Exploring resettlement stressors and help-seeking for mental health support with women from refugee backgrounds

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Thesis abstract

Despite the well-documented mental health risk factors for people with refugee backgrounds, there remain gaps in understanding resettlement stressors and barriers to help-seeking, and access to and use of mental health services for specific refugee communities in Australia. The overarching aim of this thesis was to explore resettlement stressors and barriers to help-seeking with women from two different refugee communities and to provide clinical implications for services working with these populations.

This project was guided by postcolonial feminist theory, used a Community-Based Participatory Research (CBPR) approach, and was informed by Kleinman's Explanatory Model (1978, 1980) and Andersen's Model of Health Utilisation (Andersen & Newman, 1973). In exploring resettlement factors, the thesis also takes a Social Determinants of Health approach to understanding effects on health and wellbeing. Semi-structured interviews were conducted with three groups of people, including women from the Afghan (Hazara) community with refugee backgrounds (study 1), women and men from the South Sudanese community with refugee backgrounds (study 2 & 3), and service providers working with women from refugee backgrounds in mental health services (study 4). Interview data was transcribed verbatim and thematically analysed.

In study 1, findings suggested that older women from the Afghan community may face multiple social and cultural barriers to help-seeking, including stigma regarding mental health, differences in cultural conceptualisations of mental health, racism, domestic violence, husbands acting as gatekeepers to help-seeking, language and communication difficulties, and informal help-seeking preferences.

Initially, study 2 also had a focus on barriers to help-seeking, but participants instead prioritised speaking about resettlement stressors and challenges during interviews. As such, drawing on a CBPR framework, the second study explored these issues, with results indicating that dealing with practical concerns and resettlement stressors took precedence over accessing mental health services. In particular, results identified that concerns about the younger generation, racism and discrimination, social isolation, changing gender roles, and domestic violence were key factors in womens' experiences in Australia and had ongoing effects on mental health.

Stemming from the analysis of the same data, study 3 specifically discussed the impact of negative media and political depictions of the South Sudanese community on their psychological health and well-being. Participants discussed enduring experiences of racism and discrimination that had damaging effects on their sense of identity, mental health, and hope for the future in their resettlement country. Moreover, given the specific focus of media attention on South Sudanese youth, participants expressed considerable concern about the mental health and wellbeing of their children and future generations.

Finally, study 4 focused on service providers' perceptions of the social determinants of women with refugee background's mental health and barriers to help-seeking. Barriers were identified as existing at the individual (language, gender), interpersonal (stigma, conceptualisation of mental health, isolation, racism), organisational (child protection, missed opportunity for service provision, lack of accessibility, expectations, differences in perception of need), and policy levels of the Social-Ecological Model.

Overall, thesis results indicated that women from different refugee communities face barriers to help-seeking and enduring resettlement stressors at times

long after arrival in Australia. However, accessing mental health services may be a low priority for some women, who may instead prioritise practical concerns. Results highlighted the complex intersections between gender, race, and refugee status faced by women with refugee backgrounds. These intersections created multiple challenges to resettlement, empowerment, and belonging within the broader Australian community. Participants from both communities described the way in which racism, patriarchy, language and communication barriers, economic disadvantages, and refugee status created enduring layers of inequality that structured the relative positions of women and men in their community and the broader Australian society. Implications and recommendations include more inclusive public policy, the inclusion of consideration of social determinants of health in mental health care, culturally responsive programs for women and men regarding domestic violence, and the involvement of community partners in research teams.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

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Published Works

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Conference Items

“Help-seeking for mental health services in Australia among Afghan women with refugee backgrounds”. (2018). Oral presentation at the 1st World Congress on Migration, Ethnicity, Race and Health (17-19 May) in Edinburgh. *European Journal of Public Health*, *28(*1).

“Help-seeking for mental health services among Afghan women from refugee backgrounds in South Australia” (2018). Oral Presentation at the Space and Place Gender, Sex & Sexualities Postgraduate and Early Career Researcher Conference (19-20 September) at The University of Adelaide.

“Barriers to help-seeking for mental health services: perspectives of Afghan women from refugee backgrounds” (2017). Poster Presentation at the 11th Annual Florey Postgraduate Research Conference (20 September). Awarded the School of Psychology Prize.

“Exploring Concepts of Mental Health and Help-Seeking in Refugee and Asylum Seeker Women: A South Australian Study” (2017). Oral Presentation at the Work in Progress Seminar, The Hugo Centre for Migration and Population Research (25 May) at The University of Adelaide.

“Exploring resettlement stressors and help-seeking for mental health support with women from refugee backgrounds” (2020). Oral Presentation at the Domestic Violence Working Group (6 February) at The Australian Refugee Association.

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Thesis overview

This thesis begins by discussing the global and historical context of migration issues and positioning the current research within the wider literature. Chapter 1 presents Australia’s migration policies and an overview of the literature relating to mental health issues, post-migration stressors, and barriers to service access for refugee populations. The social determinants of health are also presented in relation to refugee populations. The chapter ends with a summary of the historical contexts for the two populations involved in this research - women from the Afghan (Hazara) and South Sudanese communities in South Australia.

Chapter 2 presents the theoretical underpinnings of the thesis, including a definition of help-seeking, Kleinman’s Explanatory Model, and Andersen’s Health Model. Chapter 3 presents the epistemological assumptions and explains how the research is informed by several critical approaches, including critical realism and postcolonial feminism. The management of power relationships and navigating one’s role as a researcher through reflexive practice is then discussed. Chapter 4 outlines how the research was informed by a Community-Based Participatory Research framework and presents the method of recruitment, data collection, analysis of the data, and ethical challenges.

Data collection for this thesis was conducted in Adelaide, South Australia. References and Appendices for all chapters are collected at the end of the thesis. Research papers are presented in manuscript format, with the same typeset as the main body of the thesis, preceded by preambles situating them within the work, and outlining how they fit into the overall structure of the research.

Following the introductory chapters, four papers prepared as manuscripts are presented, each chapter contributing to the overall aim of exploring barriers to help-seeking and resettlement challenges for women with refugee backgrounds.

Study 1: “Help-seeking for mental health services among Afghan women from refugee backgrounds in South Australia” is presented in Chapter 5. Study 1 explores barriers to help-seeking and resettlement stressors for women with refugee backgrounds from Afghanistan. This was the first of two studies with women from Afghanistan and South Sudan exploring help-seeking and resettlement stressors with community members.

Study 2: “Resettlement stressors and challenges for South Sudanese women with refugee backgrounds: a South Australian study” is presented in Chapter 6. Study 2 predominantly explores resettlement stressors for women with refugee backgrounds from South Sudan, as barriers to help-seeking were not prioritised in participants’ accounts. Throughout study 2 the impact of experiences of racism and the negative portrayal of South Sudanese community members in the media was a salient theme and led to further exploration in study 3.

Study 3: “’That’s what they say in our language: one onion, all smell’: the impact of racism on the resettlement experiences of South Sudanese women in Australia” explored racism and discrimination further and is presented in Chapter 7. Specifically, study 3 presents further analysis of the salient accounts of South Sudanese participants regarding experiences of racism and negative portrayals of the South Sudanese community in Australian media. The analysis in this study is informed by principles from discursive psychology and focuses on how racism and negative portrayals of the community were constructed by participants and the impact of these issues on their resettlement experiences.

Study 4: “Social determinants of women’s mental health and barriers to help-seeking: perspectives of service providers working with women from refugee backgrounds”, presented in Chapter 8, explores the issues raised in studies 1-3 from the perspective of service providers who work with these populations.

The Discussion in Chapter 9 synthesises and triangulates the thesis results, discusses the implications of the findings, acknowledges the strengths and limitations of the work, and provides suggestions for future research.

Chapter 1. Background, aims and overview

1.1 Preface

This Combined PhD/Master of Psychology (Clinical) research presents findings from Community-Based Participatory Research (CBPR) studies exploring stressors, challenges, and barriers to help-seeking for mental health services for women with refugee backgrounds from the Afghan (Hazara) and South Sudanese communities in South Australia.

This thesis presents some findings that meet the main aims of the study, but in the spirit of CBPR, also honour the participants' voices and presents some unexpected findings and themes that arose throughout data collection.

I acknowledge my own position in this research project as a white, middle-class, female university student and how this has inevitably influenced the way that I conducted and analysed the interviews. I also acknowledge my own political values that have been central in my choice of this topic, as well as the way that I interpreted themes from interviews. These factors will be explored in depth in Chapter 3.

Women from the Afghan and South Sudanese communities were chosen as the focus of this research primarily because key members from the South Sudanese and Hazara communities in South Australia approached the researcher and indicated that research concerning mental health and help-seeking would benefit these communities. In the spirit of a community-based project, this research therefore aimed to work with communities to explore issues relevant to them, with the view of directly contributing to both scholarly knowledge and identifying issues on the ground that affect the lives of people with refugee backgrounds in South Austrtalia. In addition, I wanted to work with communities with different religious backgrounds and languages in order to explore any influences these may have on help-seeking and support needs. I hope that this thesis can highlight the need for more qualitative research in this field that documents people's stories and experiences.

1.2 Note on terminology

It is difficult to navigate the field of refugee mental health while avoiding the use of certain problematic or controversial terms. This section begins by addressing some identified problematic terms and discusses how I will navigate the use of this terminology.

1.2.1 "Refugee" and "asylum seeker"

In terms of formal definitions, the term "refugee" refers to a different group of people than "asylum seeker". Specifically, "asylum seeker" refers to an individual who is actively seeking international protection but whose claims for refugee status have not been recognised or confirmed (Phillips, 2011). "Refugee" refers to an individual outside of their country who has a well-founded fear of persecution due to their race, religion, nationality, membership of a particular social group, or political opinion, and is unable or unwilling to return to their country due to fear of persecution (UNHCR, 2015; Refugee Convention, 1951). Refugee status is declaratory in nature and is recognised by a resettlement country's practices through the 1951 Convention or the United Nations High Commissioner for Refugees (UNHCR) (Phillips, 2011; Refugee Convention, 1951).

Previous research has highlighted how the category of "refugee" has become increasingly problematic despite its original humanitarian connotations (Pittaway & Pittaway, 2004; Sajjad, 2018; Zetter, 2007). The term "refugee", especially in Western contexts, elicits images of helpless, traumatised victims with little agency (Pupavac, 2008; Krotofil & Motak, 2018). On the other hand, homogenising discourses have often portrayed people with refugee backgrounds as a threat to resettlement and host countries (Baker & McEnery, 2005; Gabrielatos & Baker, 2008; Luek, Due & Augoustinos, 2015; Sajjad, 2018; Sulaiman-Hill, Thompson, Afsar & Hodliffe, 2011). When “refugee” is paired with “woman”, it can carry multiple intersecting layers of oppression (Pittaway & Pittaway, 2004).

The label “refugee woman” carries multiple identities: the term “woman” can indicate a person of low socio-cultural status who is often targeted and used during times of war (the oppression of women and sexual violence is often used to assert power over other groups in conflict) (Pittaway & Pittaway, 2004). The term “refugee” indicates a corresponding lack of legal or political status and protection. The dual identities of this label can have a compounding effect, making women vulnerable to gender-based and sexual violence (Pittaway & Pittaway, 2004). Thus, the label of “refugee woman” can be considered disempowering as it is a marker of expoitability and denies women the expression of their other social, cultural identities.

Research indicates that the manner in which news outlets represent issues regarding migration can significantly influence public attitudes (Dempster & Hargrave, 2017; Esses, Medianu & Lawson, 2013). The term “refugee” has frequently been used in a derogatory fashion (Tribe, 2002). Indeed, from a social constructionist perspective, language constructs reality (Galbin, 2014). Therefore, the portrayal of those who are seeking asylum or are resettled following international protection in resettlement countries is powerful and can affect their resettlement experience, including by fostering beliefs and concerns regarding job competition, economic (in)stability, and security threats in the host country population (Baak, 2011; Chung, Bemak, Ortiz & Sandoval-Perez, 2008).

Although socially constructed meanings and connotations will be varied depending on the individual or group to which they apply, when negative meanings develop and are reproduced, they can influence the general or dominant meaning associated with a word. Whilst some may use the category "refugee" in a well-meaning, humanising and empathy-evoking manner, this does not alter the way in which the overall meaning of the word has changed. In addition to potentially eliciting negative connotations, the label "refugee" is also limited in its reflection of the lived experience of those it seeks to represent. For example, while the term may resonate with some individuals who feel as though it adequately represents their experience and forms part of their identity, some individuals may find the label unhelpful, problematic, and unfitting – particularly after resettlement.

In the current project, this was demonstrated in an interview conducted with two women who were South Sudanese community leaders. Extract 1 demonstrates how the category of "refugee" itself is inextricably embodied in the identity of two community leaders, Grace (50-60 years) and Susan (60-70 years).

Extract 1

Grace: we are refugees since we are born up till now. Since 1983, 34 years

Susan: yeah 34 years

Grace: refugees, and we are going to die refugees

Interviewer: but would you still call yourself a refugee or would you say, "I used to be a refugee, now I am Australian?"

Grace: we are refugees cos even though we are Australian, in Australia they are still calling us refugees so we still have to

Susan: Australia calling us refugees

Interviewer: would you rather not be called refugees?

Susan: this one the name, the name for us.

Grace: and you know when you come to country, like Australia is our second country, but they not accepting us they still calling us refugees, so we have to be refugees also.

Susan: yeah now we are citizen

Interviewer: yeah because you have been here for so long

Susan: yeah we are citizen now, we are fast forward, the other people they call us refugees

It is clear from this extract that both women felt that the label of "refugee" was given to them by the Australian public, despite their being Australian citizens. Although Susan's response to my question as to whether they would prefer not to be called refugees ("this one the name, the name for us") is ambiguous, both viewed this identity as predominantly imposed upon them by the dominant majority ("Australia calling us refugees"), symbolising the Australian public's reluctance to accept them as Australian despite their citizenship status ("but they not accepting us they still calling us refugees"). This life-long identity ("we are refugees since we are born": and "we are going to die refugees") arguably positions the two women in ways that limits how they are perceived, and indeed, how they may see themselves.

For the purposes of this thesis, as much as possible, I have attempted to use the terminology "person with a refugee background" instead of referring to participants as "refugees".

1.2.2 "Ethnicity", "race", and "culture"

The terms "ethnicity" and "race", often problematically used synonymously, are complex, multi-dimensional, fluid concepts that change over time and are subject to different and subjective interpretations (Aspinall, 2002). The term "ethnicity" originates from the Greek word "ethnos", meaning a nation. In general, ethnicity refers to “the group to which people belong, and/or are perceived to belong as a result of certain shared characteristics including geographical and ancestral origins, but particularly cultural traditions and languages” (Bhopal, 2004). However, ethnicity is not easily measured, as its characteristics are not precise or fixed. It also differs from race, nationality, religion and migrant status, but may also involve certain aspects of these concepts.

Whilst race and ethnicity are different, there are certain elements that overlap, and they are often used synonymously. The term race has historical biological connotations that can be problematic. The biological concept of race was dominant from the early 19th century largely until the end of the Second World War (Senior & Bhopal, 1994), although there are remnants of these concepts in some modern schools of thought. Broadly, it involved humans being divided into sub-groups mainly dependent upon visible characteristics.

In more recent times, researchers typically emphasise the social rather than biological origins of the concept of race (Kaplan, 2003). This perspective gives researchers and scholars a way to define different populations that appear visibly different and have different ancestral backgrounds. However, even using this more social perspective, ultimately the concept of race is still based on physical characteristics and implied biological factors (Bhopal, 2004). Furthermore, despite the biological construct of race being refuted (Smedley & Smedley, 2005), people’s understandings of race and potential associated experiences of racism are still real and warrant consideration. Ultimately, it is necessary to be cautious when using the term “race”. However, when discussing certain topics, including racism, the concept is central and unavoidable (Bhopal, 2004). The terms “ethnicity” and “race” were used cautiously and largely in the context of discussing prejudice and racism experienced by certain members of the communities. Instead, throughout this thesis I generally use the term “culture”. Barker (2002) explains that culture is both contingent and political, and in order to explore its meaning one must trace its uses and subsequent consequences (Barker, 2002). Ultimately, he argues that culture can be understood as:

> criss-crossing discursive meaning which form zones of temporary coherence, shared but always contested significance in a social space. Production and exchange of meanings, or signifying practices lead to a distinctive way of life (Barker, 2008, p.477).

