers to seeking help. For some, the fear of stigma was so severe that it caused some to withdraw, whereas others talked of concealing their thoughts. These responses inevitably lead to an escalation of mental health issues. Specifically, on a broader level, participants believed that should their mental health issue became public it could tarnish their family’s reputation within the community. Unsurprisingly, choosing isolation would have a detrimental impact on their adaptation into the new social environment. The repeated examples of behaviours characteristic of isolation that were found in the interviews is concerning, especially as the research literature suggests that isolation not only impairs cognitive functioning such as problem-solving abilities, planning and verbal reasoning, but it can also lead to negative mood, anxiety, anger and depression symptomatology.
7.8 Discrepancies Between the Findings of the Quantitative and Qualitative Studies

Within the Afghan community the researcher found that there were varying opinions depending on if they were responding to qualitative or quantitative questions. These apparent discrepancies are clearly observed when participants were asked to describe the problem in the survey and most responded by correctly identifying PTSD, however when this was raised in the qualitative section they described people with mental illness as someone with a weak personality and who was abnormal. This dissimilarity of beliefs and attitudes within the two methods raises some interesting questions for future researchers and treating practitioners. Factors influencing such divergent results could be attributed to differences in the participants’ MHL, the methodology used, or the fictional nature of the vignette as opposed to the more personalised and direct methods used in the qualitative interviews. In other words, it was far easier for participants to recognise PTSD symptomology correctly in a theoretical context that includes multiple choice answers than in a lived experience. These differences highlight how educators will need to consider individuals’ conceptualisation of mental illness irrespective of educational background.

The majority of participants in the qualitative study and a minority of participants in the quantitative study reported that they perceived mental illness as an abnormality and personal weakness. In both studies these beliefs were shaped by trauma, education, religion and culture. Even though they had migrated and were now removed from the situation the impact of war and trauma made participants vulnerable and they were less resilient in coping with post-migration challenges. Their faith in God and having friends around them helped them to overcome some of the issues related to their trauma and migration to a new environment. Some made lifestyle changes, believing that this would be a useful way to deal with their mental health issues.

7.9 Implications for Clinical Practice and Health Promotion

This study has generated several findings with some clear implications for clinical practice and health promotion. More broadly, the study raised implications for the
development of treatment programs or tailoring of existing approaches to mental illness, such as cognitive behavioural therapy.

7.9.1 Implications for refugee individuals

This current study’s findings indicate that Afghan refugees have low levels of MHL, high levels of PTSD and low levels of resilience. It is postulated that improving MHL in this population through targeted education and dissemination of information will likely lead to demystifying mental health problems and their treatment. In turn, this will potentially contribute to increased help-seeking, therefore bolstering levels of resilience.

Participants’ preferred treatment options were hobbies, exercise and vitamins. Although these activities may be useful for general wellbeing, they are not deemed to be clinically useful for the treatment of PTSD (Phoenix Australia, Centre for Posttraumatic Mental Health, 2013). While emphasis on the benefits of exercise and other healthy lifestyle choices are to be encouraged, educational programs need to place emphasis on the critical need for appropriate and suitable treatments.

Participants’ beliefs on the causes of mental illness tended to highly endorse the notion of personal weakness, an individual’s destiny or a punishment from God. Common beliefs that are steeped in superstition, fatalism and victim blaming require sensitive responses if alternative paradigms are to be presented as credible alternatives to mental health causes and treatment of community members. For this reason, targeted health promotion ideas could include culturally and religiously sensitive approaches that, while acknowledging these beliefs, also work towards developing culturally appropriate health education efforts that would change the attitudes, beliefs, and behaviours of the target group. Findings from previous research on the mental health of non-refugees suggests that community-based health promotion programs designed to improve MHL can be successful (Armstrong et al., 2011).

7.9.2 Implication for health clinicians

At a very broad-brush perspective, the findings from the quantitative MHL survey suggest possible differences in treatment preferences among members of the target
population. These require the recognition of clinicians in order that a true therapeutic alliance can be achieved when working with individual refugee clients. Close collaborative efforts with the targeted refugees can incorporate aspects of culture/religion such as prayer, which can be interwoven into the development of early intervention programs (Birman & Tran, 2013). This can be done by integrating spirituality into counselling and psychotherapy in the holistic approach of working with all of the elements of a client’s cultural identity, as mental health professionals are increasingly being called to do (Daniels & Fitzpatrick, 2013).

Psycho-education programs at the community level and for individual members of the refugee community can have a positive impact on professional help-seeking behaviour (Jorm & Kitchener, 2011). Additionally, it would be beneficial to seek the support and input of community elders, who could contribute towards the planning, development and implementation of such programs (Crosby, 2013). Other clear messages for the treating professional include the need to be informed and proficient in understanding the unique traumatic background of differing groups of refugees. Addressing and understanding the main reasons behind refugees’ mental illnesses, the experience of trauma and its short and long-term impact are important issues to take into consideration. In order to be effective, interventions need to be tackled on a number of levels, utilising a holistic approach. Therefore, education and training must go in both directions: education of refugee communities in order to improve MHL and knowledge about mental health services, as well as the education of service providers working with refugee communities (Collinetti & Murgia, 2008). Strategies need to be in place for use at early intervention stages to guide those who are helping refugees with initial resettlement, health and education promotion policy makers, implementers and health practitioners in knowing how to respond to mental health issues in a culturally sensitive manner. The participants reported that GPs are more likely to be chosen as the preferred health professionals, therefore it is critical for GPs to recognise that mental health issues can persist for many years and the association with stigma and fear may still exist.

In addition to bridging the gap between Western medical models and Afghan/Hazara participants’ treatment preferences, professionals will need to consider using a combination of treatments that incorporate pharmaceutical, traditional and lifestyle
changes. Psychotherapy that helps link causal factors such as the traumatic background of this population and the degree of trauma and persecution could assist with dispelling entrenched notions about mental illness that lead to self-isolation. This may be one method of tackling the associated stigma, which can affect actual help-seeking behaviour. Tackling stigma at the community level requires a broad approach through community education and an awareness campaign within the community. For example, recent reports by the Victorian Equal Opportunities and Human Rights Commission (VEOHRC, 2008) and Ethnic Communities Council of Queensland (ECCQ, 2012) have emphasised the importance of engaging with stakeholders to make sure that a common language is used that resonates with the various organisations/ groups/ individuals. Using a common language will help aid consistency and consolidate anti-stigma initiatives. This, in turn, will offer a more favourable environment that supports and sustains grass roots initiatives and support change through policy and, in the longer term, practice and behaviour (Thomas et al., 2016).

An implication for clinical services is that, in order to really understand what people think about mental health and their levels of MHL, it is necessary to use a combination of hypothetical survey-based methods combined with in-depth interviews and follow-up responses. This will give a true sense of beliefs and attitudes, which appear to be shaped by education, culture, trauma and religion.

As research into pre- and post-migration experiences of Afghan refugees is comparatively limited, it is likely that findings about their needs are not likely to be well-known amongst health professionals. Further, in the context of the current less than favourable public attitudes towards refugees worldwide and in Australia, this study has demonstrated that clear post-migration stressors exist and can interact with mental health issues related to, causing further impairment in the individual’s resettlement journey.

7.10 Future Directions

People working with refugee populations’ fall under a larger obligation to give these vulnerable populations the best treatment and services by understanding where they come from in terms of their culture and beliefs and their pre-arrival experiences. In
the post-migration phase, rebuilding a strong identity and sense of place can be an effective way to assist with mental health issues. Congruently, Stanley, Zane, Nagayama Hall, and Berger (2009) highlighted that in order for professionals to treat refugees effectively, they need to understand their own cultural beliefs and values. As well, there is a need for future research in the development of community health promotion programs that informs and addresses those issues that most influence the health and wellbeing of the people in the community, so that they can be supported. These types of initiations will have some challenges (e.g. building trust as an outsider, language difficulty), however, those challenges can be resolved by using community members to train people in their own community.

The findings from this study indicate that for some participants, a sense of belonging was enhanced through language acquisition, employment and educational opportunities. Language and employment further strengthened having purpose in life and their sense of belonging which enhance both wellbeing and settlement outcomes. Perhaps longitudinal studies during the first years after their arrival in Australia would increase knowledge of this matter, there remains not a great deal known about how refugees are progressing following their initial arrival period. There is very limited literature on outcomes two years after arrival.

The findings provide useful information for those designing services and for treating professionals, particularly in the delivery of culturally sensitive mental health services. Outcome from this thesis could include specific training for interpreters who assist refugees accessing services at hospitals and from their GP. One of the first actions that should be undertaken is to remove the reliance on children to act as language brokers for their families. Furthermore, the role of gender can be critical in some refugee communities, and health professionals should be educated around the need to use gender-specific interpreters in order to pave the way for women to discuss confidential issues that may be taboo for them to raise in the presence of male interpreters or children.

7.11 Limitations of the Study

Despite the best planning and intentions there are a number of limitations associated with the study. Firstly, a convenience sampling method was used for the survey;
participants were chosen because most participants were identified by their membership of the Afghan Hazara community in South Australia and were available and willing to participate. Consequently, a limitation of this study was that participants volunteered and were not randomly selected. Non-random sampling may increase the risk of identifying those who have more serious or less serious mental health problems; therefore, it can be argued that they were not necessarily representative of the entire resettled Afghan refugee community. Nonetheless, it is well recognised that there are significant difficulties obtaining representative refugee samples, and in the interest of improving the health of refugee populations there is a need to reach a pragmatic compromise between representativeness and logistic feasibility (Sulaiman-Hill & Thompson, 2010). For this reason, in order to obtain relevant and comparable data some compromise is required to allow access to and recruit participants within the ethnic minority group, rather than risk exclusion from comparative research.

Another limitation of this study was in relation to the limitations of scales available in Dari. A scale such as the HTQ, a commonly utilised measure of PTSD symptoms in refugee groups would have been ideal; however, this scale was not available in Dari. Additionally, it would have been beneficial to have comparable data that could be measured against the general Australian population. This would have required administration of a standardised, widely used measure such as the Kessler 10-item Psychological Distress Scale (Andrews & Slade, 2001), but again this scale was not available in Dari.

Limitations in undertaking direct comparisons were also embedded within the qualitative study because the findings are based on different groups, namely, the total sample versus a subgroup of that sample. Clearly, it would have been desirable to conduct interviews with all participants, because this would have permitted comparison of findings from the different approaches among all participants, but this simply was not feasible.

Research should also be framed to explore the possible benefits surrounding the role of spiritual leaders as contributors to treatment options, such as offering meditation and prayers so that such activities can complement more formal treatment plans. If taken holistically, help-seeking options would include diverse measures that were
inclusive of belief systems, traditional medicines and meditation as well as medically professional interventions. This approach would be supplemented with targeted educational programs for those within the community who have had limited education or are illiterate.

7.12 Strengths of the Study

The strengths of the current study include the use of a mixed-methods approach that permitted triangulation of the findings; a good sample size, which permitted examination of socio-demographic variables potentially associated with specific aspects of MHL; the inclusion of measures of PTSD and depression as well as exposure to trauma. It is also noteworthy that the research was conducted in an important, relevant population of Australian refugees and it is the first study to systematically examine MHL in resettled refugees. Administration of the survey instrument via face-to-face interviews and the recruitment of participants by a researcher who could speak the language and was of the same nationality helped to establish rapport and trust, thereby improving the recruitment process and the quality of the data collected. In addition, conducting most of the interview sessions in the participant’s family home allowed them to be in an environment that was familiar, which enhanced honest and open dialogue.

7.13 Conclusion

The findings from this mixed-method study of Afghan refugees resettled in Australia suggest that mental illness in the vulnerable Afghan refugee population may be improved by mental health literacy programs that target the reduction of stigma and promote a clearer understanding of the role and place of medical intervention, along with traditional and self-help measures. The findings, which are novel, have implications for both health promotion and early intervention and treatment approaches to reducing the burden of poor mental health in this vulnerable population.

Refugees are traumatised and vulnerable to mental illness, but we should not forget how strong they are by the virtue of the very fact that they have survived and are in many cases thriving in a new and challenging environment. Their journey into refugee status represented a hectic period of their lives, which the participants
described as bringing further trauma and insecurity. Many were forced to travel long
distances with no belongings, their trauma, war experience and persecution
permanent scars to remind them of their history and origins. They keep faith that
their children will experience life without the trauma and tragedy of war.
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APPENDIXES

Appendix 1  Participant information

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Appendix 1.1 Ethics consent for study

Locked Bag 1797
Penrith NSW 2751 Australia

Office of Research Services

Our Reference: 13001187 | H10048

HUMAN RESEARCH ETHICS COMMITTEE

14 March 2013

Doctor Sharreran Slewa-Younan
School of Medicine

Dear Sharreran

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H10048 “Mental Health Literacy of Resettled Afghan Refugees in South Australia: A Mixed Methods Investigation of the Community’s Beliefs Trauma Related Mental Health Disorders and Treatment Practices”, until 31 December 2014 with the provision of a progress report annually and a final report on completion.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project.

This protocol covers the following researchers:
Sharreran Slewa-Younan, Jonathen Mond, Caroline Smith, Rebecca Olson, Anita Yaser

Yours sincerely

[Signature]

Associate Professor Anne Abraham
Chair, Human Research Ethics Committee
Appendix 1.2 Ethics Safety Protocol

The researcher ensured that the research was conducted according to the protocol approved by the Human Research Ethics Committee (HREC). In case of any adverse reactions in the first instance, a prompt report was made to Western Sydney University Human Ethics committee. This was followed by contacting the Survival of Torture and Trauma Rehabilitation Services (STTARS) in South Australia, which was nominated as the best agency to deal with the unforeseen events.

Both consent forms and participation information forms were read in participants’ language to make sure that the participants understood the research aims. Participants were also assured that confidentiality was very important part of the research and no participant names were recorded.

The researcher also received debriefing during weekly or fortnightly supervision sessions.
Appendix 1.3  Announcement (Yaser, Slewa-Younan, Smith, Olson, Mond)

A research project is being conducted by Anisa Yaser (PhD candidate, University of Western Sydney), Dr Shameran Slewa-Younan (Lecturer in Mental Health, University of Western Sydney), Associate Professor Caroline Smith, Associate Professor Jonathan Mond and Dr Rebecca Olson.

The aim of this study is to investigate the Afghan refugee population's understanding of trauma related mental health. The information provided from this study will be used to better target relevant health promotion and treatment for people from an Afghan background.

Participation will involve a 60 to 120 minute interview where you will be asked questions about a hypothetical person and some information about your experiences while living in Afghanistan.

To be eligible, participants need to

1. be over 18 years of age,
2. Have been born in Afghanistan, and
3. Have arrived in Australia no earlier than 2000.

Please contact Mrs Yaser on XXXX XXX 124 for more information or to be involved in the study.
Appendix 1.4   Participant Information Sheet (General)

Participant Information Sheet (General)
An information sheet, which is tailored in format and language appropriate for the category of participant - adult, child, young adult, should be developed.

Note: if not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section 'hover your cursor over the bold text. Further instructions are on the last page of this form.

Project Title: Mental Health Literacy of Resettled Afghan Refugees in South Australia: A Mixed Methods Investigation of the Community’s Beliefs Regarding Trauma Related Mental Health Disorders and Treatment Practices.

Who is carrying out the study?
This is a collaborative research project. Members of the research team include:
Ms Anisa Yaser, PhD Candidate, School of Medicine, University of Western Sydney
Dr Shameran Slew-Younan, Mental Health School of Medicine, University of Western Sydney
Associate Professor Caroline Smith, Centre for Complementary Medicine Research, University of Western Sydney
Associate Professor Jonathan Mond, School of Sociology, Australian National University
Dr Rebecca Olson, School of Science and Health, University of Western Sydney

You are invited to participate in a study conducted by Anisa Yaser, PhD Candidate.

What is the study about?
The purpose of this study to investigate your understanding of mental health following trauma and your beliefs and attitudes about the causes of and treatments for mental health disorders following trauma.

What does the study involve?
You will be required to complete a survey and answer questions related to psychological scales. Then you will be invited to participate in a one to one interview to express your opinions and beliefs about mental health disorders and treatment practices.

How much time will the study take?
It is anticipated that completing the survey and psychological scales should take up to 1.5 hours of your time and participating in individual interviews will take approximately 30 minutes.
Will the study benefit me?
The study will not provide you with any immediate benefits, but it may assist in the development of future mental health promotion packages for resettled refugees.

Will the study involve any discomfort for me?
You may experience psychological distress or discomfort whilst completing the survey and questions related to the psychological scales. If you become distressed, the study can be stopped at any time and referral to an appropriate community mental health care services can be provided, if you so wish.

How is this study being paid for?
This study fulfills part of the requirements of a Doctor of Philosophy degree. As such financial support is being provided by the University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?
All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants.

Can I withdraw from the study?
Participation is entirely voluntary: you are not obliged to be involved and - if you do participate you can withdraw at any time without giving any reason and without any consequences.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the chief investigator's contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?
When you have read this information, Anisa Yaser will discuss it with you further and answer any questions you may have. If you would like to know more at any stage please feel free to contact Anisa Yaser on 0408 855 124.
If you'd like to see someone about a mental health concern, you can contact the following free community-based mental health services or consult your local GP:
Survival of Torture and Trauma and Assistance and Rehabilitation services (STTARS) on (08) 8206 8900.

What if I have a complaint?
This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is [To be enter upon approval]
If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form.
Appendix 1.5  Participant Consent Form

Human Research Ethics Committee
Office of Research Services

University of Western Sydney

Participant Consent Form

This is a project specific consent form. It restricts the use of the data collected to the named project by the named investigators.

Note: if not all of the text in the row is visible please 'click your cursor' anywhere on the page to expand the row. To view guidance on what is required in each section 'hover your cursor' over the bold text.

Project Title: Mental Health Literacy of Resettled Afghan Refugees in South Australia: A Mixed Methods Investigation of the Community's Beliefs Regarding Trauma Related Mental Health Disorders and Treatment Practices.

I, ____________________________ consent to participate in the research project titled Mental Health Literacy of Resettled Afghan Refugees in South Australia: A Mixed Methods Investigation of the Community's Beliefs Regarding Trauma Related Mental Health Disorders and Treatment Practices.