A particularly important point relating to the current study is Stuart Hall’s (1997) statement that “cultural meanings organize, regulate social practices, influence our conduct and consequently have real practical effects” (p. 3). Indeed, one of the aims of the current study was to assess the practical implications that cultural conceptualisations can have upon women with refugee backgrounds’ mental health care and help-seeking behaviours.

Lustig & Koester, (2000) stated that cultural identity encompasses one’s sense of belonging to a particular cultural or ethnic group. It is formed through learning and subsequently accepting traditions, religion, heritage, ancestry, thinking patterns, and social structures of a particular culture (Lustig & Koester, 2000). People internalize the belief systems, norms, and values of their culture and integrate these into their self-concept and identity (Lustig & Koester, 2000).

Amariglio et al. (1988) highlighted the importance of acknowledging the political and economic forces that can influence the definition of culture:

> The concept of overdetermination demands that we reject any essentialist definitions of culture. Thus, we cannot explain culture as the result of a single, determining social process. Indeed, we cannot base our notion of culture on a single, discursively, privileged concept. Art, music, literature, and history are the result of both economic

> and political forces, including class processes and the ordering of social behaviour. (p. 487).

More recently, process-oriented constructs of culture have explored how the formation of cultural identity can be dynamic, situational, and context-specific. Individuals who internalize multiple cultures can negotiate, transfer, and embrace their cultural identities in intercultural interactions (Heo & Kim 2013).

Drawing upon these definitions, for this study I conceptualise culture as transmitted knowledge of values, beliefs and practices that are learned and shared and can influence thinking, decision-making and subsequently, behaviour (Amariglio et al., 1988; Barker 2002 & 2008; Eshun & Gurung, 2009; Hall, 1997; Helman, 1994; Huff, Kline & Peterson, 2014; Kleinman, 1978 & 1980). Furthermore, culture is dynamic and can change over time, and cultural meaning is intertwined and inter-related with social, economic, political, and historical factors and processes.

1.3 Global and historical context

The world is currently facing a serious increase of forcibly-displaced people (UNHCR 2019) due to war, conflict, or environmental issues. Over 25.9 million people are currently classified as refugees and have been forced to leave their homes due to persecution or conflict (UNHCR, 2019). The number of individuals being forcibly displaced globally is accelerating, rising 40% over 5 years from 42.4 million people in 2011 to 65.6 million people by the end of 2016 (UNHCR, 2018). A report by UNHCR in 2017 regarding refugee trends indicated that the top five countries of origin for refugees were Syria, Afghanistan, South Sudan, Myanmar and Somalia (UNHCR, 2018). More recent statistics were unavailable from UNHCR at the time of writing, as the 2019 report had not been released (UNHCR, 2019).

Although 85% of the world’s refugees under UNHCR’s mandate were hosted by developing nations, the United States and Canada are the world’s top *resettlement* countries (UNHCR, 2018). Australia and Nordic countries also provide a number of places per year (UNHCR, 2018). Resettlement refers to the transfer of refugees from asylum countries to another nation that has agreed to take them and eventually grant them permanent settlement (UNHCR, 2018).

Forced human migration and displacement is not a new concept or phenomenon. Instead, displacement has been a key feature of human experience beginning with the formation of the modern nation-state, the embodiment of which is the regulation and control of human movement at the borders of territory (Bauman, 2016). A multitude of factors contribute to the increase of displaced people that the world is experiencing today. At the root of these is global capitalism, which is intertwined with accelerated conditions of war and state violence and climate change and is also inextricably linked to histories of colonization and contemporary imperialism. Ultimately, the mass socialisation of production and the privatisation of wealth being produced by millions of labouring individuals have resulted in a global movement of people as global capitalism initiates invasions, wars, and occupations to secure resources (Mojab, 2016).

The continued growth and expansion of capitalism has ultimately cumulated in globalisation (Rockmore, 2006). Refugees who often work for low wages in resettlement countries supply informal labour for the host economy, and are essential for capitalism (Samaddar, 2018). Globalisation has simultaneously encouraged people’s international mobility through better access to transportation and information, and also increased inequality within and between states, thus creating further incentive for people to move (Crisp, 2015).

Furthermore, this rise in global human displacement and forced migration is also a direct result of climate change (Carastathis, Kouri-Towe, Mahrouse & Whitley, 2018). There is growing evidence that environmental degradation and climate change are resulting in a significant increase in mass human displacement, migration, and relocation (Global Humanitarian Forum, 2009; Hugo, 2010). Under global capitalism, it is often the most marginalised groups within a society that suffer the worst impacts of climate change (Faber & Schlegel, 2017). Refugees are not solely displaced as a result of climate change, but also the political-economic structures that serve to perpetuate climate-related stressors that reduce resilience and recovery (Faber & Schlegel, 2017). Indeed, global capitalism is causing climate-related stresses and natural disasters to become more frequent, as well as more severe in nature (Park, 2015; Faber & Schlegel, 2017).

When discussing the root causes of the latest increase in mass displacement, the intertwined nature of factors such as climate-change and capitalism must be considered. As stated by Turhan & Amiero (2017, p. 2):

> … it must be clear that migration is often an externality of military interventions, proxy wars, imposition of structural economic reforms, multi-causal destruction of livelihoods both by rapid and slow violence through environmental change, establishment of enclosures, and corporate imperialism that have dispossessed and continue to dispossess people in different corners of the world.

A recent example of this intertwined nature of capitalism and climate change or environmental degradation resulting in a mass displacement of a population is the Syrian civil war. A five-year drought forced 1.5 million rural-dwelling people, as well as farmers, from their lands and into metropolitan areas (Sanderson & Sharma, 2016). Thus, climate-change may have been a major factor in the resulting civil war that has resulted in the displacement of five million people (Sanderson & Sharma, 2016).

1.3.1 Historical context

According to the most recent available statistics, 15,115 refugees were resettled in Australia in 2017 (UNHCR, 2018). In order to contextualise the stories within the current project, an overview of relevant recent policies is provided below.

In August 2001 a Norwegian freighter, “MV Tampa” rescued 433 predominantly Hazara (Afghan) asylum seekers from a distressed fishing vessel in international waters that entered Australian waters (BBC, 2001). The Howard Government of Australia refused permission for the Tampa to enter Australian waters, and the passengers were transported to Nauru, where they were held in offshore detention camps. The Prime Minister at the time, John Howard, famously responded to this event at the time, declaring "we decide who comes into this country and the circumstances in which they come" (Sydney Morning Herald, 2001).

Following the Tampa events, in October 2001 HMAS Adelaide intercepted a vessel carrying 223 passengers and crew, mostly consisting of asylum seekers, north of Christmas Island (Parliament of Australia, 2019). In attempts to turn back the boat and asylum seekers to Indonesia, Australian Navy crew boarded the vessel, and 14 male passengers jumped or were thrown overboard (Parliament of Australia, 2019). The commander erroneously reported to his superior that passengers had thrown children overboard. However, there was a lack of substantiating evidence regarding these controversial claims (Parliament of Australia, 2019). Both of these events triggered an Australian political controversy that resulted in the introduction of the Border Protection Bill as well as the Pacific Solution.

The Tampa events were internationally criticised, especially by countries such as Norway, as they accused the Australian government of evading its human rights responsibilities (BBC, 2001). However, domestically, the government’s Pacific

Solution attracted high levels of support, and the boat arrivals of refugees and asylum seekers were met with significant public disapproval (McMaster, 2001). The Pacific Solution involved the establishment of detention centres and offshore processing centres, including Nauru and Manus Island (in Papua New Guinea), and was intended to remove the incentive for those seeking asylum to come to Australia (Phillips, 2012).

Operation Sovereign Borders (OSB) was introduced in 2013 under the Abbott Government (Australian Border Force, 2019). OSB is a military-based border protection operation led by the Australian Defence Force aiming to intervene in and stop maritime arrivals of asylum seekers to Australia. OSB combines a “zero tolerance” stance toward maritime asylum seeker arrivals with mandatory detention in offshore detention centres (Australian Border Force, 2019). OSB is still in operation today, and in April 2017 Home Affairs Minister Peter Dutton reported that the operation had “turned back” 33 boats since its beginning (Minister for Home Affairs, 2017).

1.3.2 Offshore processing

Although the 1951 Refugee Convention states that seeking asylum is a legal right, it does not state that countries must provide legal entry or safe passage. As a result, signatory countries including Australia are obliged to examine and investigate the claims of individuals for protection from persecution, but not to ensure that they are granted refugee status (Carastathis et al., 2018). The UNHCR decides which people seeking asylum are eligible for resettlement based upon seven main categories or criteria including: legal and/or physical protection needs, survivors of torture and/or violence, medical needs, women and girls at risk, family reunification, children and adolescents at risk, and lack of foreseeable alternative durable solutions

(UNHCR, 2014). Ultimately, The Department for Immigration and Border Protection decides which individuals will be granted refugee status in Australia from the UNHCR's recommendations.

Australia currently has four offshore refugee categories: Refugee (200), In-Country Special Humanitarian (201); Emergency Rescue (203), and Women at Risk (204). Australia granted 7,909 refugee visas between 2017-2018 (14,825 including the Special Humanitarian Program (SHP) (Refugee Council of Australia, 2019). For those applying for a Refugee (200) visa, in addition to meeting various criteria including being subject to persecution, and meeting health, character and security requirements, the relevant Minister must be convinced that "there are compelling reasons for giving special consideration to granting the visa". This is in regard to the degree of persecution, the individual's connection with Australia, the lack of any other country that could provide protection for the applicant, and the capacity of the Australian community to provide for the individual's permanent resettlement (Karlsen, 2016).

1.3.3 Australia's offshore processing policy

The "Pacific Solution" implemented during 2001-2007 saw asylum seekers transported to detention centres in Papua New Guinea and Nauru for refugee determination (Magner, 2004). In Australia, since 2012 any individual arriving in Australia without a valid visa by boat has been taken to Manus Island or Nauru for processing and mandatory detention (Kaldor Centre for International Refugee Law, 2019). Christmas Island Detention Centre was opened in 2006 and accommodated men, women, and children. Reports raised serious concerns regarding the remoteness of this centre, the lack of facilities, and the treatment of detainees (Australian Human Rights Commission, 2009; 2018). This centre was closed in 2018, but Australia's Prime Minister Scott Morrison announced in February 2019 that there were plans to re-open the centre. The Nauru Processing Centre was a detention centre from 2012-2015, at which point it became an “open centre”, allowing those residing there to have greater freedom of movement (Karlsen, 2016). However, some reports indicated that Nauru’s move to open the detention centre had made it more dangerous for asylum seekers due to threats and some instances of sexual and physical assault, and overall lack of security (Allard, 2015).

Asylum seekers could be sent to these detention centres despite the fact that they had applied immediately for asylum upon arriving in Australia (Kaldor Centre for International Refugee Law, 2019). The Australian government has maintained that once transferred to Nauru or Manus Island detention centres, no individuals would be resettled in Australia. Concerningly, there is no set time limit regarding how long an individual is detained in immigration detention in Australia. As such, the length of time a person may spend in detention could range from a some weeks up to many years (Australian Human Rights Commission, 2016). The year 2014 also saw the highest number of children (222) living in offshore detention centres. However, in 2019 the Australian Government removed all children from Nauru (Johansen, 2019).

Those living on Manus Island are documented to be asylum seekers mostly from the Middle East, whilst those living on Nauru are mostly from Sri Lanka, Pakistan, and Bangladesh (Karlsen, 2016). This offshore processing arrangement has been shown to have breached international human rights standards (Kaldor Centre for International Refugee Law, 2019).

1.3.4 Onshore processing

Asylum seekers who have arrived in Australia on a valid visa are part of the onshore protection program. Since September 2013 this program has not accepted individuals who arrive in Australia by boat and without a recognised visa (Andrew &

Renata Kaldor Centre, 2019). Those who arrive by plane with no valid visa, or have their visa cancelled, find themselves placed in onshore immigration detention centres.

Statistics from Australia's Department of Immigration and Border Protection indicate that Iraq, Syria, Myanmar, Afghanistan, and the Democratic Republic of the Congo are the top five countries of origin for people entering Australia under humanitarian visas (Department of Immigration and Border Protection, 2016).

1.3.5 Current policy

In regard to the current policy, as aforementioned, the offshore resettlement program contains three categories, and there is also the Special Humanitarian category. Latest reports indicate that the Australian Government announced that it would increase the total Refugee and Humanitarian Program to 18,750 in 2018-2019. The Australian Government refers to those who arrive in Australia without a valid visa as "illegal maritime arrivals" and "unauthorised air arrivals", and they are not permitted to apply for permanent protection. However, they can apply for a Temporary Protection Visa (TPV) or a five-year Safe Haven Enterprise Visa (SHEV). TPVs were introduced in 1999, abolished in 2007 and then introduced again in 2014 (Killedar & Harris, 2017). They are granted for up to three years, and individuals are allowed to work, study, and access some government services. However, those with TPVs are not entitled to family reunification. Once three years have elapsed, TPV holders must re-apply for another TPV or a SHEV. Those granted a SHEV must declare that they intend to work or study in regional Australia.

TPVs have been shown to have detrimental effects on wellbeing and mental health due to the ongoing state of uncertainty, legal limbo, and the prospect that individuals may be sent back to a country in which they faced persection. Momartin, Steel, Coello, Aroche, Silove & Brooks (2006) compared the mental health status of a group of Persian-speaking refugees with temporary (n=49) versus permanent (n=67) protection visas. They found that those in the TPV group indicated higher scores on three psychiatric symptom measures, and that TPV status predicted anxiety, depression, and PTSD (Momartin et al., 2006). Furthermore, the Australian Human Rights Commission raised concerns that TPVs foster uncertainty and insecurity that contribute to mental health issues, and can also have serious negative impacts on children (Australian Human Rights Commission, 2013).

1.4 Migration stressors

1.4.1 Pre-migration stressors

The pre-migration period frequently involves the separation of families and communities and disruptions to social networks, as people may have to leave loved ones behind, often in dangerous and unpredictable situations (Kirmayer et al., 2011).

Previous literature suggests that pre-migration stressors and traumatic experiences may be the most consistent factors related to poor mental health outcomes in both newly-arrived and long-term settled refugee populations (Bogic, Njoku & Priebe, 2015; Lindencrona, Ekblad & Hauff, 2008). Those who report high levels of exposure to traumatic events are more likely to experience mental health difficulties during resettlement than those who report low levels, suggesting a dose-effect relationship (Bogic et al., 2015; Chen, Hall, Ling & Renzaho, 2017; Lindencrona et al., 2008). Schweitzer et al. (2018) suggest that this was also the case for refugee women-at-risk (204 visa) recently resettled in Australia, where higher numbers of trauma events predicted higher trauma symptomology post-resettlement.

Recent research supports the consideration that pre-migration stressors and post-migration stressors interact, and that interventions should target reducing post-migration stressors to improve mental health outcomes (Chen, Hall, Ling & Renzaho, 2017).

1.4.2 Migration stressors

During the migration phase, refugees may spend extended periods of time in refugee camps with poor resources, limited educational opportunities, poor healthcare, and the risk of violence within refugee camps (Kirmayer et al., 2011; Riley, Varner, Ventevogel, Taimur Hasan & Welton-Mitchell, 2017; Silove, Steel & Watters, 2010). These daily stressors can serve to exacerbate mental health problems (Murray, Davidson & Schweitzer, 2010; Riley et al., 2017).