I acknowledge that:

I have read the participant information sheet (and/or Anisa Yaser has read it to me) and have been given the opportunity to discuss the information and my involvement in the project with the researcher.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to the completion of questionnaires and scales.

I understand that my involvement is confidential and that the information gained during the study may be published, but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.

Signed: ____________________________
Name: ____________________________
Date: ____________________________

Return Address: 
Completed questionnaires will be collected on the day of testing. However they can also be mailed to Anisa Yaser or Shammar Sawa-Youran
Mental Health, School of Medicine, University of Western Sydney
Locked Bag 1797, Penrith NSW 2751, Australia

This study has been approved by the University of Western Sydney Human Research Ethics Committee.
The Approval number is: [To be inserted upon approval]
If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 1.6  Participant Consent Form for Study 2: Interview

Human Research Ethics Committee
Office of Research Services

Participant Consent Form

This is a project specific consent form. It restricts the use of the data collected to the named project by the named investigators.

Note: if not all of the text in the row is visible please ‘click your cursor’ anywhere on the page to expand the row. To view guidance on what is required in each section ‘hover your cursor’ over the bold text.

Project Title: Mental Health Literacy of Resettled Afghan Refugees in South Australia: A Mixed Methods Investigation of the Community’s Beliefs Regarding Trauma Related Mental Health Disorders and Treatment Practices.

I acknowledge that:
I have read the participant information sheet (and/or Anisa Yaser has read it to me) and have been given the opportunity to discuss the information and my involvement in the project with the researcher.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to participate in the interview process.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.

Signed: ____________________________
Name: ____________________________
Date: ____________________________

Return Address: Completed questionnaires will be collected on the day of testing. However they can also be mailed to Anisa Yaser or Shamarae Sawa-Younan
Mental Health, School of Medicine, University of Western Sydney
Locked Bag 1797, Parramatta NSW 2151, Australia

This study has been approved by the University of Western Sydney Human Research Ethics Committee.
The Approval number is: [To be inserted upon approval]
If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 2  MHL Vignette, Survey, Demographics and Measures

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Appendix 2.1 Mental Health Literacy Vignette and Survey

THE VIGNETTE USED IN THE MENTAL HEALTH LITERACY SURVEY

Below is a story regarding a hypothetical person called Mariam. The box below describes how she has been recently.

Mariam is a 37 year old married woman with 3 children, a daughter aged 7, and two sons, aged 5 and 3. Mariam has been living in Australia for the past year and has attended her local GP on several occasions with the primary complaint of an inability to sleep. The problem with her sleep started just before she left her homeland, Afghanistan, four years ago. Prior to leaving Afghanistan, Mariam was attacked by the Taleban and she was beaten and threatened with death. She reports that during the attack she felt intense fear and helpless. She currently reports constant nightmares in which images of death, killing and being attacked by masked men disturb her sleep. She avoids talking about her attack and watching Afghan news channels in case there is a story about the Taleban. She is easily startled when she hears loud sounds such as a car backfiring or fireworks. She has very little interest in things around her, including her children’s lives and feels little affection towards them. Finally, when questioned on how she views her future and plans for her life, Mariam replies that she does not have a future and doesn’t believe she will live a long life.

*Replaced with Ahmad in the case of male participants
General Information

First we would like to ask you some questions about yourself and your background:

1. Are you male or female?
   - Male □
   - Female □

2. What is your date of birth? _______________________

3. What is your country of origin? _______________________

4. What language do you speak at home? _______________________

5. When did you leave your home country? _______________________

6. When did you arrive in Australia? _______________________

7. In which country did you spend most time in on route to Australia? _______________________

8. How did you travel to Australia? _______________________

9. What is your current migration or refugee status in Australia? (Please tick one box)
   - Permanent Resident □
   - Australian Citizen □

10. How did you arrive in Australia? (Please tick one box)
    - Refugee □
    - Asylum Seeker □
    - Immigrant □

11. Have you ever been on a temporary protection visa (TPV)? (Please tick one box)
    - No □
    - 3 Year TPV □
    - 5 Year TPV □
12. How many years of education have you completed? _______________________

13. What is your marital status? (Please tick one box)
   - Never Married
   - Married
   - Fiancée/ Partner
   - Divorced
   - Widowed

14. Where do members of your family live? (Tick all boxes that apply)

<table>
<thead>
<tr>
<th>Family Members</th>
<th>Australia</th>
<th>Other Western or European Nation</th>
<th>Afghanistan</th>
<th>Other Middle Eastern or African Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children over 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children under 18 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers or sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended family (e.g. uncles, aunties, cousins, grandparents etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify all countries that apply _______________________

15. How concerned are you about the safety of family members in Afghanistan or other parts of the Middle East or Africa? (Please tick one box)
   - Not at all worried
   - A little worried
   - Quite worried
Extremely worried
Attitudes and Beliefs about a Health Problem

1. What would you say is Mariam’s main problem? (Tick one box only)

   1. Fear
   2. No real problem, just a phase
   3. Depression
   4. Weak character
   5. Nervous breakdown
   6. Post-Traumatic Stress Disorder
   7. Serious medical condition (e.g. brain tumour)
   8. Stress
   9. Not integrating well in Australia/homesickness
   10. Physical condition (e.g. migraine or back pain)
   11. Other
   (please write below)

   ____________________________________________________________

2. If Mariam went to a doctor, what do you think he or she (i.e. the doctor) would say is Mariam’s main problem? (Write one number from 1-11 below):

   ____________________________________________________________

3. Do you think each of the following types of treatment or activities would be “helpful”, “harmful” or “neither helpful nor harmful” for Mariam? (Tick one box only for each option)

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting information about the problem and available services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Just talking about the problem (e.g. to a family member or close friend)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improving diet and/or getting more exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Reading the Koran
5. Drinking alcohol to relax
6. Reading a self-help book
7. Getting out and about more/finding some new hobbies
8. Hypnosis
9. Psychotherapy focusing on changing thoughts and behaviours (cognitive behaviour therapy)
10. Traditional therapies (e.g. herbs, cupping, leeching)
11. Trying to deal with the problem on her own
12. Admission to a psychiatric hospital
13. Psychotherapy focusing on causes that stem from the past
14. Having a prayer session or reading with a religious leader
15. Relaxation (e.g. having a massage)
16. Psychotherapy focusing on relationships with others

Which one of these treatments do you think would be most helpful for Mariam?

Write one number from 1 to 16 here: ______________________

4. Do you think each of the following medicines would be “helpful”, “harmful” or “neither helpful nor harmful” for Mariam? (tick one box only for each option)

<table>
<thead>
<tr>
<th>Medicine Type</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anti-depressant medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

256
(e.g. Prozac)

2. Vitamins and minerals (e.g. Vitamin C)

3. Medication to help you relax (e.g. Xanax, Valium)

4. Herbal medicines (e.g. Basal=Kharghol, Kalamata=Gandabaghal, Khash-khash=opium poppy seeds, rose leaf tea)

Which one of these medicines do you think would be most helpful for Mariam?

Write one number from 1-4 here: ____________

5. There are a number of different people or groups who might be able to help Mariam. Do you think each of the following people or groups would be “helpful”, “harmful”, or “neither helpful nor harmful”, for Mariam? (Tick one box only for each option)

<table>
<thead>
<tr>
<th>Person/Service</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Religious leader or priest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Afghan social group/club</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Psychiatrist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. GP or family doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Psychologist</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Close male friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Community religious organisation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Community mental health worker/team (e.g. social worker, mental health nurse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

257
<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Telephone counselling line (e.g. “lifeline”)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Close female friend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Family member</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Which one of these people or groups do you think would be most helpful for Mariam?

Write number from 1-11 here: _____

6. How difficult do you think Mariam’s problem would be to treat? (Tick one box only)

1. not at all
2. a little
3. moderately distressing
4. very distressing
5. extremely distressing
7. How distressing do you think it would be to have Mariam’s problem? (Tick one box only)

1. not at all
2. a little distressing
3. moderately distressing
4. very distressing
5. extremely distressing

8. How sympathetic would you be towards someone with Mariam’s problem? (Tick one box only)

1. not at all sympathetic
2. a little sympathetic
3. moderately sympathetic
4. very sympathetic
5. extremely sympathetic

9. How serious do you think Mariam’s problem is?

1. not at all serious
2. a little serious
3. moderately serious
4. very serious
5. extremely serious

10. What do you think would be the likely result if Mariam received the sort of help you think is most appropriate? (Tick one box only)

1. Full recovery with no further problems
2. Full recovery, but problems will probably re-occur
3. Partial recovery
4. Partial recovery, but problems will probably re-occur

259
5. No improvement

6. Get worse

11. How many Afghan people in your local community do you think might have a problem like Mariam’s? (Tick one box only)

1. Very few women/men, less than 10%
2. More than 10% but less than 30%
3. More than 30% but less than 50%
4. More than 50% but less than 70%
5. More than 70% but less than 90%
6. Most women/men, 90% or more

12. This is a question about the possible causes of Mariam’s problem. How likely do you think each of the following is a factor in this sort of problem developing in anybody? (Tick one box only for each option)

<table>
<thead>
<tr>
<th>Causes</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Not Likely</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Having a parent or parents with psychological problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Having a bad childhood (e.g. poverty, loss of parent/s, being physical, sexually or verbally abused)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>3. Coming from a worn torn country</td>
<td></td>
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<tr>
<td>4. Punishment from God</td>
<td></td>
<td></td>
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<tr>
<td>5. Poor physical health</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>6. The problem is destiny (it was meant to happen to Mariam)</td>
<td></td>
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<tr>
<td>7. Moving to a new country (e.g. losing contact with family and friends)</td>
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<td></td>
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<tr>
<td>8. Family problems (e.g. arguments with spouse, financial pressure, unemployment)</td>
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<tr>
<td>9. The problem is genetic or</td>
<td></td>
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</tr>
</tbody>
</table>
10. Experiencing a traumatic event (e.g. kidnapping, assault, bombing, torture, death of a loved one, etc.)

11. Being a person with a weak character

Which one of these reasons do you think is most likely to be a cause of Mariam problem developing in anybody?

Write one number from 1-11 here: _____

13. This is a question about the type of people who are likely to develop a problem like Mariam’s. Do you think each of the following people would be “very likely” “likely”, or “not likely” to develop a problem like Mariam’s? (Tick one box only for each option)

<table>
<thead>
<tr>
<th>Risks</th>
<th>Very Likely</th>
<th>Likely</th>
<th>Not Likely</th>
<th>Depends</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Left Afghanistan prior to 2001</td>
<td></td>
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<tr>
<td>4. People who have families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Young people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Unemployed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. People who are single/on their own</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Those who are very religious</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Being from a Muslim background</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Older people</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Served in the army</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Which one of these factors do you think is most likely to be a greatest risk factor in a problem like Mariam’s developing in anybody?

Write one number from 1-17 here: _____

14. Do you think that Mariam would be discriminated against by others in the community if they knew about the problem she has, for example, by a family member, friend, employer, health or government professional?

   No □
   Yes □

If yes, can you please give three examples of ways you think Mariam would be discriminated against?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

15. Imagine Mariam is someone you have known for a long time and care about. You want to help her. What would you do?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
16. Do you think that you might currently have a problem like Mariam’s? (Tick one box only)

- No □
- Yes □

17. Do you think that you have ever had a problem like Mariam’s? (Tick one box only)

- No □
- Yes □

18. Has anyone in your family or circle of friends ever had a problem like Mariam’s? (Tick one box only)

- No □
- Yes □

19. If you had a problem like Mariam’s, which of these people would you most likely to approach first for help? (Tick one box only)

1. Family member □
2. Close female friend □
3. Psychologist □
4. Religious leader □
5. Close male friend □
6. Community religious organisation □
7. Telephone counselling line □
8. GP or family doctor □
9. Community mental health worker/team □
10. Psychiatrist □
11. Afghan social group/club □
12. None or the above- I wouldn’t want anyone to know □
13. Other (please specify) □
20. Have you ever been told by a health professional, such as a doctor or psychologist, that you might have a problem like Mariam’s?

No ☐  Yes ☐  

If yes, what year was this? ___________________

21. Have you ever sought help for a problem like Mariam’s?

No ☐  Yes ☐  

If yes, when was this?

In last 3 months ☐  6 to 12 months ago ☐  Over 12 months ago ☐  
Before coming to Australia (please specify below) ☐  
________________________________________

22. Who did you seek or receive services from? (Tick all boxes that apply)

1. Close female friend ☐  
2. GP or family doctor ☐  
3. Telephone counselling line ☐  
4. Community mental health worker/team ☐  
5. Community religious organisation ☐  
6. Psychiatrist ☐
Appendix 2.2  Demographic characteristics of participants (N = 150)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male, (%)</td>
<td>74 (49.3)</td>
</tr>
<tr>
<td>Female, (%)</td>
<td>76 (50.7)</td>
</tr>
<tr>
<td>Age in years, mean (SD)</td>
<td>32.81 (12.2)</td>
</tr>
<tr>
<td>Language</td>
<td></td>
</tr>
<tr>
<td>Dari</td>
<td>147 (98.0)</td>
</tr>
<tr>
<td>Hazaragi</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>Others</td>
<td>1 (.7)</td>
</tr>
<tr>
<td>Main country of transit</td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>68 (45.3)</td>
</tr>
<tr>
<td>Iran</td>
<td>53 (35.3)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>24 (16.0)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>1 (.7)</td>
</tr>
<tr>
<td>Other</td>
<td>4 (2.7)</td>
</tr>
<tr>
<td>Travel transportation to Australia</td>
<td></td>
</tr>
<tr>
<td>Plane</td>
<td>97 (64.7)</td>
</tr>
<tr>
<td>Boat</td>
<td>53 (35.3)</td>
</tr>
<tr>
<td>Current status in Australia</td>
<td></td>
</tr>
<tr>
<td>Permanent resident</td>
<td>66 (44.0)</td>
</tr>
<tr>
<td>Australian citizen</td>
<td>77 (51.3)</td>
</tr>
<tr>
<td>Bridging visa</td>
<td>6 (4.0)</td>
</tr>
<tr>
<td></td>
<td>N (%)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Spouse visa</td>
<td>1 (.7)</td>
</tr>
<tr>
<td>Arrival status in Australia</td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td>64 (42.7)</td>
</tr>
<tr>
<td>Asylum seeker</td>
<td>52 (34.7)</td>
</tr>
<tr>
<td>Immigrant</td>
<td>34 (22.7)</td>
</tr>
<tr>
<td>Temporary Protection Visa (TPV)</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>113 (75.3)</td>
</tr>
<tr>
<td>3 year TPV</td>
<td>30 (20.0)</td>
</tr>
<tr>
<td>Bridging visa</td>
<td>5 (3.3)</td>
</tr>
<tr>
<td>Spouse visa</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>Years of education, mean (SD)</td>
<td>6.07 (5.196)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>38 (25.3)</td>
</tr>
<tr>
<td>Married</td>
<td>93 (62.0)</td>
</tr>
<tr>
<td>Fiancé/partner</td>
<td>4 (2.7)</td>
</tr>
<tr>
<td>Divorced</td>
<td>2 (1.3)</td>
</tr>
<tr>
<td>Widowed</td>
<td>13 (8.7)</td>
</tr>
</tbody>
</table>
Appendix 2.3 Afghan War Experience Scale (AWES)

<table>
<thead>
<tr>
<th>Event</th>
<th>NO</th>
<th>Once</th>
<th>Several Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Destruction of your house</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Destruction of your village or neighborhood</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Participation of one or more family members in the war</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Rocket landing on your house</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Death of a family member</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Injury of a family member</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Loss of your family income</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Disappearance of a family member</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Separation from a family member</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming a refugee from your village or city</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being injured yourself during the war</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Losing your property and wealth</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being put in jail</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being beaten</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Having a family member in jail</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>A family member being beaten</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to afford to buy the things your family needed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 2.4  Connor-Davidson Resilience Scale 2 (CD-RISC 2)

### Connor-Davidson Resilience Scale 2
(CD-RISC 2)

For each item, please mark an ‘X’ in the box below that best indicates how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

<table>
<thead>
<tr>
<th>not true at all (0)</th>
<th>rarely true (1)</th>
<th>sometimes true (2)</th>
<th>often true (3)</th>
<th>true nearly all the time (4)</th>
</tr>
</thead>
</table>

1. I am able to adapt when changes occur.
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]

2. I tend to bounce back after illness, injury, or other hardships.
   - [ ]
   - [ ]
   - [ ]
   - [ ]
   - [ ]
INSTRUCTION

Listed below are symptoms or problems that people sometimes have. Please read each one carefully and describe how much the symptoms bothered you or distressed you in the last week, including today. Place a check in the appropriate column.

<table>
<thead>
<tr>
<th>PART I</th>
<th>Anxiety Symptoms</th>
<th>Not at all</th>
<th>A little</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Suddenly scared for no reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Feeling fearful</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Faintness, dizziness or weakness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Nervousness or shakiness inside</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Heart pounding or racing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Trembling</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>Feeling tense or keyed up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Spell of terror or panic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Feeling restless or can’t sit still</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PART II DEPRESSION SYMPTOMS</td>
<td>Not at all</td>
<td>A little</td>
<td>Quite a bit</td>
<td>Extremely</td>
</tr>
<tr>
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</tr>
<tr>
<td>11</td>
<td>Feeling low in energy, slowed down.</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>Blaming yourself for things</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Crying easily</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14</td>
<td>Loss of sexual interest or pleasure</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>Poor appetite</td>
<td></td>
<td></td>
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<tr>
<td>16</td>
<td>Difficulty falling asleep, staying asleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Feeling hopeless about future</td>
<td></td>
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<tr>
<td>18</td>
<td>Feeling blue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Feeling lonely</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>Thought of ending your life</td>
<td></td>
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</tr>
<tr>
<td>21</td>
<td>Feeling of being trapped or caught</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22</td>
<td>Worry too much about things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Feeling no interest in things</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>24</td>
<td>Feeling everything is an effort</td>
<td></td>
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<td>25</td>
<td>Feeling of worthlessness</td>
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</table>
SCORING

Responses are summed and divided by the number of answered items to generate the following scores:

Trauma Events

Total number of events = Sum of all items for which response differs from "NO"

Total events experienced = Sum of all items with positive response to "EXPERIENCED."