During the migration process, refugees may also be held in detention centres with no indication of how long they will be there, fostering a sense of hopelessness, and perpetuating mental distress (Kirmayer et al., 2011). For many refugees, stress related to uncertainty about the future can be a significant stressor during the migration phase (Schwarz-Nielsen & Elklitt, 2009). These factors prompted researchers to suggest that service providers who work with these populations need to consider not only the individuals they work with, but also their family systems, communities, and social networks in other countries (Kirmayer et al., 2011).

1.4.3 Post-migration stressors

Resettlement is usually a positive, hopeful experience that impacts positively on an individual's well-being (Kirmayer et al., 2011). However, when expectations are not met, or when people face losses associated with migration, enduring structural barriers, inequalities, harsh policies, or racism in host countries, they can be left demoralised and at risk of poor mental health outcomes (Kirmayer et al., 2011; Hameed, Sadiq & Din, 2018). The general experience of upheaval and resettlement, language barriers, and perceived stigma have also been identified as post-migration stressors that may impact upon mental health outcomes (Miller & Rasmussen, 2010).

Research investigating the contributing factors to mental health outcomes with refugee populations has often focused on the negative influence of pre-migration factors, including exposure to traumatic events (Carlson & Rosser-Hogan, 1991; Li, Liddell & Nickerson, 2016; Steel et al., 2009 ; Schweitzer et al., 2018).

More recently, post-migration and resettlement-related stressors have been identified as significant correlates of poor mental health outcomes for recently-arrived refugee populations (Chen, Hall, Ling & Renzaho, 2017; Fisher, 2013; Li, Liddell & Nickerson, 2016; Porter & Haslam, 2005; Renzaho, 2016; Schweitzer, Melville, Steel & Lacherez, 2006; Schweitzer, Brough, Vromans & Asic-Kobe, 2011; Umi, Chi, Kim, Palinkas & Kim, 2015). For example, Schweitzer et al. (2006) interviewed and surveyed 63 resettled Sudanese refugees, involving the use of the Post-migration Living Difficulties checklist. Worry about family back home (95%), employment opportunities (82.5%), and acculturation difficulties (73%) were the most commonly endorsed post-migration stressors. They found that although trauma was a significant predictor of mental health status, the consideration of post-migration stressors was very important (Schweitzer et al., 2006).

Post-migration stress has been defined as stress experienced in adapting to a new environment (including communication difficulties, racial discrimination and unemployment), loss of cultural and social support (including limited access to traditional foods, activities, and social networks), and fear for family members left behind in the home country (Steel et al., 2009).

Other significant resettlement stressors that have an adverse effect on mental health include living in temporary accommodation, and limited access to employment and economic opportunities (Porter & Haslam, 2005). Evidence from various international qualitative studies suggest that the main domains of resettlement stress include social isolation, discrimination, social loss, exposure to violence, and social and economic strain (Hollifield et al., 2002; Lindencrona, et al., 2008; Porter, 2007; Porter & Haslam, 2005; Tang, Oatley & Toner, 2007).

The cultural gap between an individual’s traditional home society and that of their host country can result in distress at the individual level, as well as the breakdown of social and cultural norms (Kartal & Kiropoulos, 2016). This kind of conflict between losing or adjusting aspects of one’s original culture and learning new aspects of a host culture is referred to as acculturative stress (Berry, 1997; Milner & Khawaja, 2012; Poppit & Frey, 2007). Acculturation has been described as “the meeting of cultures and the resulting changes” (Berry, 2005, p. 698). However, in reality, and especially in the context of refugees resettling to a host country, it induces more change in one group than the other (Berry, 1997).

Generally, in Australian culture, the individual is seen as autonomous, self-contained, and independent of others. This is in stark contrast to (for example) the collectivist Sudanese culture, in which the individual is usually viewed as a part of and interconnected with their family or community (Milner & Khawaja, 2012). In these cases, acculturation can entail learning a new language, accepting new laws and cultural values, learning about new traditions and world views, and navigating new systems of governance and health (Milner & Khawaja, 2012). Cultural change from country of origin to host country can pose challenges for an individual’s identity (e.g. differences in gender roles and social roles), as well as family relationships (Hameed, Sadiq & Din, 2018; Kirmayer et al., 2011). The level of support received in the host country or the lack thereof can significantly impact upon an individual’s mental health and how well they adjust to their new life (Kirmayer et al., 2011).

Additionally, the experience of prolonged detention (Fazel & Silove, 2006; Steel et al., 2006), lengthy and challenging refugee determination procedures (Steel et al., 2009), constrained access to services, loss of socioeconomic status, non-recognition of previous educational qualifications (Porter & Haslam, 2005), as well as the loss of meaningful social roles (Colic-Peisker & Walker, 2003) including gender roles (Fisher, 2013), levels of daily activity (Miller et al., 2002), and experiences of discrimination (Correa-Velez, Gifford & Barnett, 2010) have also been identified as exacerbating distress during resettlement.

A recently developed longitudinal study of humanitarian migrants, “Building a New Life in Australia” (BNLA), is the first Australian, nationwide, longitudinal cohort study that has been funded by the Australian Department of Social Services (De Maio, Silbert, Jenkinson & Smart, 2014). Data is collected annually to identify factors that influence the settlement of humanitarian migrants in Australia.

The project was designed to improve knowledge regarding factors that help in successful resettlement of humanitarian migrants in Australia (Rioseco, De Maio & Hoang, 2017). Approximately 2400 participants who had been granted a permanent humanitarian visa in the previous 3-6 months were recruited to the study. The participants included individuals from diverse cultural backgrounds, including 19 language groups, the most common languages being Arabic, Persian, English, and Dari (Rioseco et al., 2017). The data for the first wave of the project was collected in October 2013-March 2014 and involved home visits. Since then the following waves have collected data from October-March each year, with data for the fifth wave being collected in February 2018. Chen, Hall, Ling & Renzaho (2017) used the BNLA data to examine pre-migration and post-migration stressors for participants living in Australia. Of the 2399 participants, 762 had PTSD and 394 had a significant mental illness. The average number of pre-migration traumatic events was 2.1. The main post-migration stressors identified were poor social integration (64%), economic problems (59%), worrying about family and friends overseas (49%), and loneliness (18%).

These recent findings support the previous research claiming that post-migration stressors may be significant indicators of mental health outcomes for refugee populations and that they require further attention when developing services to meet needs. The BNLA data is the most comprehensive, longitudinal data to be collected in Australia in over a decade, and gives researchers and policymakers a revealing, quantitative view of the experiences of newly arrived humanitarian entrants' resettlement needs.

Older refugees may face increased risk factors for psychological distress (Slewa-Younan, Santalucia, McDonald & Salem, 2016; Slade & Borovnik, 2018). They often arrive later to join families in resettlement countries and enter into environments where other family members have already settled and are more familiar with the host country (Kirmayer et al., 2011). Issues for older refugees can include difficulties in learning the language and acculturation, separation from extended family, friends and social networks, living in unfamiliar surroundings, increased isolation as social connections are lost, dependency on others due to language and mobility difficulties, fewer opportunities for meaningful work, and loss of social status as a respected elder in the new cultural context (Carlin, 1990; Chenoweth & Budrick, 2001; Kirmayer et al., 2011; Kuo, Chong & Justine, 2008; Slade & Borovnik, 2018).

The collective and cumulative effects of pre-migration and post-migration experiences can leave refugees more vulnerable to experiences of psychosocial distress or mental illness (Schweitzer et al., 2006). However, it has been argued that separating pre- and post- migration experiences into binary categories may oversimplify and blur together the past and present (Savic, Chur-Hansen, Mahmood & Moore, 2013). Instead, the impact of pre- and post- migration experiences on mental health may need to be considered as complex and interconnected.

Considering pre-migration trauma alone cannot aid clinicians in predicting mental disorders. However, post-migration factors may moderate the capability of resettled refugees to heal from pre-migration trauma experiences (Hynie, 2018).

1.4.4 Resettlement stressors for women

The UNHCR states that "those women or girls who have protection problems particular to their gender, and lack effective protection normally provided by male family members" (UNHCR, 2011, p.263) are vulnerable to gender-related human rights violations in addition to traumas. Athough both men and women with refugee backgrounds face significant difficulties, women's gendered experiences both before, during and after migration, can mean their support needs are different and heightened (Comas-Diaz & Jansen, 1995; Deacon & Sullivan, 2009) from those of men.

The majority of research has focused on trauma with samples including both men and women. However, the experience of women, especially those who are at-risk or without protection, are likely to be qualitatively different from men, and may include gender-related violence that may have additional social and physical ramifications, such as pregnancies, shame, and community exclusion (Bartolomei, Eckert & Pittaway, 2014; McKay, 1998; Wachter, Heffron, Snyder, Nsonwu & Busch-Armendariz, 2016).

Low socio-economic status, language and communication barriers, and the subsequent impact upon employment opportunities, access to education, and health-care services can be particularly difficult for women post-resettlement (Shishehgar, Gholizadeh, DiGiacomo, Green, Davidson, 2017). Following resettlement, women's wellbeing and mental health can be closely connected to that of their children – including their children's mental health, adaptation, and their ability to thrive in a new country or environment (Ajduković & Ajduković, 1993; Almqvist & Broberg, 1999).

Overall, research has indicated that factors such as being a woman, older, and well-educated are each associated with higher risks for poor mental health (Porter & Haslam, 2005). Paradoxically, higher levels of education and economic resources before displacement may result in a greater loss of status, instead of having a protective effect during resettlement (Porter & Haslam, 2005). In their study with Congolese women with refugee backgrounds (n=29) in the USA involving interviews and focus groups, Wachter et al. (2016) found that the responsibilities of raising children alone in a resettlement country can be overwhelming. Casimiro, Hancock & Northcote, (2007) conducted interviews and focus groups with women with refugee backgrounds from Iraq (n=35), Sudan (n=34), and Afghanistan (n=11) in Perth, Australia. Results highlighted the fear for personal, psychological, and cultural insecurity reported by Muslim women due to the current political climate.

Schweitzer et al. (2018) investigated psychiatric symptoms using a cross-sectional survey of 104 refugee women-at-risk (204 visa) from various ethnic groups in Australia. Many participants were from African countries (78.9% from Eritrea, Ethiopia, South Sudan, Rwanada, Burundi and Kenya), with remaining participants (21.1%) coming from South Asian countries (Afghanistan), West Asian countries (Iran, Iraq and Syria), and South-East Asian countries (Myanmar and Thailand). The survey involved the Harvard Trauma Questionnaire, Hopkins Symptom Checklist, and the Post-migration Living Difficulties Checklist. Results revealed that newly-arrived refugee women-at-risk were at an increased risk of psychiatric disorders and required comprehensive psychiatric assessments for early intervention. Participants flagged post-migration living difficulties as significant stressors, including worry about family overseas, communication, loneliness, boredom, and transport. Interestingly, few participants reported experiences of racial discrimination, acculturation stressors, or employment difficulties.

Authors suggested that participants had only lived in Australia for less than 3 months and may have not yet experienced any periods of "destabilisation" (Gonslaves, 1992) in which they must set up their lives as well as gain employment to survive. Mangrio, Zdravkovic & Carlson (2019) interviewed 11 recently-arrived women with refugee backgrounds living in Sweden regarding the resettlement process. Women reported a sense of loneliness, suffering from being separated from family, and the pressures of wanting to achieve something of value and contribute in the resettlement country (Mangrio et al., 2019).

1.5 Mental health and service access

1.5.1 Prevalence of mental health issues

The refugee experience usually involves dangerous journeys following forced migration, exposure to multiple, and often unpredictable traumatic events, major losses, and the distress of leaving former lives and resettling in a new country (Fazel, Wheeler & Danesh, 2005; Bogic et al. 2012; Priebe, Giacco & El-Nagib, 2016). Numerous studies have demonstrated the negative psychological consequences of these experiences (Dapunt, Kluge & Heinz, 2017; Fazel, Wheeler & Danesh, 2005; Fegert, Diehl, Leyendecker, Hahlweg & Prayon-Blum, 2018; Hameed, Sadiq & Din, 2018; Lund et al., 2018; Murray, Davidson & Schweitzer, 2010; Palmer & Ward, 2007; Silove, Ventevogel & Rees, 2017; Turrini et al., 2017).

One meta-analysis indicated that refugees and asylum seekers suffered significantly poorer mental health outcomes than non-refugee populations (Porter & Haslam, 2005). Kirmayer et al. (2011) conducted an extensive review of the literature, examining 113 articles, including 10 systematic reviews and 5 meta-analyses to identify the prevalence and risk factors for mental health problems among new immigrants and refugees. In comparison to immigrants (who often had better mental health outcomes than the general population), refugees and asylum seekers were more likely to suffer from PTSD, depression, chronic pain, and other somatic complaints. Refugees' adverse mental health outcomes were attributed to their experiences of war, torture, forced migration, time spent in refugee camps, and uncertain immigration status (Kirmayer et al., 2011).

Generally, three types of transition that refugees often experience have been identified as changes in personal social networks, shifting socio-economic systems, and the change of cultural systems (Bhugra, 2004; Kirmayer et al., 2011; Rogler, 1994). According to Kirmayer et al. (2011) the migration trajectory for refugees is comprised of three components: pre-migration, migration, and post-migration resettlement. Each of these phases is associated with specific risks and exposure to potentially traumatic experiences. Pre-migration and migration stressors are briefly outlined below, before a more extensive examination of post-migration stressors – the focus of this thesis – is provided.

Research regarding mental health disorders in refugee populations has traditionally been based upon a Western biomedical model, focused on the psychopathological effects of trauma before migration, and has varied significantly in prevalence rates (Bogic et al., 2015; Fazel et al., 2005; Hollifield et al., 2002; Khawaja, White, Schweitzer & Greenslade, 2008). Broadly, prevalence rates for general mental illness following resettlement suggest that the rates are similar to the host population (Giacco, Laxham & Preibe, 2018). However, post-traumatic stress disorder appears to be consistently higher in refugee populations (Giacco, Laxham & Preibe, 2018). Furthermore, for individuals with refugee backgrounds who have lived in a host country for an extended period of time, the rates of anxiety and depression are higher and associated with poor social integration (Giacco, Laxham & Preibe, 2018).

In a systematic review of the literature, Fazel, Wheeler & Danesh (2005) found that refugees may be at a heightened risk of psychiatric morbidity due to experiences of forced migration and traumatic events. The authors reviewed 20 eligible surveys providing results for 6743 adult refugees. Results revealed that 9% met criteria for PTSD, and 5% met criteria for major depression. In addition, there was substantial evidence for psychiatric comorbidity. The authors concluded that refugees resettled in Western countries might be up to ten times more likely to have PTSD than the general populations of those countries.

An extensive review conducted by Steel et al. (2009) identified 181 surveys taken by 81,866 refugees from 40 countries. Results suggested that a dosage effect may exist, whereby exposure to torture and the total number of traumatic events that an individual has experienced are the strongest predictors of PTSD and depression (Steel et al., 2009).

Bogic et al. (2015) conducted a systematic review of the literature to assess prevalence of mental disorders in long-settled war refugees (five years or longer after displacement). In their search they identified 29 studies and found that there was significant between-study heterogeneity in prevalence rates. For depression, the results ranged from 2.3-80%, for PTSD the results ranged from 4.4-86%, and for unspecified anxiety disorder the range was 20.3-88% (Bogic et al., 2015).

Heeren et al. (2014) conducted a study in Switzerland using a questionnaire assessing symptoms of PTSD, anxiety and depression, comparing asylum seekers (n=65), refugees with permanent protection visas (n=34), illegal migrants (n=21), labour migrants (n=26), and residents (n=56). They found that refugees and asylum seekers were 7.6-10.9 times more likely to experience PTSD symptoms and 4.5-25.2 times more likely to experience symptoms of depression than other labour immigrants living in Switzerland.