Trauma Symptoms

DSM/III-R Score = Items 1-16
## Impact of Events Scale Revised

*Instructions:* The following is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you during the past 7 days with respect to the disaster. How much were you distressed or bothered by these difficulties?

<table>
<thead>
<tr>
<th>Item</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
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<td>1.</td>
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</tbody>
</table>
Appendix 2.7  WHO Disability Assessment Schedule II (WHO-DAS 2)

World Health Organization
Disability Assessment Schedule II
Phase 2 Field Trials – Health Services Research
12-Item Self-Administered Version

The questionnaire asks about difficulties due to health conditions. Health conditions include
diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or
emotional problems, and problems with alcohol or drugs.

Think back over the last 30 days and answer these questions thinking about how much difficulty
you had doing the following activities. For each question, please circle only one response.

In the last 30 days, how much difficulty did you have in:

<table>
<thead>
<tr>
<th>S1</th>
<th>Standing for long periods such as 30 minutes?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>S2</td>
<td>Taking care of your household responsibilities?</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>S3</td>
<td>Learning a new task, for example, learning how to get to a new place?</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>S4</td>
<td>How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>S5</td>
<td>How much have you been emotionally affected by your health problems?</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

Please continue to the next page ...
In the last 30 days, how much **difficulty** did you have in:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S6</td>
<td><strong>Concentrating on doing something for ten minutes?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S7</td>
<td><strong>Walking a long distance such as a kilometre (or equivalent)?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S8</td>
<td><strong>Washing your whole body?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S9</td>
<td><strong>Getting dressed?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S10</td>
<td><strong>Dealing with people you do not know?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S11</td>
<td><strong>Maintaining a friendship?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>S12</td>
<td><strong>Your day to day work?</strong></td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

| H2 | **Overall, how much did these difficulties interfere with your life?** | Not at all | Mildly | Moderately | Severely | Extremely |
| H3 | **Overall, in the past 30 days, how many days were these difficulties present?** | RECORD NUMBER OF DAYS |
| H4 | In the past 30 days, for how many days were you **totally unable** to carry out your usual activities or work because of any health condition? | RECORD NUMBER OF DAYS |
| H5 | In the past 30 days, not counting the days that you were totally unable, for how many days did you **cut back** or **reduce** your usual activities or work because of any health condition? | RECORD NUMBER OF DAYS |

*This completes the questionnaire. Thank you.*
Appendix 3  Data Analysis

Appendix 3.1 T-Test of associations with correctly identifying PTSD and sociodemographic variables and psychology scales: Problem recognition .......................... 277
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Appendix 3.4 Crosstabs: Testing correctly ID PTSD by gender ................................................. 285
Appendix 3.1 T-Test of associations with correctly identifying PTSD and socio-demographic variables and psychology scales: Problem recognition

<table>
<thead>
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<th>Variable</th>
<th>Correct_ID</th>
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<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>Mean</th>
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### Appendix 3.2  Independent samples test

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<th>t-test for Equality of Means</th>
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</tr>
<tr>
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<td>-------------------------</td>
<td>-----------------------------</td>
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<tr>
<td><strong>HSCL_25_DEP_AVE</strong> Score</td>
<td>0.075, 0.785, -0.802, 148, 0.424, -0.09710, 1.2115, -0.33651, 0.14230</td>
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<tr>
<td><strong>HSCL_25_AX_AVG</strong> Score</td>
<td>0.228, 0.634, -0.221, 148, 0.826, -0.02939, 1.3307, -0.29235, 0.23357</td>
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<td><strong>AWES_Total_Score</strong></td>
<td>1.541, 0.216, -0.553, 148, 0.581, -0.32776, 0.59234, -1.49829, 0.84277</td>
<td>-0.598, 104.257, 0.551, -0.32776, 0.54828, -1.41498, 0.75946</td>
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<td><strong>CDRISC2_Total</strong></td>
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<td>Equal variances not assumed</td>
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Appendix 3.3  Nonparametric tests of associations as in Appendix 3.2

## Hypothesis Test Summary

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<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig.</th>
<th>Decision</th>
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</thead>
<tbody>
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<td>The medians of Age are the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Median Test</td>
<td>.945</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>The distribution of Age is the same across categories of Correct_ID_PTSD.</td>
<td>Independent Mann-Whitney U Test</td>
<td>.234</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>The medians of Years of Education are the same across categories of Correct_ID_PTSD.</td>
<td>Samples Median Test</td>
<td>.006</td>
<td>Reject the null hypothesis.</td>
</tr>
<tr>
<td>The distribution of Years of Education is the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Mann-Whitney U Test</td>
<td>.001</td>
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</tr>
<tr>
<td>The medians of Months_In_Aust are the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Median Test</td>
<td>.900</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>The distribution of Months_In_Aust is the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Mann-Whitney U Test</td>
<td>.631</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
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<td>Independent Samples Median Test</td>
<td>.775</td>
<td>Retain the null hypothesis.</td>
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<tr>
<td>The distribution of IOES_Total_Score is the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Mann-Whitney U Test</td>
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<td>Retain the null hypothesis.</td>
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<td>The medians of HSCL_25_Total_Scale_Score are the same across categories of Correct_ID_PTSD.</td>
<td>Independent Samples Median Test</td>
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<td>Retain the null hypothesis.</td>
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<td>Independent Samples Mann-Whitney U Test</td>
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<td>Independent Samples Median Test</td>
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<td>Independent Samples Mann-Whitney U Test</td>
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</table>

Asymptotic significances are displayed. The significance level is .05.
<table>
<thead>
<tr>
<th>Null Hypothesis</th>
<th>Test</th>
<th>Sig.</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 The medians of HSCL_25_AX_AVG_Score are the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Median Test</td>
<td>.732</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>14 The distribution of HSCL_25_AX_AVG_Score is the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Mann-Whitney U Test</td>
<td>.626</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>15 The medians of AWES_Total_Score are the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Median Test</td>
<td>.893</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>16 The distribution of AWES_Total_Score is the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Mann-Whitney U Test</td>
<td>.874</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>17 The medians of CDRISC2_Total are the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Median Test</td>
<td>.691</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>18 The distribution of CDRISC2_Total is the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Mann-Whitney U Test</td>
<td>.696</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>19 The medians of WHO_DAS_12_Total_Score are the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Median Test</td>
<td>.111</td>
<td>Retain the null hypothesis.</td>
</tr>
<tr>
<td>20 The distribution of WHO_DAS_12_Total_Score is the same across categories of Correct_ID_PTSD.</td>
<td>Independent-Samples Mann-Whitney U Test</td>
<td>.152</td>
<td>Retain the null hypothesis.</td>
</tr>
</tbody>
</table>

Asymptotic significances are displayed. The significance level is .05.
Appendix 3.4  Crosstabs: Testing correctly ID PTSD by gender

Case Processing Summary

| Cases | | | | | |
|---|---|---|---|---|
| | Valid | Missing | Total | |
| N | Percent | N | Percent | N | Percent |
| Gender * Correct_ID_PTSD | 150 | 100.0% | 0 | 0.0% | 150 | 100.0% |

Gender * Correct_ID_PTSD Crosstabulation

| Count | Correct_ID_PTSD | | | |
|---|---|---|---|
| Gender | no | yes | Total |
| Male | 49 | 25 | 74 |
| Female | 55 | 21 | 76 |
| Total | 104 | 46 | 150 |

Chi-Square Tests

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>.667a</td>
<td>1</td>
<td>.414</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity Correction</td>
<td>.409</td>
<td>1</td>
<td>.522</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>.668</td>
<td>1</td>
<td>.414</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td></td>
<td></td>
<td>.480</td>
<td>.261</td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>.663</td>
<td>1</td>
<td>.416</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>150</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.69.
b. Computed only for a 2x2 table
Appendix 4  Publications

Appendix 4.1  Beliefs and knowledge about post-traumatic stress disorder amongst resettled Afghan refugees in Australia............................................................. 287
Appendix 4.1 Beliefs and knowledge about post-traumatic stress disorder amongst resettled Afghan refugees in Australia

Abstract

Background: Resettled refugees are at high risk of trauma-related mental health problems, yet there is low uptake of mental health care in this population. Evidence suggests poor mental health literacy (MHL) may be a major factor influencing help-seeking behaviour among individuals with mental health problems; this study sought to examine the MHL of resettled Afghan refugees in Adelaide, South Australia.

Methods: Interviews were completed with 150 (74 males; mean age 32.8 years, SD = 12.2) resettled Afghan refugees living in Adelaide, South Australia. A convenience sampling method was employed and participants were comprised of volunteers from the Afghan community residing in the northern suburbs of Adelaide. Following informed consent participants were presented a culturally appropriate vignette describing a fictional person suffering from post-traumatic stress disorder (PTSD). This was followed by a series of questions addressing participants' knowledge and understanding of the nature and treatment of the problem described. Self-report measures of PTSD symptoms and co-morbid psychopathology were also administered.

Results: Thirty-one per cent of the respondents identified the problem depicted in the vignette as being PTSD, while 26 per cent believed that the main problem was ‘stress’. Eighteen per cent of participants believed that ‘getting out and about’ and ‘learning new hobbies’ would be the most helpful form of treatment for the problem described. Followed by ‘improving their diet’ and ‘getting more exercise’ (16%).

Conclusion: The results of this study demonstrate aspects of MHL that appear to be specific to Afghan refugees who have resettled in Australia. They indicate the need for health promotion and early intervention programs, and mental health services, to recognize that variation in MHL may be a function of both the cultural origin of a refugee population and their resettlement country. Such recognition is needed in order to bridge the gap between Western, biomedical models for mental health care and the knowledge and beliefs of resettled refugee populations.

Keywords: Mental health literacy, Post-traumatic stress disorder, Afghan refugees

Background

Over the past two decades there has been an increased interest in research examining the mental health outcomes of refugees because of their exposure to potentially traumatic events (PTES) both prior and subsequent to their displacement from their homelands [1]. Common refugee experiences include torture, war or civil unrest, the loss of family and friends through violence, and prolonged periods of deprivation. Exposure to these adverse events can have a significant impact on psychological health and wellbeing, most commonly manifesting by the psychiatric conditions of post-traumatic stress disorder (PTSD) and depression (2–4).

Research in this field is now seeking to move beyond documenting the impact that trauma exposure has on
mental health outcomes in refugees, with an increased number of studies seeking to inform best practice treat-
ment, early intervention and health promotion strategies for these populations [5]. This is based on the knowl-
edge that factors such as cultural differences can influ-
ence the acceptability and efficacy of such interventions [6]. Indeed, it has been consistently documented that in
spite of the high prevalence of mental health disorders in refugee groups [7], their mental health utilisation is
well below that of the general population [8]. A lack of understanding of what constitutes mental illness may be
a barrier to the uptake of mental health care, due in part
to differences in cultural perceptions of mental health
[9]. For example, evidence suggests that Muslim refugees
tend to hold differing views of mental health and that
this may be associated with reduced utilisation of these
services [10, 11]. Thus, elucidating refugees’ awareness
and understanding of mental health problems and their
treatment has the potential to improve the uptake of
mental health care where this is needed and inform the
development of health promotion and early intervention
programs.

Mental Health Literacy (MHL) refers to “knowledge
and beliefs about mental disorders which aid their rec-
ognition, management or prevention” [12, p. 183]. This
encompasses (a) the ability to recognise specific disor-
ers; (b) knowledge of how to seek mental health infor-
mation; (c) knowledge of risk factors and causes of
self-treatments; and of professional help available; and
(d) attitudes that promote recognition and appropriate
help-seeking. MHL aims to (i) empower the public with
an understanding of mental health disorders, thereby
facilitating the implementation of prevention and early
intervention programs [12]; and (ii) empower individuals in need of mental health care with the means by which to make an informed decision about accessing this care.

Since the seminal paper in 1997 [12], there have been
multiple national surveys of MHL conducted with the
general Australia population [14, 15], demonstrating
the under development of public knowledge and the
need for targeted mental health education and promo-
tion campaigns [13]. By comparison, the MHL of spe-
cific communities such as resettled refugees remains
far less investigated [13]. It is acknowledged that given
the diversity and heterogeneous nature of this commu-
nity, which originates from a range of cultures, nation-
alities and religions, studies of refugee mental health are
best undertaken specific to a refugee subgroup. Thus, a
recent study of MHL relating to PTSD among resettled
Iraqi refugees in Australia [16] found that individuals in
this community had low levels of problem recognition
(<15% correctly identified PTSD when presented with
a vignette of this condition) and diverse beliefs concern-
ing treatment options including preferences for both
Western biomedical approaches and reading religious
texts [16].

Data from the Australian Department of Immigration
and Border Protection (DIBP) notes that since 2010 the
highest proportion of those deemed ‘irregular maritime
arrival’ are more commonly known as asylum seekers, who
subsequently apply for offshore protection are those that
originate from Afghanistan [17]. Further, there is a small
but growing literature documenting poor physical and
mental health outcomes of resettled Afghan refugees
[18]. Indeed, in a systematic review that included stud-
ies conducted with Afghan refugees resettled in Western
nations, it was reported that depression and PTSD preva-
ience rates were as high as 57 and 100%, respectively [4].

Taken together, these considerations suggest that
research addressing the MHL of these individuals rela-
ting to PTSD would also be of interest. The goal of the
current study was, therefore, to examine knowledge of,
and beliefs about, the treatment of and help-seeking for
PTSD amongst Afghan refugees resettled in Australia.
We were also interested to consider the associations
between participants’ socio-demographic characteristics,
level of PTSD and depression, and responses to particu-
lar aspects of MHL.

Methods

Study design and participants

Approval for the study was obtained from the rel-

ative university Human Research Ethics Committee
(H100046). Efforts were made by the author (AY) to pro-

mote the study in the South Australian Afghan commu-
nity through network of Afghan cultural, religious and
other Afghan gatherings, and by placing flyers (translated
into Dari) on the walls of venues (e.g., grocery stores)
known to be frequented by the Afghan population in
Adelaide, South Australia. The flyers included informa-
tion concerning the study aims, the time commitment
entailed in participation and the inclusion criteria. Prior
to the flyers being posted, a meeting was held with com-

munity leaders to explain the project and to seek permis-
sion to place the flyers on venues deemed appropriate.
This permission was granted.

A combination of convenience and snowball sampling
was employed to maximise participation. Most partici-
ants voluntarily responded by contacting the researcher
on the mobile number provided on flyers; a small number
of participants were introduced to the research through
family or friends, the latter passing contact details onto
the researcher. Once participants confirmed their will-
ingness to participate the researcher then followed up
by phoning each individual back to explain the aim of

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the research and set a convenient time for the interview. Interviews were conducted individually and, most often, in the homes of the participants. Several interviews were conducted at the Adelaide and South Australian University libraries as well as public libraries. Two interviews were conducted in researcher AY’s office. Prior to each interview participants were provided with a participant information sheet that briefly outlined the study and aims of the research. Following this they were asked again if they wished to participate in the research project. Written informed consent was then obtained from all participants. Next, a culturally appropriate vignette describing a fictional person suffering from posttraumatic stress disorder (PTSD) was presented, followed by a series of questions addressing participants’ knowledge and understanding of the nature and treatment of the problem described. Self-report measures of PTSD symptoms and co-morbid psychopathology were also administered. The process of data collection was undertaken by author AY (fluent in Dari and English) and each session ranged from 60 to 90 min, with traditional cultural hospitality arrangements, including participants preparing and offering sweets, tea or coffee, accounting for this variation in the length of each interview. Of the total 164 people who initially made contact, 14 declined participation nominating work or family commitments as reasons for non-participation. The inclusion criteria included having been born in Afghanistan, having left Afghanistan during or after 2006, being fluent in Dari and/or English, and being between 18 and 70 years of age. Recruitment during or following 2006 was required in order to establish a more homogenous sample in terms of exposure to conflict, namely, individuals who were living in Afghanistan following the arrival of the Taliban regime. All participants were provided with (translated) information sheets containing details of local specific mental health services. In appreciation of their time, a food gift voucher in the amount of AUD $35.00 was provided to all participants upon completion of the survey.

Measures
The mental health literacy survey
The survey was modelled on Jorm et al’s [12] protocol, with modifications by the authors (SSY, AY and JM) for the study of PTSD in refugees. Specifically, the vignette was developed based on the consensus of several authors (GYS and AY) experienced in the assessment and/or clinical treatment of PTSD in refugees. Care was taken to ensure the vignette was culturally appropriate through the use of simple language, respecting cultural sensitivities and assigning common names to the fictional characters in the vignette. The final survey was translated into Dari and independently back-translated into English using a nationally accredited translation and interpreting service. All discrepancies were checked and rectified by the translators and the research team [19]. The vignette (see Additional file 1), which was read aloud by the interviewer, described a fictional Afghan refugee ‘Mariam/Alireza’ (sex of vignette character was matched to sex of participant being interviewed), who had been exposed to trauma prior to leaving Afghanistan and who was suffering symptoms of PTSD, according to criteria outlined in the 5th edition of the diagnostic and statistical manual of mental disorders (DSM-IV-TR, American Psychiatric Association). A prompt card in Dari was provided so that the participant could follow the description as it was read and participants were advised that they could refer back to the vignette at any time during the interview. Following the presentation of the vignette, participants were asked: ‘What would you say is Mariam/Alireza’s main problem? Participants were required to choose only one answer from a number of options. Listed in random order, these were: ‘fear’; ‘no real problem’; ‘just a phase’; ‘depression’; ‘weak character’; ‘nervous breakdown’; ‘posttraumatic stress disorder’; ‘serious medical condition’ (e.g., brain tumour); ‘stresses’; ‘not integrating well in Australia/homelessness’; and ‘physical condition’ (e.g., migraine or back pain). Participants’ beliefs about the helpfulness of various interventions for the problem described in the vignette were also assessed. Specifically, participants were asked whether each of a number of interventions, within the categories of treatment activities, medicines and people, would be helpful, harmful, or unlikely to help (helpful or unlikely to help for the person described in the vignette). The selection of treatment activities, medicines and people in this study were based on a consensus of several authors (SSY and AY) experienced in the assessment and/or clinical treatment of PTSD in refugees and reflective of those offered in the 2014 National Survey of Mental Health Literacy and Stigma (NSMHLIS) [15]. Additionally, participants were asked which intervention within each category they believed would be most helpful for this person.