More recently, Shawyer, Enticott, Block, Cheng & Meadows (2017) conducted a survey to estimate the prevalence of psychiatric disorders with refugee and asylum seekers attending a refugee health service in Melbourne, Australia. They screened for general psychiatric disorders using the Kessler-10 (K10) as well as PTSD, using the PTSD-8. They found that the prevalence of mental illness was 50.4% (as measured by the K-10), while 22.9% of participants screened positive for PTSD in the last month, and 31.3% of participants screened positive for PTSD in their lifetime (Shawyer et al., 2017).

However, criticisms from systematic reviews highlight the need for more methodologically consistent and rigorous research regarding the mental health of refugee populations (Bogic et al., 2015; Fazel et al., 2005). Numerous limitations in estimating the prevalence of mental health disorders in refugee populations have been raised.

Firstly, there are inherent issues with using assessments for psychiatric disorders that have been developed in Western populations (Fazel et al., 2005).

Davidson, Murray & Schweitzer (2010) highlight the ongoing need to develop culturally-comparable measures of assessment for psychological issues with refugee populations. Although there have been attempts to develop appropriately-normed tests, issues remain surrounding conceptual and linguistic equivalence and test-retest reliability (Davidson et al., 2010).

Secondly, there have been significant variations in sampling methods, as well as differences in surveys and the use of diagnostic instruments (Bogic et al., 2015; Fazel et al., 2005). Bogic et al. (2015) noted that in their review, less than 20% of the assessment instruments used were specifically developed to work with refugee populations. Furthermore, 40% of the studies reported no reliability or validity data. Instruments that have not been developed specifically for refugee populations are limited to Western conceptualisations of mental health and may not appropriately reflect a comprehensive range of symptoms or the meaning of distress in “non-Western” cultures (Hollifield et al., 2002).

Finally, in the systematic review by Bogic et al. (2015), the prevalence rates of mental disorders were somewhat related to the country of origin as well as the resettlement of the participant (Bogic et al., 2015). For example, Bogic et al. (2015) highlighted that refugees from ex-Yugoslavia and Cambodia had the highest rates of depression, PTSD and anxiety, and refugees from Vietnam and the Middle East and Sub-Saharan Africa reported the lowest rates.

There are risks associated with underestimation and overestimation of these prevalence rates. A selective citation of lower prevalence rates may see a neglect in funding for refugee mental health, whereas citation of higher prevalence rates may stigmatise refugees, medicalise their experiences (Colic-Peisker & Tilbury, 2003), and suggest that there is a degree of disability associated with such psychiatric morbidity (Fazel et al., 2008).

1.5.2 Protective factors and strengths

Some literature suggests that certain mental health professionals may focus on a dominant Western deficit-focused model that pathologizes the refugee experience and defines people with refugee backgrounds as traumatised individuals or victims (Hutchinson & Dorsett, 2012). Viewing people with refugee backgrounds through this lens runs the risk of alienating them further from their resettlement society and denies the inherent strength in the face of their often-times dangerous journey and previous experiences (Hutchinson & Dorsett, 2012).

The resettlement experience is stressful and demanding, as people are often separated from their family, home, way of life, and culture (Schweitzer et al., 2006). Despite this, research suggests that many people with refugee backgrounds end up thriving in their new resettlement country and environment (El-Bushra & Fish, 2004). The majority of individuals from war-torn countries who experience traumatic events and survive do not go on to develop significant mental disorders (Rosner, Powell & Butollo, 2003). Indeed, people with refugee backgrounds demonstrate “courage and strength by coping with conditions of extreme deprivation and surviving against adversity” (Tiong, 2006, p. 8).

Hutchinson & Dorsett (2012) conducted an extensive literature review regarding resilience in people with refugee backgrounds. They identified various factors that either work to build or impede resilience in refugee populations. Personal qualities or internal resources were identified as a major contributor to refugee resilience. Among women, personal qualities including optimism, adaptability, and perseverance helped them to survive and cope (Toth, 2003). Believing in one’s own strength to negotiate life’s challenges (Brough, Gorman, Ramirez & Westoby, 2003), a general positive attitude, and having hope for the future helped some women with refugee backgrounds to cope (Khawaja, White, Schweitzer & Greenslade, 2008). One study suggested that for women with refugee backgrounds, the construction of resilience was more linked to the notion of “moving on” from adversity instead of the well-known concept of “bouncing back” from it (Pulvirenti & Mason, 2011).

In their study with service providers working with women with refugee backgrounds, Pulvirenti and Mason (2011) pointed out that resilience is a dynamic, contextual, and fluid concept, discrediting the essentialist idea of resilience as residing within an individual alone. Furthermore, Lenette, Brough and Cox (2012) found that building resilience is related to interactions between a person and their environment rather than static, inherent, individual traits. Their study with women supported the notion that resilience is underpinned by a dynamic process and is constructed through everyday processes involving both challenges as well as opportunities.

These studies equate resilience with the theory of social constructionism, implying that knowledge about the world originates from exchanges between individuals situated within their social, cultural, and historical contexts (Payne, 2011). However, “resilience” has recently received criticism in the literature, including the observation that it is an individualistic concept that attempts to mitigate systemic problems (Traynor, 2018), and that labelling people as “resilient” may work as an excuse for inaction on the behalf of governments and the development sectors (Nunn, 2018).

Various qualitative studies with refugee populations support the idea that external forms of support, including extended family, friends and community, are important during the resettlement period (Correa-Velez, Gifford & Barnett, 2010; Schweitzer, Greenslade & Kagee, 2007; Sossou, Craig, Ogren & Schnak, 2008).

Religion and spirituality have also been identified as important protective factors and strengths for people with refugee backgrounds. Khawaja et al. (2008) found that some participants with refugee backgrounds accepted or resigned themselves to a situation that they could not control and believed that their fate was in God's hands. A belief in God may also help people regain a sense of control and meaning in their lives (Schweitzer et al., 2007). Sossou et al. (2008) revealed that spirituality could help people with refugee backgrounds through hard times and give them strength in the form of "belief in a higher power, calling on dead relatives, or something deep inside" (p. 378).

1.5.4 Barriers to help-seeking and mental health care

Help-seeking has been defined as "any communication about a problem which is directed toward obtaining support, advice or assistance in times of distress" (Gourash, 1978, p. 413), and can be either formal (e.g. accessing services) or informal (e.g. assistance from an extended social network). The concept of help-seeking and related theories will be explored in further depth in Chapter 2, as these form the underlying theoretical frameworks for this thesis.

It has been established that although refugee populations may be at higher risk of mental health disorders, access to appropriate mental health services in resettlement countries is overall low (Bernier, 1992; Giacco, Laxham & Preibe, 2018; Kirmayer et al., 2011; Priebe et al., 2016), especially for recently-settled refugees (Gerritsen et al., 2006).

Kirmayer et al. (2011) noted that people with refugee backgrounds were significantly less likely than the general population to seek help from mental health services, even when they experienced similar levels of distress, citing studies of Chinese, Ethiopian, Caribbean, Vietnames and Phillipino immigrants and refugees all residing in Canada (Chen & Kazanjian, 2005; Fenta, Hyman & Noh, 2006; Kirmayer et al., 2007). This was attributed to both cultural and structural barriers, including lack of ability to take time off work, the desire to deal with the problem themselves, lack of ability to explain their problems due to cultural and linguistic differences, and fear of stigmatization (Chen, Kazanjian & Wong, 2009; Nadeem et al., 2007; Whitley, Kirmayer & Groleau, 2006).

In many countries, mental health services are only associated with hospitalisation or treatment of psychotic or severely ill patients. Consequently, seeking help from mental health services can be highly stigmatized, and individuals are often extremely reluctant to attribute their symptoms to a mental health disorder (Kirmayer et al., 2011). Not only would stigma affect a patient, but in many cultures it would also reflect upon the patient’s family (Kirmayer et al., 2011).

Slewa-Younan et al. (2015) interviewed 225 Iraqi refugees in Sydney, Australia to explore levels of psychological distress as well as help-seeking behaviours. Thirty-one percent of participants met the criteria for significant PTSD symptomatology. Of these participants, only 32.9% reported ever accessing services or seeking help for their mental health problems. However, in an Australian study comparing survey results of 1611 Vietnamese refugees and 7961 Australian-born respondents, Steel et al. (2005) found that Vietnamese participants reported lower levels of anxiety, mood and substance use disorders compared with the host population. Interestingly, the study reported that the Vietnamese sample reported higher levels of disability from mental health disorders and demonstrated similar levels of mental health service access to the host population.

Barriers to seeking help for mental health issues that may be more prevalent among women with refugee backgrounds include a lack of mental health literacy, social and gendered roles in the domestic space, differences in cultural conceptualisations of mental health issues, lack of knowledge of services, reluctance to disclose distress outside the family, concerns about stigmatisation, socio-economic status, social support networks, and feelings of shame (Ahmad et al., 2004; Dennis & Chung-Lee, 2006; Drummond, Mizan, Brocx & Wright, 2011; O'Mahony & Donnelly, 2010; O'Mahoney & Donnelly, 2007b; O'Mahony, Donnelly, Raffin Bouchal & Este, 2012; Rodrigues et al., 2003; Teng, Robertson, Blackmore & Stewart, 2007).

Differences in cultural concepts of mental health, illness and treatment, service accessibility, language problems, lack of knowledge about existing services, trust, distrust of authority and systems, prioritisation of resettlement stressors, working with interpreters, engaging family and community, the approach of mental health providers, and continuity of care have been identified as barriers to accessing mental health services for refugee populations (Colucci, Minas, Swarc, Guerra & Paxton, 2015; Ellis, Miller, Baldwin & Abdi, 2010; Kaya, Karadag Caman, Kilic & Uner, 2018).

Language barriers can work as an obstacle to service provision, as individuals may not be able to communicate or express themselves adequately, leaving them feeling powerless and disadvantaged (Shakespeare-Finch & Wickham, 2009). Furthermore, language issues may indirectly affect people with refugee backgrounds' job and housing opportunities, as well as inclusion in Australian society overall (Schweitzer et al., 2007). Young people from families with refugee backgrounds may learn the language of their resettlement country faster than their older family members (Reedy, 2007). As a result, the young person may take on the communicator or cultural broker role within their family, which can increase pressure or place a strain on parent and child relationships (Reedy, 2007).

Stigma remains one of the most highly-cited barriers for refugee populations to access mental health care (Morris, Popper, Rodwell, Brodine & Brouwer, 2009; Saechao et al., 2012; Shannon et al., 2014). Abdullah & Brown (2011) have suggested that there is cultural variation within stigmatising attitudes and behaviours for different groups. They posit that these are predominantly determined by cultural norms regarding what entails “healthy” and “unhealthy”, or acceptable and unacceptable behaviours.

Shannon et al. (2014) conducted 13 focus groups with people with refugee backgrounds from Burma, Bhutan, Somalia and Ethiopia to investigate the difficulties that people have discussing mental health issues. Results suggest that there are many nuanced reasons behind the stigma that some refugees face surrounding mental health concerns. One theme identified was that a history of political repression could render people silent. In other words, some participants reported that members of their communities had been persecuted for voicing political ideas and subsequently found it difficult to open up about their suffering, even when they were physically safe. Another theme referred to the fear of expressing emotions in case they were perceived as “crazy” due to fear of being alienated by their community, losing their job or house, or being hospitalised (Shannon et al., 2014). Furthermore, Shannon et al. (2014) identified that some participants did not believe that talking with others or sharing their suffering helped reduce symptoms and that they worried about a lack of confidentiality.

In a recent study, Kaya et al. (2018) highlighted the difference in perceptions of barriers according to people with refugee backgrounds and service providers.

Refugee participants listed language problems, as well as lack of knowledge regarding existing services, as the most common barriers to accessing services. According to policy makers and service providers, life challenges and physical health problems were higher priorities for refugees, reducing their likelihood of presentation for mental health concerns (Kaya et al., 2018).

Lack of the use of interpreters has also been identified as one of the most significant barriers to accessing services (Feldman, 2006). Often individuals prefer to use family members, or ad-hoc interpreters instead of professional interpreters; however, this has been advised against (Blake, 2003). Professional interpreters do not only translate language but also cultural concepts, norms, and frameworks. However, the presence of interpreters from the same cultural community often raises confidentiality concerns, as clients and workers may know each other and therefore not wish to disclose personal matters (Kirmayer et al., 2011). Kirmayer et al. (2011) stressed that an individual's needs must be assessed before recruiting an interpreter to determine the language they would be comfortable communicating in. It is also essential not to make assumptions based on religion, nationality and ethnicity, but rather to identify exactly which community and cultural group an individual feels they are part of before a session (Kirmayer et al., 2011).

A set of barriers to the provision of mental health care is the labelling of trauma stories, assigning Western diagnostic labels to natural reactions to traumatic situations or events or focusing too heavily on the psychopathological elements of refugee experiences (Hutchinson & Dorsett, 2012). Conceptualising people with refugee backgrounds within a deficit or pathology framework runs the risk of denying the resilience of survivors' stories and disqualifying people's capacity for self-governance (Pupavac, 2002).

Furthermore, using a solely Western, biomedical model and assigning labels such as “PTSD” to the refugee experience categorises people and diverts attention away from the individual’s own understandings of their distress and choice of treatment (Summerfield, 1999). Papadopoulos (2001) argues that some therapists associate people’s current stressors or difficulties too strongly with their refugee background whilst not considering positive attributes and resilience. A sole focus on the trauma story can shift power dynamics in the therapeutic relationship, and the client can rely too heavily upon their therapist, fostering dependence (Papadopoulos, 2001). As Papadopoulos (2005) states, if a person with a refugee background is “essentially pathologized and seen as a victim, invariably the therapist is likely to occupy the saviour role” (p. 37). However, the difficulty lies in the fact that many mental health professionals who work in certain services are required to diagnose an individual’s presentation in order to establish eligibility for services (Watters, 2001). These conditions illustrate the complexity of working in this area and reveals how the system can perpetuate and position people with refugee backgrounds within a deficit framework.

Within the literature, three approaches have been suggested to help to overcome or reduce barriers to care for people with refugee backgrounds (Giacco, Laxham & Preibe, 2018). These include the creation of outreach services, the combination of mental, physical and social care, and the distribution of information regarding mental health care entitlements to both refugee populations as well as health care professionals (Deville et al., 2011).

1.6 Social determinants of health and access to mental health care

This thesis draws upon the social determinants of health and the Social-Ecological Model (SEM) as a framework for understanding resettlement stressors and the impact of such stressors on mental health; these are outlined below. The World Health Organisation defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 2014). Following this, WHO defines social determinants of health as “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (WHO, 2011).

Social determinants of health are often responsible for health and mental health inequalities within and between countries (International Organisation for Migration, 2019). Such determinants generally include individual lifestyle factors, community influences, living and working conditions, socio-economic status, and cultural and environmental conditions that determine the general health and wellbeing of individuals.

As already alluded to, when considering refugee mental health, it is important to acknowledge that both mental and physical health are not solely determined by biological factors but also significantly by social factors (Hynie, 2018). The risks of developing mental health issues are higher for people from groups who have less access to power, material resources, or who are disadvantaged in terms of policy, political and economic factors (Braveman & Gottlieb, 2014). The post-migration environment and social conditions for people with refugee backgrounds often place them in a situation of disadvantage, inequality, and at the lower end of the social gradient. This is the result of both forced migration and the resettlement country’s policies and politics, as well as its attitudes towards refugees and asylum seekers (Hynie, 2018).

The SEM examines the influence of social determinants of health independently, as well as their interactions, and also allows the exploration of person-environment interactions (Stokols, 1996). It considers individual, interpersonal, environmental, organisational, and policy levels relating to health services. Individual level factors include language, personal beliefs, misconceptions, personal financial factors, education levels, and past experiences.