Exposure to war-related violence and loss
Following completion of the MHL survey the Afghan War Experience Scale (AWES) was used [20] to assess exposure to war-related violence and loss. The scale, developed with the Afghan population, asks participants to indicate whether they have experienced the noted 17 war-related experiences of violence or loss with response choices including never (0), once (1), or more than once (2). Scores on the 17 items are totalled, yielding a possible range of 0–34, with higher total scores reflecting greater exposure to war-related experiences. This scale
was administered to document levels of exposure to war-related violence and loss.

PTSD symptoms
The impact of events scale-revised [21] (IES-R; 18), a widely used, self-report scale that assesses PTSD symptomatology, was also adopted in this study. It has strong psychometric properties with internal consistency reported as 0.96 [22]. In a recent study [23], Morina and Colleagues (2013) examined the diagnostic utility of the IES-R in two samples of war-affected populations (n = 3313 and n = 856), noting that a score of 34 or above indicates a high probability of clinically significant PTSD symptomatology. Cronbach’s alpha in the current study was 0.965.

Self-reported depression symptoms
Severity of depression symptoms was assessed using the Hopkins Symptoms Checklist-25 (HSCL-25). The HSCL-25 is a 25-item questionnaire made up of two subscales measuring anxiety symptoms (10 items) and depression symptoms (15 items). The HSCL-25 has been used extensively in refugee populations, including Afghan refugees [18]. For the purposes of this study, the depression subscale is reported and the noted community cutoff point for the HSCL-25 depression subscale of 1.75 was utilized [24]. The HSCL-25 demonstrates high internal consistency (α = 0.85), high test–retest reliability (r = 0.82 for each subscale), and good validity (88% sensitivity, 73% specificity) in diagnosing depression [24]. Cronbach’s alpha in the current study was 0.958.

Demographic information obtained included: age in years; sex; arrival status (refugee, asylum seeker; immigrant); length of time (months) in Australia; length of time (months) externally displaced; marital status (never married, married/living as married, separated, or divorced, widowed); and years of formal education completed.

Statistical analyses
With 150 respondents, the study had 80% power at 5% significance level to detect a medium effect size of between 0.20 and 0.37 using 1–3 degrees of freedom Chi square test, and an effect size of 0.33 for Mann–Whitney tests of associations between key demographic variables, symptom levels and specific aspects of MHL. Statistical analysis was carried out using IBM SPSS Statistics version 22.0. The effect of socio-demographic characteristics and symptom levels on the HSCL-25 (depression) and IES-R (as defined in the scale descriptions) on responses regarding problem recognition and beliefs about interventions were examined using Mann–Whitney U tests, Kruskal–Wallis tests, Spearman’s rank correlations or Chi square tests, as appropriate (for the purpose of this analysis, responses to questions concerning the perceived helpfulness of particular interventions were recoded; helpful = 1, harmful = −1, and neither = 0). Pairwise post hoc comparisons of significant socio-demographic characteristics were performed using Dunn’s procedure [25] with a Bonferroni correction for multiple comparisons, with adjusted p values reported. In view of the number of tests conducted, a significance level of 0.010 was employed for all tests. Missing data was low, in the order of <1% and was handled by listwise deletion. Where appropriate, data for levels of general psychological distress and PTSD symptomatology derived from the Second (2007) Australian National Survey of Mental Health and Wellbeing (NSMHWB) [14] and responses from the 2011 National Survey of Mental Health Literacy and Stigma (NSMHL) [15] were used for comparative purposes.

Results
The demographic and clinical characteristics of participants (n = 150) are shown in Table 1.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (Total = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>74</td>
</tr>
<tr>
<td>Female</td>
<td>76</td>
</tr>
<tr>
<td>Age in years, mean (SD)</td>
<td>31.0 (12.1)</td>
</tr>
<tr>
<td>Years of education, mean (SD)</td>
<td>6.1 (5.2)</td>
</tr>
<tr>
<td>Months in Australia, mean (SD)</td>
<td>71.4 (48.6)</td>
</tr>
<tr>
<td>Months externally displaced, mean (SD)</td>
<td>6.5 (6.4)</td>
</tr>
<tr>
<td>Arrival status to Australia</td>
<td></td>
</tr>
<tr>
<td>Refugee</td>
<td>64</td>
</tr>
<tr>
<td>Asylum seeker</td>
<td>52</td>
</tr>
<tr>
<td>Immigrant</td>
<td>34</td>
</tr>
<tr>
<td>Mortal status</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>38</td>
</tr>
<tr>
<td>Married/partner</td>
<td>12</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
</tr>
<tr>
<td>Widowed</td>
<td>13</td>
</tr>
<tr>
<td>Exposure to traumatic event (AMCS), mean (SD)</td>
<td>12.0 (9.0)</td>
</tr>
<tr>
<td>Hopkins symptoms checklist (depression subscale only)</td>
<td>22</td>
</tr>
<tr>
<td>Probable PTSD</td>
<td>69</td>
</tr>
</tbody>
</table>

* HSCL-25 ≥ 1.75
* IES-R ≥ 34

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In the NSMHLW, reported rates of PTSD in NSMHLW ranged from 6.6% for 12-month prevalence to 12.2% for lifetime prevalence, which are between two to fivefold less than in our sample. Similarly, 14.7% of our sample was scoring above the cut-off for probable depression (≥1.75) which is greater than both the 12-month and lifetime prevalence rates for depression reported in the NSMHLW of 4.1 and 11.6%, respectively. The average number of traumatic events experienced by the under-18-year sample was 12.9 (SD = 3.3).

**Mental health literacy survey**

In response to the question “What would you say is Marianna Ahmad’s main problem?” 46 respondents (38.7%) chose PTSD, and a further 59 (26%) chose fear. Moreover, 23 respondents (15.3%) thought the character was suffering from depression, with stress being the next most commonly selected option by 19 respondents (12.7%). Collectively, these responses accounted for 84.7% of all responses. By way of comparison, 34.3% of the general Australian public surveyed in the 2011 NSMHLW gave the correct psychiatric label of PTSD to the vignette.

Table 2 shows the percentage of respondents who considered interventions within each subcategory (treatment activities, medicines or people) as “helpful,” “harmful,” or “neither” for the problem described. As can be seen, “Improving diet or exercise” was the treatment activity most often considered helpful (96.7%) followed by

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Helpful</th>
<th>Harmful</th>
<th>Neither</th>
<th>Most helpful*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatments and activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading a self-help book</td>
<td>88.7%</td>
<td>0%</td>
<td>11.3%</td>
<td>6%</td>
</tr>
<tr>
<td>Finding new hobbies</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Psychotherapy focusing on relationships with others</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Prayer session</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Improving diet or exercise</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Psychotherapy focusing on past</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Relaxation</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Psychotherapy focusing on changing thoughts and behaviours</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Getting information about problems</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Reading a self-help book</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Trying to deal with problem alone</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Talking about problems</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Admission to a psychiatric hospital</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Traditional therapies</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Drinking alcohol to relax</td>
<td>84.7%</td>
<td>0%</td>
<td>15.3%</td>
<td>1%</td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamins and minerals</td>
<td>76.2%</td>
<td>2%</td>
<td>22.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Herbal medicines</td>
<td>76.2%</td>
<td>2%</td>
<td>22.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>76.2%</td>
<td>2%</td>
<td>22.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Medication to help relax</td>
<td>76.2%</td>
<td>2%</td>
<td>22.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>People</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Family member</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>GP</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Religious leader</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Other female friend</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Afghan social group/club</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Case male-female</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Community mental health worker</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
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<tr>
<td>Community help organization</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Telephone counseling line</td>
<td>99.5%</td>
<td>0%</td>
<td>0.5%</td>
<td>0%</td>
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</tbody>
</table>

*Percentage of sample rating the specific intervention item as 'most helpful' for treating problem described in vignette.
getting information about the problem' and 'psychotherapy focusing on past' (both responses equally selected by 86.7%). The single most helpful treatment activity selected was 'finding new hobbies' (88%). By comparison, the top three helpful interventions selected by participants in the NSMHLs were 'physical activity' (93.5%), 'get out more' (88%), and 'learn relaxation' (87.9%). With respect to medication, 'vitamins and minerals' were most commonly noted as helpful (76%), with 'herbal medicine' seen to be the most helpful medication (33.3%). This differs slightly from that reported in the NSMHLs, where antidepressants (43.4%) and vitamins (36.6%) were seen as helpful. In terms of assistance from people, the Afghan participants most frequently cited psychiatrists as being helpful (99.3%), followed by psychologists (98.7%) and GPs (96.7%). In the NSMHLs, by comparison, the person considered most likely to be helpful were counsellors (91.3%), GPs (86.6%) and psychiatrists (84.3%).