1.6.1 Migration

Migration has been conceptualised as cutting across the social determinants of health, as it often fuels health inequities and can also expose individuals to increased health risks and result in negative health outcomes (IOM, 2019). The characteristics of migration are influenced by social and cultural determinants, especially socio-economic conditions (Bauer, 2014; Napier et al., 2014). In turn, public services, including education and health care, must meet the needs of an increasingly diverse population, as migrants and refugees come with different beliefs about health and culture, and different experiences of health care and health systems (Piacentini, O’Donnell, Phipps, Jackson & Stack, 2019).

People who are displaced often have to endure a myriad of cultural, economic, behavioural, and communication barriers that can negatively influence their physical, mental, social, and emotional wellbeing. Women, for whom the determinants are often more severe, are particularly vulnerable during the migration process (IOM, 2019). The health and wellbeing of a displaced person is determined by their psycho-social context, the experiences in their country of origin, and events that occur during transit and in the resettlement country (IOM, 2019).

1.6.2 Individual determinants

1.6.2.1 Language. Language has been demonstrated to be a persistent social determinant for refugee populations influencing access to healthcare services. Studies have reported that perceived low levels of English in English-speaking resettlement countries can inhibit the appointment-making stage of healthcare access, as well as the appointments themselves. (Bellamy, Ostini, Martini & Kairuz, 2015; Cheng, Vasi, Wahidi & Russel, 2015; Clark, Gilbert, Rao & Kerr, 2014; Drummond, Mizan, Brocx & Wright, 2011; Nicol, Al-Hanbali, King, Slack-Smith & Cherian, 2014; Riggs, et al., 2012; Sheikh-Mohammed, MacIntyre, Wood, Leask & Isaacs, 2006).

Underutilising interpreting services can impede access to, as well as quality of, service provision. Some studies reported the practice of informal interpreting, involving patients relying on children or family members to interpret sensitive health information (Gray, Hilder & Donaldson, 2011). Although using family members as interpreters has been warned against (MacFarlane et al., 2009), Gray, Hilder & Donaldson (2011) have highlighted that this may be occurring on a regular basis due to the lack of uptake of official interpreters.

Gartley & Due (2016) conducted interviews with mental health professionals in Australia (n=7) and reported that interpreters were necessary and important when working with clients with refugee backgrounds. Participants reported that interpreters could help to build a strong therapeutic alliance, and clients were reported as being more comfortable to disclose sensitive information if there was continuity in the interpreter used. Furthermore, the study revealed that interpreters also served as cultural brokers and brought unique cultural insight to sessions. However, Gartley & Due (2016) also highlighted that there were challenges in using interpreters, especially in relation to therapy and the therapeutic alliance. These included the process of working with an interpreter being complex, issues with conveying meaning, and when therapists had different expectations of interpreters (for example, whether the interpreter should remain distant or whether the interpreter should be known to the client).

Training of interpreters has also been highlighted as important, as Flores, Abreu, Barone, Bachur, & Lin (2013) found that the use of untrained interprters led to overall poorer quality in care, less satisfied patients, and more frequent errors in communication. On the other hand, Karliner, Jacobs, Chen & Mutha (2007) found that when using professionally trained interpreters there were less communication errors, increased understanding, and improved clinical outcomes. However, Piacentini et al. (2019) have highlighted that previous literature which has taken a "language problem" approach has often ignored the important effects of multiple variables (for example, migration status, trajectory, and conditions of stay) on the experience of intercultural communication in health care environments. They expressed the need to acknowledge the diversity of migrant populations and also attend to how migration-specific variables can intersect with language and reproduce or maintain inequality in health care settings (Piacentini et al., 2019). Overall, Piancentini et al. (2019) have argued that an over-simplified focus on language barriers in the development of policy failed to encapsulate the complexities inherent in providing health care to diverse migrant populations.

1.6.2.2 Culture. Culture is a complex and multi-layered concept that many scholars have attempted to define (see Tylor 1871; Linton, 1945; Hofstede, 1984; UNESCO, 2002). Drawing on various definitions, culture can be conceptualised as composed of values, beliefs, norms, symbols, and behaviours, which are largely learned (Eshun & Gurung, 2009).

Eshun & Gurung, (2009) have summarised the definition of culture as a "general way of life or behaviours of a group of people which reflect their shared social experiences, values, attitudes, norms, and beliefs" (p. 4). They state that culture is "transmitted from generation to generation, and changes over time", and that "it has been conceptualised as something that is cyclical or self-reinforcing, consists of tangible and intangible behaviours, and is crucial for survival and adaptation" (Eshun & Gurung, 2009, p. 4). As such, cultural traits and norms affect how we think, how we respond to distress, and how comfortable we are expressing our emotions (Eshun & Gurung, 2009).

Kirmayer et al. (2011) have highlighted the importance of the cultural dimension of the illness experience. Culture can influence each aspect of illness and adaptation, including interpretations of and reactions to symptoms, explanations of illness, patterns of coping and of help-seeking, adherence to treatment, styles of emotional expression and communication, and relationships between clients, their families and health care providers (Kirmayer et al., 2011). An individual's culture can also influence how they communicate their symptoms, as well as how they perceive treatment efficacy and how willing they are to seek treatment (Eshun & Gurung, 2009).

Sam & Moreira (2012) have suggested that culture and mental illness are mutually embedded in each other, and that it is essential for practitioners to understand that the role of culture in mental health is essential for comprehensive and accurate diagnoses and treatment. People with refugee backgrounds who are suffering from mental health problems often present with physical symptoms and complaints, using culture-specific bodily idioms to communicate distress (Kirmayer, 2001). Consequently, this can lead to under-recognition and treatment of common mental disorders (Kirmayer, 2001).

The vast majority of Western cultures conceptualise mental illness from a bio-medical model that views mental illness to be "fundamentally biological in origin, and … psychopathology [as] essentially homogeneous with only superficial variations in presentation across peoples" (Thakker & Ward, 1998, p. 502). The bio-medical model reflects an individualist ideology in which mental illness is diagnosed and treated as something individual and independent of culture. In contrast, Marsella & Yamada (2000) have postulated that mental illness is rooted in an individual's culture as well as being influenced by socio-political and economic structures.

Castillo (1997) highlighted various ways in which culture can influence one's mental health:

1. The individual's personal experience of the illness and associated symptoms;
2. How the individual expresses their experience or symptoms within the context of their cultural norms;
3. How the symptoms expressed are subsequently interpreted and diagnosed;
4. How the mental illness is treated and the outcome of treatment.

The way in which culture can influence mental health with reference to Kleinman's Explanatory Model (1980) will be further elaborated on in Chapter 2.

Thus, there is a general consensus within the literature that culture can influence mental illness and wellbeing (Castillo, 1997; Eshun & Gurung, 2009; Lin, Inui, Kleinman & Womack, 1982). However, it is important to recognise that cultures are not homogenous collectives that speak with one cohesive voice. Instead, culture is fluid in nature, and it is important for mental health practitioners to acknowledge that there are differences between individuals and families within the same overarching cultural background (James, 2003). As such, different groups in resettlement countries encounter various barriers that act to deter them from receiving and accessing proper mental health care (Donnelly et al., 2011; Edge & Newbold, 2013; Hansson et al., 2010; Kirmayer et al., 2011; Patil, Maripuu, Hadley, & Sellen, 2015; Thomson Chaze, George, & Guruge, 2015).

1.6.3 Environmental, political and socio-economic determinants

1.6.3.1 Institutional and organisational. The SEM highlights the role that institutions and organisations play in influencing the refugee population's understanding of healthcare systems in resettlement countries such as Australia. This includes the degree to which refugee populations are aware of services, and how much healthcare information is translated into relevant languages and distributed within communities (Taylor & Haintz, 2018).

Studies have identified that many resettled refugees may not be aware of services or know how to use them due to a lack of appropriately translated health material (Clark et al., 2014; Nicol et al., 2014). For example, one qualitative, community-based study conducting focus groups and interviews with 39 refugee women from nine different countries and 5 community health nurses indicated that community members as well as service providers believed that appropriate written information regarding health services was scarce (Nicol et al., 2014).

1.6.3.2 Socio-economic status. A person's socio-economic status and level of income has been shown to be a powerful determinant of health for people from all age groups (Allen, Balfour, Bell & Marmot, 2014). People from refugee backgrounds have often been forced to leave behind material possessions as well as businesses, properties, savings, employment, investments, and documentation that proves their qualifications (Hynie, 2018).

Often individuals' socio-economic standing in a resettlement country can be markedly different to their original position in their country of origin. When refugees arrive in a host country in a position of poverty, they can remain as such for many years (Bakker, Dagevos & Engbersen, 2014).

Furthermore, due to government policies and at times non-recognition of or lack of proof of qualifications, people from refugee backgrounds may experience limited economic opportunities (Hynie, 2018). One meta-analysis of 59 articles that compared refugee mental health to the general population revealed a significant relationship between refugee participants' mental health and measures of their economic opportunities (Porter & Haslam, 2005).

1.6.3.3 Employment. Unemployment rates in refugee populations are generally higher than those in host country populations (Fozdar & Torezani, 2008; Krahn, Derwing, Mulder & Wilkinson, 2000). Furthermore, once employed, refugee populations are regularly under-employed, whereby they are placed in positions that do not meet their qualification level (Colic-Peisker, 2009; Fozdar & Torezani, 2008; Krahn et al., 2000).

People with refugee backgrounds may face extensive barriers to employment, including low levels of English language skills, non-recognition of qualifications from their home countries, discrimination, visa restrictions, and lack of required vocational training (Krahn et al., 2000; Li, Liddell & Nickerson, 2016).

1.6.3.4 Housing. Adequate housing, means "to have a home, a place which protects privacy, contributes to physical and psychological wellbeing and supports the development and social integration of its inhabitants" (Bonnefoy, Braubach, Moissonnier, Monolbaev & Röbbelin, 2003, p. 413), and has been recognised as a fundamental human right.

Substantial research has drawn a link between housing and health outcomes and general wellbeing (Baker et al., 2014; Bonnefoy, 2007; Brauback, 2011;

Thomson, Thomas, Sellstrom & Petticrew, 2009; Ziersch, Walsh, Due & Duivesteyn, 2017). Following this, there is a considerable amount of literature regarding the necessity to consider housing as a social determinant of health, as it has been shown to have a significant impact upon overall levels of wellbeing, as well as specific mental health and physical health outcomes (Baker, Mason, Bentley & Mallett, 2014; Bentley, Baker, Mason, Subramanian & Kavanagh, 2011; Braubach, 2011; Howden-Chapman, 2002; Marmot, 2005; Webb, Blane & de Vries, 2013; Ziersch, & Due, 2018). Certainly, for refugee populations, access to appropriate housing can be the most significant indicator of successful integration into a host country (Ager & Strang, 2004; Ager & Strang, 2008; Phillimore & Goodson, 2008; Ziersch, & Due, 2018).

However, there is significant evidence that refugee populations face a range of housing challenges and difficulties (Bakker Cheung & Phillimore, 2016; Carter, Polevychok & Osborne, 2009; Beer & Foley, 2003; Ziersch, & Due, 2018). There are a range of different ways that housing can impact upon an individual's or family's health. Poor physical housing conditions, for example, unsafe drinking water, the presence of mould or damp, and structural issues can result in poor health conditions, and overcrowded living quarters can increase the likelihood of spreading diseases.

Housing difficulties, including difficulty attaining suitable housing, and financial strains can also negatively affect mental health and impede access to other resources, including employment and education (Acevedo-Garcia, 2000; Dunn, 2000; Evans, Wells & Moch, 2003; Howden-Chapman, 2002; Ziersch, & Due, 2018). For certain populations, including refugees and asylum seekers, these effects can be bi-directional, whereby health and social factors such as education, ethnicity, and socio-economic status can impede an individual's potential to attain appropriate housing (Baker et al., 2014; Mallett et al., 2011; Ziersch, & Due, 2018).

1.6.3.5 Racism and discrimination. Racism or racial discrimination broadly refer to deliberate activities (often by a dominant group) to exclude others from participating and contributing to society (Hollinsworth, 2006; Joyce, Earnest, De Mori & Silvagni, 2010). It can also be defined as assumptions, perceptions and activities that cultivate inequality and exclusion of individuals based on race, physical distinctions, and sociocultural traits amongst members of a given society (Dunn & Nelson, 2011).

Numerous studies have revealed that people with refugee backgrounds in Australia have experienced racial discrimination and social exclusion in vocational education programmes and TAFE institutes (Correa-Velez & Onsando, 2009; Joyce et al., 2010; Onsando & Billett, 2009; Onsando & Billett, 2017) Brough et al. (2003) revealed that young people with refugee backgrounds experienced racism within the school environment, and that this racism may impact upon their capacity to develop relationships with other Australian children. Additionally, Correa-Velez et al. (2010) conducted a study with 97 young people with refugee backgrounds and revealed that one in five participants had been discriminated against due to their ethnicity, race, or religion. Racism has been found to be associated with poor social and emotional wellbeing outcomes and overall poor mental health (Preist, Paradies, Gunthorpe, Cairney & Sayers, 2011).

The language used to represent people with refugee backgrounds in the media can have a significant impact on the way in which events are understood and whether refugee populations are included or excluded (Goodman, Sirriyeh & McMahon, 2017). Gale (2004) noted that the theme of “border protection” in media representations of asylum seekers and refugees emphasised notions of national sovereignty and portrayed Australia as a “Western” nation that must uphold its long-held Christian traditions that do not align with the arrival of “boat people” (Gale, 2004). Indeed, the way in which the Australian media portrays and reports upon migration issues often refers to how refugees will affect “us” – “us” usually referring to Australian citizens.

Representation of refugees and asylum seekers as “boat people”, “criminals”, or “illegals” perpetuates the historical fear of the “Other” that can be traced back to anti-Chinese sentiments during the 1850s or the White Australia Policy of 1901 (Gale, 2004). News reports in Australia often focus heavily on the impact that refugees will have upon the developed, first-world West and are quieter about the political, social, and economic reasons that have forced refugees to seek asylum in the first instance. These discursive constructions position refugees and asylum seekers as “others” compared to those who live in Australia, speak English, and hold Australian citizenship.

Furthermore, governments and policy makers have strategically labelled the increase of displaced people as a “crisis” in order to push an agenda of more restrictive and selective immigration legislation and border protection (Franck, 2018). There are many beneficiaries from a “refugee crisis” as commercial actors secure profits from the provision of infrastructure and technology to improve border security, as well as through the provision of services to transport, house, feed, provide services to, and eventually deport displaced people (Franck, 2018). In fact, Franck (2018) has argued that ultimately the refugee journey has become a profitable business and their refugee status is being commodified. Franck (2018) has coined this phenomenon as “disaster capitalism” and has explained how theatrics and the use of language such as “crisis” play an important role in the process.

1.6.3.6 Policies. Government policies in host countries directly affect people with refugee backgrounds and can negatively impact on their health and mental health (Silove et al., 2017), especially those that foster uncertainty and hopelessness

(Killedar & Harris, 2017). The international phenomenon of terrorism has further eroded the spirit of the 1951 Convention and resulted in stereotyping and discrimination towards particular refugee groups in Australia (Silove et al., 2017). Since the 1980s Australia has implemented deterrence policies for asylum seekers. Clinical studies have suggested that those holding TPVs are more likely to report psychological distress and suffer from depression compared to those who hold a permanent visa (Johnston, Allotey, Mulholland & Markovic, 2009).

Recommendations have been made to remove policies of mandatory detention and to increase the allocation of permanent refugee visas (Killedar & Harris, 2017). Indeed, family reunification has been identified as a crucial factor in the wellbeing of those refugees who have resettled in host countries (Savic et al., 2013). In Australia, it is possible to apply for visas to reunite family members either through the Special Humanitarian Program (SHP) or through the family stream of the regular Migration Program (Parliament of Australia, 2016). However, there can be enormous waiting periods for families to be reunited and no guarantee that their visa applications will be accepted.

In August 2012 it was reported that there were 16,300 outstanding family reunification SHP applications, as well as a backlog that may delay family reunion expected to exceed 20 years (Australian Government, 2012). Although no more recent official statistics are available, this number has probably risen given the increase in people seeking asylum since 2012 worldwide (UNHCR, 2019). Separation from family has been shown to be an ongoing source of stress and despair not only amongst asylum seekers, but also amongst resettled refugees in Australia (Savic et al., 2013). Given the current regulations on family reunification visas, for many it is now a matter of finding ways to cope with the impact of separation from family members.

Refugee policies are of course ever-changing, depending upon the government in power, although the increasingly restrictive policies seen in Australia appear to have bipartisan support. The direct and indirect effects that these policies have, not only on the individual lives of asylum-seekers and refugees living in Australia, but also their families and friends, include their impact upon mental health. Arguably, government policies directly impact upon the lives of refugees living in Australia and need to be considered as a social determinant of health, as they can determine access to healthcare and mental heath care, housing, employment, and family reunification, which all influence individual and family health and wellbeing.

1.7 The current project

The current research project was conducted with two groups of women with refugee backgrounds from the South Sudanese and Afghan (Hazara) communities in South Australia and with service providers who worked with these populations. The project aimed to add to the literature regarding resettlement stressors and challenges, and barriers to help-seeking for mental health issues for these populations.

As highlighted throughout this chapter, women with refugee backgrounds may be at particular risk of psychological distress due to extra risk factors they face on their journey to a resettlement country, including sexual violence, unwanted pregnancies, harassment, health issues, and separation from children (Kastrup, 2006). Once they have arrived in a resettlement country, women, especially mothers, may face the challenge of navigating different gender roles and changes within family dynamics (Hebbani, Obijiofor & Bristed, 2009).

In order to contextualise the stories and perspectives of women from these two communities, it is appropriate to briefly summarise the political and social context for each group.

1.7.1 Afghanistan

Afghanistan is a country that has endured years of conflict, including civil war and international invasion. It is now regarded as the second most dangerous country in the world to live in, second to Syria (Global Peace Index, 2018). Throughout the 1980s, the Democratic Republic and Soviet war saw almost 6 million Afghan refugees forced to seek international protection, mostly in Iran and Pakistan (UNHCR, 2010).

Although the occupation of the Soviet Union only prevailed from 1979 to1989, the subsequent civil war prevented Afghan refugees from returning to their homes (Halimi, 2002). During the war approximately 150,000 Afghan refugees were able to permanently migrate to other nations, including the United States, Australia, and other European countries (Halimi, 2002).

The year 1996 saw the emergence of the Taliban – a Sunni Islamic fundamentalist military group (D'Souza, 2016). Initially, the United States favoured the Taliban for various political reasons, as well as the fact that they took control of the country with minimal resistance, providing some stability. However, as time went on the Taliban's methods regressed, and the focus was shifted to oppressive religious reform instead of economic development. The Taliban's oppression, combined with a landscape strewn with explosive mines left behind by the Russians, as well as the most intense drought in more than a century, resulted in a massive exodus by civilians to refugee camps in surrounding countries (Halimi, 2002). Since 2001 more than one hundred thousand people have lost their lives, approximately one-third of them being civilians. As the conflict is still ongoing, Afghanistan now accounts for over 2.7 million of global refugees (Cornish, 2017) with over 1 million internally-displaced people (UNHCR, 2015).

Following the Pashtuns and the Tajiks, Hazaras are the third largest ethnic group in Afghanisan (Phillips, 2017). The majority of Hazaras are Shiite Mulsims, a factor that has resulted in them being condemned as “infidels” at various times throughout history and fuelled their persecution (Phillips, 2017). Hazaras are still a persecuted group – their persecution originates from a largely unresolved, centuries-old religious and ethnic animosity that has historically and presently resulted in massacres, discrimination, displacement, and dispossession of land. This historical persecution was brutally re-ignited by the Taliban, especially between 1996-2001 (Phillips, 2017). As a result of their persecution, Hazaras make up the majority of Afghani boat arrivals to Australia.

Afghanistan is one of the top countries of refugee application to Australia since 2010 (Department of Immigration and Border Protection, 2014), 12,228 refugees from Afghanistan being resettled in Australia between 2010-2015 (Australian Government, 2015).

Most Afghan refugees came to Australia through refugee camps, and a high number come from middle-class, professional backgrounds (Mehraby, 2002). Most of the population of Afghanistan identify as Muslim (99%). Of this, 75%-80% are Sunni Muslims, and the remaining 15%-20% are Shiite Muslims (Razaiat & Pearson, 2002).

Studies have suggested that there are high levels of prevalence of mental health issues amongst the Afghan population (Alemi, James, Cruz, Zepeda & Racadio, 2014; Slewa-Younin, Yaser, Guajardo, Mannan, Smith & Mond, 2017).

A recent systematic review involving studies with Afghan refugees who had settled in various Western nations revealed that prevalence rates of depression were 57%, and PTSD was 100% (Alemi et al., 2014).

In regard to Afghan women, psychologists in Afghanistan have stated that mental health issues are increasing amongst women who bear the brunt of gender-based violence, conflict and poverty (Ehari, 2017). In 2002, a national, population-based mental health survey was conducted by the Centers for Disease Control and Prevention in Afghanistan to ascertain estimates of mental health status of the disabled and nondisabled population over 15 years of age (Cardozo, Bilukha, Crawford, Shaikh, Wolfe, Gerber & Anderson, 2004). Of 407 participants, 62% reported experiencing at least 4 traumatic events over the last 10 years, including lack of food and water, and lack of shelter. They found 67.7% of nondisabled and 71.7% of disabled participants reported symptoms of depression, and 72.2% of nondisabled and 84.6% of disabled participants reported symptoms of anxiety. Additionally, 42% of participants from both nondisabled and disabled groups reported PTSD symptoms. Women reported significantly poorer mental health status than men, including higher prevalence for symptoms of depression, anxiety, and PTSD, as well as lower social functioning.

These results mirrored another study conducted by the Physicians for Human Rights conducted during the Taliban regime that reported high rates of symptoms of PTSD, depression, and anxiety in women (Amowitz, Heisler & Iacopino, 2003). Additionally, 84% of participants reported experiencing feelings of hatred regarding what had happened to them and their family during the war (Cardozo et al., 2004).

Another factor potentially increasing women's risk of mental health issues is that maternal mortality rates in Afghanistan are the second highest in the world (the ratio being 16000/100,000 live births) (Afghanistan Health and Nutrition Sector Strategy, 2008-2013).

A study conducted in Kabul in Afghanistan revealed that almost half of the female sample had lost their husbands, and subsequently reported high levels of distress, social withdrawal, and somatic symptoms (Miller et al., 2006). However, there is a lack of longitudinal data regarding the prevalence of mental health issues for resettled Afghan women with refugee backgrounds in Australia.

There are compelling reasons for further investigation into prevalence rates for Afghan refugees, as this population continues to resettle in Australia due to prolonged exposure to war. Further to this, many women with refugee backgrounds may not have received adequate psychological support in Afghanistan, considering the country's below-average mental health infrastructure (WHO, 2011).

Some studies suggest that people with refugee backgrounds who are Muslim may hold differing conceptualisations and views about mental health, and that this may be one reason behind reduced access to mental health care services (Al-Krenawi & Grahm, 2000; Sabry & Wohra, 2013).

Mental health literacy refers to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 183). Yaser et al. (2016) conducted a study investigating mental health literacy using culturally appropriate vignettes with 150 Afghan refugees resettled in Adelaide, South Australia. They found that 31% of participants identified the vignette as being PTSD, whilst 26% identified it as "fear". In terms of beliefs as to what would be helpful treatment, 18% of participants reported that 'getting out and about more or finding some new hobbies' would be the most useful treatment for the described problem. Ultimately, this study highlighted the need to acknowledge that a variation in mental health literacy may be a function of both the cultural origin of a refugee population as well as their resettlement country (Yaser et al., 2016). Slewa-Younan et al. (2017)

further supported these results, highlighting that there may be high rates of PTSD symptomatology and low uptake of mental health care among Afghan refugees resettled in Australia.

Specifically, for Afghan women with refugee backgrounds, lack of awareness of services, husbands acting as gatekeepers to accessing support, access to interpreters (Rintoul, 2010), and low mental health literacy (Yaser et al., 2016) have been identified as potential barriers to seeking mental health support. Only minimal research thus far has examined how cultural beliefs and culturally specific concepts of mental illness may affect help-seeking in this population.

1.7.2 South Sudan

The current conflict in Sudan has been one of the longest-lasting in modern African history (UNMIS, 2005). As part of the Anglo-Egyptian Condominium between 1899-1955, the United Kingdom and Egypt shared a separate administrative arrangement throughout the north and south of what we now know as Sudan (Warbug, 1993). Sudan achieved independence in 1955, but before this was realised, significant conflict had already erupted between the north and the south (Warbug, 1993).

In 1972 the Addis Ababa Agreement was established, which allowed for the regional self-government of Sudan’s southern areas (Shinn, 2004). This agreement temporarily ceased conflict and hostilities between the two major parties involved in the conflict – the Government of the Democratic Republic of the Sudan and the Southern Sudan Liberation Movement (SSLM) (Shinn, 2004).

During 1983, the Addis Ababa Agreement collapsed, and violence again started between the north and the south over resources, religion, and self-determination (Beswick, 1991). From 1993 onwards, the Intergovernmental Authority on Development for the East African region started a peace process that would finally bring the main parties together for negotiations (UN, 2019). Unfortunately, this was not accomplished until early 2005, when the Comprehensive Peace Agreement (CPA) was signed between the leaders of the north and the south of Sudan (UNMIS, 2005). The CPA stated that there was an “urgent need to bring peace and security to the people of the Sudan” (UNMIS, 2005). There was an agreement to a permanent ceasefire, to form an interim national unity government, and for a referendum within six years (UNMIS, 2005).

In 2005, Salva Kiir became the First Vice President of Sudan’s national unity government (Ylonen, 2014). In 2011, a referendum for the Southern Sudanese population was conducted, with 98.83 per cent voting for independence from Sudan. On 9th July 2011, South Sudan became the world’s youngest nation, with Salva Kiir (Dinka) as South Sudan’s first President and Riek Machar (Nuer) as the Vice President (de Vries & Schomerus, 2017).

During 2013, President Salva Kiir made a number of political changes that set the scene for the crisis that was about to unfold (Rolandsen, 2015). One of the more drastic changes occurred in July 2013 when President Salva Kiir dismissed Vice-President Riek Machar as well as the national cabinet and removed 17 high-ranking police officers. From August onwards there were multiple reports of conflict and violence due to ethnic tensions between Dinka and Nuer, especially in South Sudan’s Jonglei State (UNHCR, 2013). Reports emerged of civilians being killed and humanitarian aid being looted, resulting in large-scale civilian displacement (UNHCR, 2013). In December 2013, a civil war erupted when President Salva Kiir accused former Vice-President Riek Machar of plotting to overthrow him.

The ongoing conflict has since killed thousands of people and displaced more than 1.5 million (Gerenge, 2016). Further to the conflict, in 2017 a famine was declared in parts of South Sudan in what has been described as a man-made catastrophe due to the civil war as well as economic collapse (BBC, 2018). There are currently over two million refugees and asylum-seekers in the regions surrounding South Sudan, including Sudan, Uganda, Ethiopia, Kenya, and the Democratic Republic of Congo (UNHCR, 2019).

The 2016 Census revealed that 7,697 South Sudan-born people live in Australia (Australian Bureau of Statistics, 2018). Of these people, 75% are now Australian citizens, while 20% are not yet Australian citizens. The majority of South Sudanese people in Australia live in Victoria, followed by New South Wales (Australian Bureau of Statistics, 2018). Most South Sudanese arrived in Australia between 2001 and 2006 before South Sudan declared independence in 2011 (Refugee Council, 2016).

Research concerning prevalence of mental health issues in the South Sudanese communities in Australia is limited. In terms of pre-migration prevalence rates, one post-conflict study was conducted in Juba, the capital city of South Sudan in 2007. Roberts, Damundu, Lomoro & Sondrop (2009) conducted a cross-sectional, random cluster survey with 1242 South Sudanese adults using the Harvard Trauma Questionnaire to measure levels of PTSD and the Hopkins Symptom Checklist-25 to measure levels of depression. Results indicated that 36% of participants met criteria for PTSD and 50% met criteria for depression. In a cross-sectional community study in South Sudan with 1200 participants, Ayazi, Lien, Eide, Swartz & Hauff (2014) found that exposure to traumatic events and socio-economic disadvantage were significantly associated with anxiety. Furthermore, once controlling for age, sex, rural settings, and low socio-economic status, they found that exposure to trauma was independently associated with anxiety diagnosis. The same authors with the same

South Sudanese participants in another study found that exposure to a higher number of traumatic events, younger age, living in a rural area, unemployment, lack of regular income, and having a traditional religion were significantly associated with having psychotic-like experiences (Ayazi et al., 2016).

Schweitzer et al. (2006) conducted the first major study looking at mental wellbeing with the Sudanese refugee population in Australia. The authors conducted semi-structured interviews with 63 participants from Sudan (including South Sudan) and administered questionnaires assessing for symptoms of anxiety, depression (Hopkins Symptoms Checklist) and PTSD (Harvard Trauma Questionnaire), as well as the Post-migration Living Difficulties questionnaire. The mean level of trauma types experienced was 5.6, and 44% of participants reported experiencing 5 or more categories of trauma. The most common trauma experiences included separation from family (85%), murder of family or friends (68%), and lack of food and water (59%) or shelter (57%). Additionally, 25% of participants reported clinically high levels of psychological distress, and women reported higher levels of symptoms of depression and anxiety. Interestingly, participants had higher levels of depression associated with longer time spent living in Australia (Schweitzer et al., 2006).

In a study exploring the mental health beliefs of resettled Sudanese refugees, Savic, Chur-Hansen, Mahmood and Moore (2016) conducted 25 in-depth qualitative interviews with Sudanese community representatives and health and social work professionals. Sudanese key informants reported that the concept of depression was relatively foreign, and that emotional distress was not something that necessarily warranted professional support but was rather an everyday experience requiring family and community support. Hearing voices or not making sense was reported to be more likely conceptualised as “mental health issues” than depression. However, seeking help for these kinds of mental health issues was reported to be significantly stigmatised, with people often labelled as "crazy" or "mad" (Savic, et al., 2016). The study highlighted the potential inappropriateness of Western bio-medical psychological therapies for this population.

Research suggests that unique factors may work as barriers to impede mental health service access for members of African refugee communities in Australia (Drummond et al., 2011; Green, 2004). For example, Drummond et al.'s survey (2011) with 51 West African refugee women analysed comparative data from 100 Australian women and found increased barriers for West African women in accessing mental health care, including shame, fear of others' judgements, and logistical hurdles (for example, not knowing where to get help or how to get there). In a qualitative study with both men and women from South Sudan, the authors identified resettlement and settlement difficulties, including change of gender roles, language proficiency, unemployment, host society unacceptance or intolerance, lack of recreational opportunities, and lack of community connectedness, as well as mental health issues (Abur & Mphande, 2019).

Furthermore, experiences of racism during the resettlement period have been identified as stressors in a study with students from South Sudan living in Australia (Baak, 2019). The way in which the media negatively represents events involving members of the community (in this case, the murder of a young man originally from Sudan) can exacerbate feelings of lack of belonging for the wider South Sudanese community (Baak, 2011).

The negotiation of maintaining important cultural and social histories as well as developing inter-community relationships has also been shown to be difficult for some South Sudanese community members in Australia (Marlowe, 2013).