Factors affecting response to particular questions
Participants who selected PTSD as the main problem had more years of education (82.8%) than participants who selected fear as the main problem (44.1%) (p = 0.001), whereas participants with fewer years of education were more likely to consider reading the Koran (r = -0.267, p = 0.001) and using traditional therapies (r = -0.272, p = 0.001) as helpful compared with participants with higher levels of education. Other participants were more likely to consider a prayer session (r = 0.275, p = 0.001) and religious leaders as helpful (r = 0.385, p = 0.001) than younger participants. There were no other associations between demographic characteristics and responses to the MIH survey that were significant at the 0.01 level and no associations between clinical characteristics, namely, those with clinically significant levels of PTSD or depression symptomatology and responses to the MIH survey that were significant at the 0.01 level.

Discussion
This study sought to elucidate aspects of MIH relating to PTSD in a group of Australian-based resettled Afghan refugees, namely, problem recognition and beliefs about the helpfulness of activities, treatments and treatment providers. Approximately one-third (30.7%) of the participants identified the problem described in the vignette as PTSD. Improving diet or exercise, finding new hobbies, getting information about the problem and specific psychotherapy were the treatments most likely to be considered helpful for the problem described, whereas psychiatrists, psychologists and GPs were the treatment providers most likely to be considered helpful for the problem described, whereas psychiatrists, psychologists and GPs were the treatment providers most likely to be considered helpful for the problem described. Taking vitamins and minerals was also highly regarded, whereas the use of psychotropic medication was viewed less favorably. Participants with lower levels of education were less likely to identify the problem described as PTSD and both participants with lower levels of education and older participants were more likely to consider religious worship to be helpful than participants with higher levels of education and younger participants. There were no associations between participants' levels of PTSD and depressive symptomatology and the aspects of MIH addressed.

Of note is that the proportion of participants in the current study who identified the vignette as describing a person with PTSD was similar to, although slightly lower than, that of the general Australian population (30.7% versus 34.3%) [15]. While this finding is encouraging, particularly when compared with the very low rates of identification of PTSD (14.2%) observed in our previous study of Iraqi refugees resettled in Australia [16], it is still far from ideal. Further, whereas almost half (45%) of participants in the current study had clinically significant levels of PTSD, identification among this sub-group was no better than that observed among asymptomatic participants. If less than one-third of individuals with clinically significant symptoms of PTSD recognize that they have this problem then it is not surprising to find low uptake of mental health services in this sub-group [12]. The finding that participants with higher levels of education were more likely to identify the problem described as PTSD than those with lower levels of education may reflect an association between higher levels of education and greater exposure—and receptiveness—to western, biomedical models of mental health problems and their treatment.

The finding that self-help interventions, such as improving diet and exercise, finding new hobbies, and getting information about the problem, were highly regarded in the treatment of PTSD among participants in the current study is consistent with findings from studies of MIH relating to a broad range of mental health problems in various populations, including the Australian NSMHLs [15]. In the current study, this finding may reflect not just a universal preference for the use of less confronting and less potentially stigmatising interventions, but also an expression of the perceived importance of 'keeping oneself busy'; this being a coping mechanism known historically to be favoured in Afghan populations [26]. At the same time, participants in the current study viewed the use of specific psychotherapy in the treatment of PTSD favourably. The vast majority considered both "psychotherapy focusing on changing thoughts and behaviour" (84%) and "psychotherapy focusing on the past" (86.7%) to be helpful. In this respect the current study participants' views are consistent with "evidence-based practice", in which the use of specific
psychotherapy, along with that of anti-depressant medication, is advocated in the treatment of PTSD [27]. The preference for the use of "vitaminas y minerales" and "herbal medicine" over the use of anti-depressant and/or anxiolytic medication in the treatment of PTSD observed among participants in the current study is also consistent with findings from previous studies of MHL in relation to various mental health problems observed in various study populations [33], although participants in the Australian NSMHL S regarded the use of anti-depressant medication more favorably than participants in the current study. Evidence suggests that interventions and ceremonial rituals, such as spiritual leaders reading the Koran or praying with the person who is unwell, are readily available and acceptable in cross-cultural communities, whereas medications such as antidepressants were said to worsen the symptoms of mental illness in at least one study of Somali refugees [34]. In the current study, 62.3% of participants reported reading the Koran and 37.3% reported believing that prayer sessions would be helpful for the problem described. Consistent with this finding, Miller and colleagues (2009) [35] noted that faith in God and prayer are among the ways Afghan report coping with mental illness.

Also of interest is the finding that participants in the current study considered psychiatrists, along with psychologists and general practitioners, to be the 'treatment providers' most likely to be helpful. This was comparable with participants in the Iraqi refugee study where 84.5% selected seeking help from a psychiatrist as most helpful [16]. Both the Iraq and Afghan studies showed variations from the preferred treatment providers noted in the NSMHL S, where counselors followed by GPs were most helpful in treating PTSD [15]. The reason for these differences warrants further examination, as there may be social or cultural elements surrounding the role of psychiatrists that are particular to the Iraqi and Afghan populations. It should be noted that PTSD is perceived to be severe among individuals in these cultures as being a more severe "brain-based" illness than certain other mental health problems, such that treatment even from a mental health professional who is also a physician is warranted. Finally, another reason for the higher endorsement of psychiatrists observed among participants in the current study may not only crosscut from the trust they place in the biomedical community, but it also is possible that this endorsement reflects, in part, an artifact of social desirability in responses.

Finally, it is notable that a majority of participants in the current study (78.7%) believed that 'dealing with the problem alone' would be harmful. This is in contrast to the Iraqi study, where more than half of the participants believed that trying to deal with problems alone is possibly helpful [16]. Hence, Afghan refugees appear to recognize that help from some source at least is important when dealing with the symptoms of PTSD, whereas dealing with the problem in isolation may be considered to be beneficial—necessary perhaps—among certain other refugee populations.

These differences and similarities across two refugee populations in resettled Australia provide useful insights for treating professionals particularly in the delivery of mental health education and promotion and highlight the need for studies of MHL to be conducted with specific communities of interest at the local level rather than attempting to generalize from studies of the mainstream community or from the same cultural group in a different part of the world. More generally, differences in treatment preferences suggest different ways in which clinicians may need to respond to and work with refugee communities if they wish to achieve true therapeutic alliances. This can be done through close collaborative efforts with targeted refugee in which the incorporation of aspects of culture, such as the importance of prayer, can be woven into the development of intervention programs [38], in addition to seeking the support and input of community elders [39]. This then needs to be dovetailed with better informed treating professionals, proficient in understanding the unique traumatic background of differing groups of refugees. Furthermore, greater consideration will need to be given to understanding resettlement stressors at the local level in development of such programs. Related lessons concern the relative importance of addressing PTSD and related symptomatology in resettled refugee populations and addressing individuals' immediate needs. It may be that, depending of where the refugee is in their resettlement journey, addressing the immediate expressed needs of refugees and providing opportunities for the establishment of social capital and resilience, may be more appropriate than a Western biomedical approach to their mental health care [6, 32]. In future research, this line of thought would be helpful in assessing both aspects of MHL, deemed to be pertinent and sources of post-resettlement stress, so that the relative importance of these variables in informing programs aimed at reducing the impact of post-traumatic stress can be examined.

Strengths of the current study included the relatively large sample size, which allowed analysis of the associations between MHL, clinical characteristics and socio-demographic characteristics and the inclusion of measures of both PTSD and depression as well as exposure to trauma. Administration of the survey instrument via in-person interviews and the recruitment of participants by a researcher who could speak the language, and was of the same nationality as participants, helped to establish rapport and trust and thereby improved the recruitment process and the quality of the data collected.
A limitation of the current study is the use of self-report measures of mental health. Additionally, participants were volunteers from within the resettled Afghan community, thus, the self-selected convenience sample may have introduced bias. However, it should be noted that a lack of a clear sampling frame and limitations with Census data hinder true assessment of representativeness of such difficult-to-reach populations [33]. Hence, the generalizability of the current findings to the total population of Afghan refugees residing in Adelaide is unclear. For example, it is possible that those socially engaged and connected individuals were over-represented among study participants, given the recruitment methods employed. If so, then responses to certain items of the MHI-5 survey may have been more optimistic and/or informed than would be the case in a more representative sample. On the other hand, participants in the current study had markedly elevated levels of PTSD symptomatology relative to the general Australian population, and study representativeness was not considered to be paramount for an initial study of this kind in a difficult-to-access population. Future research with this population should include assessment of other key variables, such as actual help seeking and post-settlement stressors, as mentioned above.

In conclusion, the current study suggests Afghan refugees resettled in Australia are likely to have very high levels of distress and PTSD symptomology. Of greater concern, the study revealed a poor understanding of mental health symptoms with large numbers of participants not seeking treatment deemed appropriate for their mental illness, based on the vignette. The results of this study demonstrate differences in terms of MHI and treatment practices between the Afghan population and both mainstream and arrival populations. This indicates the need for specific and targeted mental health services and treatment plans, which recognize cultural differences and values in order to bridge the gap between Western medical models for treating Afghan refugee treatment preferences.

Additional file

Additional file 1. The vignette used in the mental health literacy survey.

Abbreviations


Authors’ contributions

KF conceived the study, SS and KF designed the study and the survey instrument with input from LM and CS, LM analysed with data management. All authors contributed to revisions. All authors read and approved the final manuscript.

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Competing interests

The authors declare that they have no competing interests.

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