For women from South Sudan, marital problems, parenting challenges, communication, employment, and settling into the wider community have been identified as inter-cultural differences encountered during resettlement (Hebbani, Obijiofor & Bristed, 2013). For some South Sudanese women, identity, self-esteem and mental wellbeing is closely associated with their role within family and community.

There is often a strong value placed on children and family within close-knit communities (Hayward, Hajdukowski-Ahmed, Ploeg, & Trollope-Kumar, 2008). Elders, extended family, and other community members often provide support to each other, and a family's name and reputation can also be highly valued. Family reputation can often be associated with raising children, and as such, the reputation can often reflect directly back upon mothers (Hayward et al., 2008).

1.8 Aims and objectives of the present thesis

Previous research has identified significant resettlement stressors for refugee populations, leading to negative mental health outcomes. However, research also indicates that there are significant barriers to help-seeking and service access. While women experience unique and additional stressors and barriers, little research has explored these specifically for women, and particularly for Hazara women and women from South Sudan. As such, this research aims to identify the resettlement stressors and challenges, support needs, and barriers to help-seeking unique to the South Sudanese and Afghan refugee communities in South Australia, with a particular focus on women.

This project explored the following research questions:

1. Guided by women's concerns in interviews: What resettlement challenges and stressors do women from this community face?

2. What barriers to help-seeking currently exist in the community? How could these barriers to help-seeking be overcome?
3. What support needs do community members have, and how can they be taken up by service providers and policy?

Chapter 2: Theoretical underpinnings

This chapter discusses how Kleinman’s Explanatory Model (1978, 1980) and Andersen’s Model of Health Utilisation (Andersen & Newman, 1973) guided this research and provided a conceptual framework and theoretical perspective in which to understand help-seeking with women from refugee backgrounds.

Kleinman’s model was an important consideration in this research, as the concept of mental illness has an extensive history of contestion within the medical and social sciences (Deacon, 2013).

A further challenge is how to define mental illness when working cross-culturally, as what constitutes a mental illness is influenced by cultural and contextual factors, and also changes over time. The majority of theory and practice relating to mental illness has emerged from Western cultures and Western understandings (Gopalkrishnan, 2018). Although these theories have allowed great developments in mental healthcare systems, there are inherent issues in applying these monocultural understandings of mental health in the context of non-Western cultures (Aroche & Coelle, 2004; Fernando, 2014).

Several challenges must be acknowledged when examining “local concepts” of mental illness. Firstly, it is difficult to define a “local concept”, as local knowledge is considerably context-dependent and idiosyncratic, as well as consistently changing, being reproduced, and evolving (Kokanovic, Dowrick, Butler, Herrman & Gunn, 2008). Local knowledge can also be influenced by historical changes and shifting geographical boundaries and territories (Ventevogel, Jordans, Reis & de Jong, 2013). Past attempts to discover and document “folk illnesses”, or “culturally bound syndromes” have been condemned for attempting to force local knowledge into a rigid system (Ventevogel et al., 2013). It can be particularly challenging to study local concepts, given the inherent changing nature of the social world (including beliefs and culture) and the efforts of individuals to process and adapt to these changes (Ventevogel et al., 2013).

Kleinman’s model transcends the biomedical framework and provides an interpretive lens to explore cultural factors within healthcare systems. Using this model as an interpretive lens, as well as taking a post-colonial feminist perspective, allows the generation of transformative knowledge that can lead to equitable and improved health care outcomes for refugee women (Anderson, 2002). Transformative knowledge refers to knowledge that reveals unequal power relations based on race, class, and gender (Anderson & Reimer Kirkham, 1998), all issues relevant for the population of this study.

As well as Kleinman’s model, Andersen’s model guided my thinking in regard to analysing any social inequalities in access to mental health services. The model addresses the concern that minority groups may face increased barriers and overall less health care provision compared to the rest of the population As such, Kleinman’s model and Andersen’s model provided guidance throughout the research process.

In this chapter I address the current literature on help-seeking and mental health literacy and how these concepts relate to the refugee experience. I then present Kleinman’s model and Andersen’s model and discuss the relevance of using these models in my research approach exploring help-seeking for women with refugee backgrounds. I then acknowledge some inherent challenges in applying the overall Western concepts of “help-seeking” and “mental health literacy” when working with cross-cultural populations and issues exploring concepts of mental illness.

2.1 Help-seeking

Help-seeking has been defined as “any communication about a problem which is directed toward obtaining support, advice or assistance in times of distress” (Gourash, 1978, p. 413). Help-seeking can be either formal (e.g. accessing services or from qualified, recognised professionals) or informal (e.g. assistance from an extended social network). Previous research has identified low rates of help-seeking amongst people with refugee backgrounds in resettlement countries such as Australia (Kayrouz et al., 2015).

Previous studies have investigated beliefs about help-seeking for mental health issues with a focus on formal or professional help-seeking rather than informal help-seeking (Kuo, Kwantes,Towson & Nanson, 2007; ten Have et al., 2010). Formal help-seeking refers to accessing support from a general practitioner, counsellor, psychologist, psychiatrist, or attending a doctor’s or mental health clinic (Jorm et al., 1997c). Some studies have indicated that those from collectivist cultures tend to prioritise and value seeking help from in-group members (Hofstede, 2001; Shulruf, Hattie & Dixon, 2007). Furthermore, Kuo et al. (2007) found that those who reported higher levels of interpersonal harmony or beliefs about social cooperation, unity and family support were more likely to positively endorse professional help-seeking for mental health support.

Some research has explored mental health care utilisation and help-seeking with refugee and asylum seeker populations. As noted in the previous chapter, these populations have high mental health needs; however, research suggests that they also under-utilise mental health services (Satinsky, Fuhr, Woodward, Sondorp & Roberts, 2019).

In their systematic review of 27 studies assessing utilisation and access to mental health services in Europe, Satinsky et al., (2019) found that language barriers, difference in symptom expression, discrepancies between expectations, lack of awareness of services, stigma, and cultural differences in help-seeking all contributed to underutilisation of services for refugee and asylum-seeker populations. Markova & Sandal (2016) found that Somali refugees in Norway prioritised informal help-seeking and perceived it to be important to first seek social support within the Somali community or to visit a sheikh to assist them with "de-possession" (exorcism) to treat mental illness. Similarly, Kurdish refugees have been documented to favour informal help-seeking, with families of Kurdish refugees who were suffering from psychosis in the UK preferencing traditional healers (Leavey, Guvenir, Haase-Casanovas & Dien, 2007). Former Yugoslavian refugees living in Germany and the UK reported informal help-seeking preferences for posttraumatic stress disorder due to beliefs that Western doctors would be unhelpful (Jankovic et al., 2011).

A collectivist culture has been associated with positive beliefs regarding formal or professional help-seeking (Tata & Long, 1994; Yeh, 2002). Collectivist cultures often value in-group harmony (Imada & Yussen, 2012) and prioritize group goals and needs, resulting in a strong group or social identity (Shulruf et al., 2007). Those who possess a collectivist cultural identity will often value and expect "security, social order, respect for tradition, and politeness" (Lustig & Koester, 2000, p. 74).

Collectivism is associated with the belief that the self is embedded within important social relationships (Markus & Kitayama, 1991). Rules, duties, norms, and customs are highly valued and closely adhered to (Lykes & Kemmelmeier, 2014). Individuals within collectivist cultures are likely to perceive themselves as interdependent and act according to their group membership and the context that they are in (Markus & Kitayama, 1991). Generally, Afghan and South Sudanese cultures have been defined as high-context (being close-knit, relational and placing a high value upon interpersonal relationships) (Hall, 1976) and collectivist (prioritizing the group over the individual) in nature (Ivanciu & Popica, 2015).

In terms of causal beliefs relating to mental illness, greater endorsement of both biological as well as social causes of mental illness generally indicates more comprehensive knowledge regarding Western mental health definitions, and as a result, identification of the need to seek formal help from a professional (Jorm et al., 1997; Chen & Mak, 2008). Tata & Leong (1994) revealed that higher levels of endorsement of collectivism was associated with greater positive beliefs relating to formal or professional psychological help-seeking. Aligning with these findings, Yeh (2002) found that those who valued relationships and connectedness tended to have more positive beliefs regarding formal or professional help-seeking for mental health support.

In addition to help-seeking, previous research has identified social support (Thompson, 1995, p.43) as important for general wellbeing and overall functioning, and social support has been shown to impact directly on mental health in general populations (e.g. non-refugee specific) (Taylor & Stanton, 2007). However, in relation to help-seeking behaviours, paradoxically, higher levels of social support are generally correlated with lower rates of use of certain mental health services.

Two US longitudinal studies indicated that individuals with more social contacts were less likely to access mental health services (Maulik, Eaton & Bradshaw, 2009; Sherbourne, 1988). Results of international studies vary slightly, but all report a similar theme: larger, more supportive social networks are associated with less access to formal mental health care (Pescosolido, Wright, Alegria, & Vera, 1998; Lasebikan, Eme & Asuzu, 2012). These findings were supported in longitudinal and cross-sectional studies (Faccincani, Mignolli & Platt, 1990; Fleury, Grenier, Bamvita, Perreault & Caron, 2012).

For many people with refugee backgrounds, social support is a helpful resource for coping with stress caused by resettlement challenges (Stewart et al., 2010); however, it may also constrain efforts to seek further professional help.

Mental health literacy (MHL) has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997a, p.184). Generally, MHL involves the ability to recognise symptoms of mental illness, knowledge of causes of mental disorders, beliefs that promote recognition and seeking appropriate help, and knowledge of informal and formal sources of assistance (Jorm et al., 1997a). MHL is overall a Western concept, and studies have demonstrated that Western populations show higher levels of medical and mental health knowledge as well as less stigma towards mental illness (Angermeyer & Dietrch, 2006; Jorm, 2000).

Altweck, Marshall, Ferenczi & Lefringhausen (2015) proposed and examined a mediational model of MHL that was moderated by cultural background. Working cross-culturally with Indian and European American populations, they found significant cultural differences in knowledge as well as beliefs about causes and help-seeking for mental illness They indicated that informal help-seeking beliefs played a significant role in the Indian sample, while being a negligible factor in the European American sample. They also found that collectivism was positively associated with causal beliefs of mental health in the European American sample, and with informal help-seeking beliefs in the Indian sample (Altweck et al., 2015).

As MHL is predominantly a Western concept it may overlook culturally nuanced and specific beliefs, explanatory models, and conceptualisations of “mental health". As such, the terminology of MHL was avoided in this thesis, and instead there was a focus on the ways in which participants conceptualised mental health.

2.2. Kleinman's explanatory model

Kleinman's Explanatory Model (1980, 1978) was used as a theoretical perspective and guided the research and interview questions in this study. The model allows the conceptualisation of health, illness, and healing as part of cultural systems. According to Kleinman (1980, 1978), understanding social and cultural processes of populations is essential, as these processes determine the ways in which individuals act, feel, think, and subsequently make decisions to access health care services. This thesis therefore examines participants' beliefs, values and understandings regarding mental health to explore how their mental health care behaviour is influenced by cultural knowledge and values.

Definitions of culture have changed over time, influenced by many anthropologists' definitions (Barker, 2008; Barker, 2002; Hall, 1997; Helman, 1994; Kleinman, 1980). Culture has been defined as a set of rules or guidelines that people inherit due to membership of a particular society (Helman, 1994). These guidelines can determine how they view and behave in the world - in other words, "culture can be seen as an inherited lens" (Helman, 1994). Thus, culture shapes how an individual observes and understands the world and also how they learn to live in it and interact with others (Helman, 1994). Culture is learned, shared, and transmitted on to future generations of people who live in the specific society (Helman, 1994). Importantly, culture has been defined as fluid, dynamic, and changing over time, depending upon environments (Huff, Kline & Peterson, 2014). Kleinman (1978) views culture as a system of symbolic meanings that can influence the social reality of an individual and those around them.

In order to contextualise the current study, it is necessary to briefly summarize the underlying theoretical positions in cross-cultural studies. The absolutist perspective poses that culture has no part in the expression of behaviour (Sam & Moreira, 2012). Essentially, human behaviour is overall the same in all cultures. For example, "depression" is "depression" regardless of where one observes it (Berry & Sam, 2010). This view assumes that the presentation, expression, and meaning of mental illness are all the same, uninfluenced by culture (Eshun & Gurung, 2009).

On the other hand, the relativist perspective assumes that all human behaviour and the expression of mental illness should be interpreted within a cultural context. The relativist position originates from anthropology and assumes that all human behaviour is culturally patterned. Essentially, the position attempts to avoid categorising or understanding individuals from an external or removed cultural perspective (Sam & Moreira, 2012).

Between the absolutist and the relativist positions, the universalist perspective poses that specific behaviours or mental illnesses are common to everyone, but that the development, expression, and response to the condition is influenced by culture (Berry, 1995). This position assumes that the meaning of human behaviour is dependent upon the cultural context in which it occurs, but that behaviour can also be understood across societies (Sam & Moreira, 2012).

Kleinman (1980) has argued that the biomedical model does not capture cross-cultural issues of care. The biomedical model, he posits, does not take into account lay people's explanations and ways of thinking about illness and mental illness, and the model is saturated with Western cultural assumptions. Furthermore, he argues that the biomedical model cannot account for the meaning contexts of illnesses. Instead, Kleinman proposes that an ethno-medical model that takes these factors into consideration when comparing explanatory models of illness cross-culturally would be more appropriate.

Drawing upon his work exploring depression, Kleinman (1998) argued that culture is significantly important to the experience of depression, including the meaning construction, social relationships, and occurrence of depression within families and communities, as well as the trajectory of depression. From an anthropological perspective, "suffering" is a cross-cultural phenomenon, is often part of the experience of depression, and is experienced by everyone globally. However, what "suffering" means to one person will be experienced significantly differently from someone else (Kleinman, 1991).

The category and function of mental illness are not absolutes; rather they "emerge from a dialectic connecting – and changing – social structure and personal experience…the golden thread running through ethnographies of life in different cultural systems" (Kleinman, 1988, p. 3). This dialectic functions as a mediator between the social world and the thoughts and actions of the individual, creating experiences.

Language is an important mediator between social and personal worlds. Value hierarchies, symbolic meanings, and visual forms make up cultural processes which order social life (Kleinman, 1988). Accordingly, it is important to consider the continual changing social context of women with refugee backgrounds when exploring their access to mental health services.

2.2.1 Social reality

Health-care systems are forms of social reality – they are socially and culturally constructed. Social reality is the "transactional world in which everyday life is enacted" (Kleinman, 1980, p. 36), in which social roles are performed, in which people interact and negotiate with each other, and in which status relationships are established under cultural norms and rules. In other words, it refers to the world of human interaction that exists outside the individual and between individuals (Kleinman, Eisenberg & Good, 1978). An individual living in a certain culture internalises social reality as a system of meanings and norms that subsequently governs behaviour, perceptions of the world, communication with other people, and understandings of the external and interpersonal environments (Kleinman, 1980).

Social realities differ between professions, societies, social groups, families, and individuals. Anthropologists and sociologists have noted that smaller, traditional societies tend to have more similar and homogenous social realities that are shared by most members of the community. On the other hand, they have noted that more developed, Western societies have many distinct social realities (Kleinman, 1980, p. 37). Individuals may hold social realities that are a mix of modern and traditional beliefs, values, and concepts, and that are held together in varying patterns of assimilation, and at times, contradiction.

Kleinman (1980) has noted that even in supposedly homogenous social worlds, individuals differ, often significantly, in their social realities. People differ in their awareness, understanding and acceptance of social norms, and the degree to which they adhere to norms in everyday life. This subsequently affects how individuals think about and react to sickness, and the choices that they make about seeking help, and evaluating the effectiveness of health care available to them.

Social realities may differ according to socioeconomic class, level of education, family differences, ethnicity, religion, and occupation. These are all relevant considerations for women with refugee backgrounds in their country of resettlement, as they are likely to have lived within culturally diverse systems before arriving in Australia, influencing their social realities and subsequent health-care decisions. Indeed, Kleinman (1978) defined culture as a system of symbolic meanings that can influence social realities and the experiences of others. This is relevant to the current study, as participants' environments are linked to culture as well as to experiences of health and illness. As such, it is important for healthcare professionals to understand women with refugee backgrounds' conceptualisations of mental health and also how cultural values and beliefs may shape these experiences in order to better understand their help-seeking behaviours.

2.2.2 Structure of health-care systems

Kleinman (1978) has proposed that health, illness, and health care are all aspects of cultural systems and need to be understood interactionally and in relation to each other. Kleinman (1978) has further stated that internal structures of health care systems are composed of common and "culture laden components". The internal structures are alike across cultural boundaries, but the content differs within the social, cultural, and environmental contexts of each system.

Each health care system is made up of three overlapping sectors, including the professional sector, the popular sector, and the folk sector. Every sector has a unique and distinct explanation and understanding of health, illness, and treatment. In reality, this is an important consideration, as different views and beliefs about health and illness may be brought to light in diverse health care provider-client interactions.

2.2.3 Sectors of the health-care system

2.2.3.1 Professional sector: in most societies, this sector is comprised of organised healing professions, including modern scientific medicine and psychiatry. An individual is usually removed from their home/family environment to a facility where the emphasis is placed on their diagnosis or disease. In the professional sector, "medical realities", including diagnostic activities, become the focus of therapeutic treatments (Kleinman, Eisenberg & Good, 1978). Individuals must accept their "clinical reality" (health-related aspects of social reality) as legitimate. Kleinman (1980) defines clinical reality as the socially-constituted contexts that influence illness and clinical care, including beliefs, expectations, and norms associated with health care seeking, practitioner-patient relationships, and evaluation of outcomes (Kleinman, 1980 p. 41).

Thus, to comprehend women from refugee backgrounds' decision-making processes about help-seeking for mental health issues, it is essential to first explore their expectations, interactions, and relationships with service providers, family members, and community members concerning care and treatment.

2.2.3.2 Popular sector: this sector consists of a matrix containing several levels. The levels are individual-based, family-based, social nexus-based, and community-based. The popular sector is the most direct determinant of care. It is a non-professional, lay, non-specialist area where illness is first defined and conceptualised, and health activities are initiated. Approximately 70%-90% of illness is managed in this sector in both Western and non-Western societies (Kleinman, 1980).

The perception and experience of symptoms of mental illness or disease are first encountered by an individual within the family. This is where the labelling, evaluation of symptoms, and sanctioning of a sick role (or not) takes place. Subsequently, it is also within the family that the decisions about what to do, and engagement in specific help-seeking behaviours with other sections of the health-care system, occur. Decisions to access other sectors are influenced by the popular culture's values and beliefs about illness and health and individuals' explanatory models.

After people receive treatment at a professional level, they usually return to the popular sector to review and evaluate the treatment that they have received, and also to decide which steps to take next. The popular sector interacts with the other sectors; however, the folk and professional sectors are fairly isolated from each other (Kleinman, 1980).

A woman from a refugee background may draw upon her cultural knowledge or past experiences within her family to cope with mental distress. Alternatively, the woman may consult with her family and decide to seek help from a traditional healer, a refugee organisation, a General Practioner, or all of these options. At all levels of the matrix of the popular sector (from individual-based to consulting with others), family or community with whom the individual interacts may facilitate or impede access to health care (help-seeking from the professional or folk sectors).

2.2.3.3 Folk sector: this sector consists of individuals who specialise in traditional forms of healing. These healers occupy a space between the professional and popular sectors of Kleinman's model. There is a significant function of folk medicine in many parts of the world, especially in non-Western, developing countries (Kleinman, 1980). Folk healers are most commonly consulted in societies where poor health and mental health is associated with social causes such as witchcraft, or being haunted by ancestral ghosts, spirits, or supernatural forces (Helman, 1994).

There is significant interaction between sectors, as some people may utilise all three. For example, a woman with a refugee background may first seek help from the professional sector, throughout her experience in this sector may receive advice from the popular sector, and as a consequence also visit a healer from the folk sector.

2.3 Andersen's health model

Andersen's Model of Health Service Utilisation (1973) was initially also used as an interpretive lens to examine social inequalities in access to health services. The model addresses the concern that minority groups may receive less health care provision compared to the rest of the population (Andersen & Newman, 1973), and has been used extensively to investigate the use of health services (Babitsch, Gohl & von Lengerke, 2012). Andersen & Newman (1973) define the utilisation of health services as a type of individual behaviour.

Thus, the model conceptualises access to services as a result of decisions made by the individual, which are constrained by their position in society and the subsequent level of accessibility and availability of health services. The best way to improve access to care is to focus on the context as well as individual determinants (Andersen, 1995; Andersen & Davidson, 2007). Contextual factors include the circumstances and environment of health care access as well as community characteristics (Andersen, Davidson & Baumeister, 2013).

An individual's likelihood of access to health services is considered to be a function of three individual and contextual characteristics:

2.3.1 Predisposing factors

These are socio-cultural characteristics that include demographic factors such as age and gender, social factors including education, occupation, ethnicity, and social relationships, and psychological factors including health beliefs.

Social characteristics include how supportive the community is towards health and access to health services, and also include educational level, ethnic and racial composition, employment level, and crime rate.

Factors relating to context that may predispose individuals to use health services include social composition of communities, collective or shared values, cultural norms, and political perspectives (Babitsch et al., 2012). These are existing conditions that predispose people to engage in, or disengage from, service use (Andersen, 1995).

2.3.2 Enabling factors

These are the logistical aspects of obtaining care, including whether an individual has the financial means to access care, a regular source of care, the ability to transport oneself, health insurance, and knowledge of health care services.

In terms of individual financial factors, this involves consideration of income and whether an individual has the means to pay for health services or has health insurance.

At the contextual level, this also includes whether there are available resources within the community, the relative price of services, income per capita, and the general rate of health insurance coverage (Babitsch et al., 2012).

Organisational factors include whether the individual has a regular source of care and also the nature of the care provided. It also considers whether an individual has access to transportation and how far they may have to travel and then wait for health care services (Babitsch et al., 2012). These factors facilitate or impede the use of services (Andersen, 1995).

2.3.3 Need factors

These are functional or health issues that promote the need for access to health care (e.g. level of discomfort of symptoms). Need factors are considered the most immediate cause of service access and use. They are the conditions that laypeople recognise as requiring healthcare (Andersen, 1995).

According to this model, need is split into two: perceived and evaluated. Evaluated need is considered measurable and more objective (often a professional's judgement on someone's health status), whereas perceived need is more subjective, and is somewhat determined by health beliefs (Babitsch et al., 2012). Perceived need can be explained by the severity and discomfort of symptoms, predisposing and social characteristics (gender, age, ethnicity, education), and health beliefs (health literacy, health attitudes, cultural explanations) (Andersen et al., 2013). In the words of Andersen himself:

> How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help, (Andersen, 1995).

If access can be predicted entirely or partly by enabling factors or variables such as ethnicity or minority or class status, then it is considered to be unequal (Andersen & Newman, 1973). Thus, there is a clear theoretical basis for using the Andersen model to effectively study social inequalities leading to differences in health service utilisation.

Andersen's model has been employed as a theoretical basis for studies investigating health-seeking behaviours in refugee populations by numerous international and Australian researchers (Cheng et al., 2015; Irfan, Irfan & Spiegel, 2012; Portes, Kyle & Eaton, 1992; Ruiz-Rodriguez, Lopez-Moreno, Avila-Burgos & Acosta-Ramirez, 2006; Wenjing, Dorstyn, Denson, 2016).

The model was initially used in this thesis as an interpretive lens to examine social inequalities and how this may influence help-seeking among refugee women. However, as the research progressed this model became less central when it became apparent that help-seeking was not a topic of priority in interviews with participants.

Chapter 3. Epistemological assumptions and reflexive practice

In addition to the models discussed in Chapters 1 and 2, this research has been informed by several critical approaches in the social sciences. Specifically, this research used a critical inquiry approach and was informed by critical realism and postcolonial feminism.

As postcolonial feminism has been significantly influenced by the critical social perspective, in this chapter I outline several relevant critical inquiry concepts and then explain why this theoretical lens, including critical realism, provided an avenue to extend knowledge when working with women from refugee backgrounds.

I then outline the foundations of postcolonial feminist perspective theory and the importance and relevance of this perspective when exploring help-seeking for mental health services and resettlement challenges and stressors with women from refugee backgrounds.

Drawing from these perspectives, I also discuss how I managed power relationships and navigated my role as a researcher and activist through reflexive practice. Community-Based Participatory Research (CBPR) and the methodology used in this thesis will be further discussed in Chapter 4.

3.1 Critical inquiry

Critical inquiry addresses issues related to power inequities, structural constraints, and oppressions within societies. Critical enquiry that deepens social analysis is based on the assumption that thought and action is socially located and is oriented toward social justice. This kind of critical thinking is informed by a historical perspective, moves between the individual and structural level to demonstrate the dialectical relationship between them, and explores the foundational causes for health and social problems that are entrenched in social structures (Murray & Poland, 2006).

Michel Foucault’s work (1980) underlies much of critical inquiry and post-colonial feminist theory. His work explored the relationship between power and knowledge. In essence, he connected the production of knowledge with power relations and discourse, arguing that knowledge is subject to change under the power relations within social institutions. His theory regarding discourse placed emphasis on the relationship between knowledge, truth and power.

Foucault argued that power relations are circulatory, and that power is the effect of discursive struggles over meaning and production of knowledge (Day, 2012). He further argued that discourse is created and perpetuated by those who have power, control, and means of communications (Foucault, 1978). Foucault used the term power/knowledge to indicate that power is established through accepted forms of knowledge, scientific understanding and “truth”. He stated that present forms of “truth” are influenced, and at times determined by, dominant discourses in the health care sector, this being a set of dominant discourses embedded where power and knowledge are both produced and maintained.

Through Foucault’s understanding of power, then, we are able to consider ways in which research participants are located within relations of power outside of the immediate interview setting, as well as being able to consider where I as researcher am positioned in a multidimensional fashion. Whilst tensions of power relations cannot easily be resolved, bringing awareness and attention to them by using a reflexive approach can be useful for understanding the different ways in which power operates. This theoretical lens has aided my understanding of how gender, culture and historical factors may impact upon an individual’s health and health care practices (Donnelly, 2004; Anderson, 2004).

A fundamental objective of critical inquiry is to establish conditions for open communication and to expose hidden power imbalances. Thus, it involves the examination of assumptions, and takes a more reflexive approach, recognising the ways in which these views may be influencing practice and research. A critically reflexive practice and methodology can become more cognizant of the extent to which we hold privilege, knowledge and power in relation to other social groups (Browne, Johnson, Bottorff, Grewal & Hilton, 2002). Furthermore, critical inquiry can assist in reflection upon how the production and presentation of knowledge within a certain ideological foundation can actually sustain and perpetuate existing power relations, inequalities, and helplessness, which can subsequently further marginalize women with refugee backgrounds (Anderson, 2002).

Another goal of critical inquiry is that of transformative change in favour of social justice. The critical inquiry approach uses reflection to generate strategies for social justice, and therefore opens up new possibilities for the contribution of knowledge that address health inequalities. Thus, it allows a way to explore the context of any individual’s experience and also provides an analytic lens to address socio-political repressive conditions that potentially influence health and health care (Mahony & Donnelly, 2010; Browne, 2000).

3.2 Critical realism

Roy Bhaskar (Bhaskar, 1978; 1991;1998) applied critical realism to the development of a meta-theory for social science in general and outlined primary features of critical realist philosophy (Fleetwood, 2014). Firstly, he highlighted the importance of generative mechanisms, including structures, powers, and relations that explain how things work beneath an observable experience. In other words, this involves looking beyond empirical outcomes such as “if A then B”, and examining the contributing underlying mechanisms.

Bhaskar also identified the multi-layered character of the real world, arguing that reality can be understood as being comprised of complex overlapping layers. He stated that each layer had its own distinct properties but that they interacted as part of a whole (Bhaskar, 1978; 1991; 1998). There are also underlying layers that influence effects at higher levels. Bhaskar conceptualised this as an empirical level referring to that which we can observe, an actual level referring to the occurrence of events, and the real level referring to the real power of things that may or may not manifest as actual occurences or empirical events.

Bhaskar highlighted the interplay between social structures and human agency and that social reality is transformational. He argued that society continues to exist because agents reproduce or transform structures and mechanisms that they come across in their social actions. In other words, individuals’ conscious behaviour and activity unconsciously influences and reproduces the structures that govern their activity. An example of this is that speaking and conversing requires grammar structure (Bhaskar, 1978; 1991; 1998).

Critical realism combines realist ontology with a relativist epistemology (McEvoy & Richards, 2003). Critical realists are critical of a “factual truth”, but still maintain that a reality exists that is not dependent upon human perception. Critical realism posits that there is a single reality but that there can be multiple interpretations of that reality (Fleetwood, 2014). In other words, that there is a reality “out there” but it is always mind-independent. A mind-independent reality refers to the idea that things exist separate from our beliefs or our accounts of them.

Critical realism posits a stratified, emergent, generative ontology and theorizes that reality is constituted by the actual, the empirical, and the real. The actual refers to events and outcomes that happen in the world, but we can only perceive these things through observation or experience. We can never actually get to what something is; instead, there is only ever an account of what the actual is. Underneath the actual are factors within the real, and it is these underlying explanatory factors that critical realism seeks to understand and explain more thoroughly. These are the underlying factors that cause change in the realm of the actual.

Critical realism in relation to these explanations recognizes the role of agency and structure. It recognises that there is interplay between agency and structure, that is, things happen in the world not only because of individual agency, but also because of their context (Fleetwood, 2014).

In this research, when conducting interviews, I considered that women's stories were at the empirical and real levels, but that there may be other influences at the actual level. Drawing on this theory, women's stories are influenced by generative mechanisms, including structures, power, and relations, including the interviewer and interviewee relationship. What a woman was willing to share or not share as well as how she spoke about her experiences would have been influenced by these generative mechanisms.

Within this research, a critical realist approach allowed exploration of the connections between participants and their families, the community, and of how the broader social and cultural context may shape their understandings and experiences of mental health and their mental health care access. A critical realist perspective allowed me to examine how experiences of racism and discrimination, social injustices, and unequal social relations could function as barriers to accessing services for women with refugee backgrounds.

3.3 Postcolonial feminism

Postcolonial feminism was developed during the 1980s in response to and as a critique of the feminist movement that largely focused on the experiences of women solely from Western cultures (McEwan, 2001). It seeks to explore the ways in which racism and the long-lasting political, economic, and cultural impacts of colonialism affect non-Western women or women of colour (Weedon, 2000). It examines the gendered history of colonisation and how this continues to affect the status and experiences of women today.

Postcolonial feminism critiques Western feminism by acknowledging the challenges and differences amongst and between diverse groups of women (Mohanty, 1988). Furthermore, it provides a wider lens to explore the complex and interconnected layers of oppression that exist within societies (Lewis & Mills, 2003). The concept of colonisation within postcolonial feminist theory can refer to the literal act of colonisers acquiring lands, or it can also refer to forms of social, discursive, political, and economic oppression (Lewis & Mills, 2003).

Postcolonial feminism has strong links with indigenous movements as well as the wider and more general postcolonial theory. Racism is a key issue within postcolonial feminism – a topic that Western feminism has often viewed as a secondary issue to the patriarchy and somewhat separate (Lorde, 1984). As Audre Lorde, (1984) argued, "as white women ignore their built-in privilege and define *woman* in terms of their own experiences alone, then women of Color become 'other'...".

Essentialism has been a thoroughly debated subject within postcolonial theory. Essentialism refers to "the assumption that groups, categories, or classes of objects have one or several defining features exclusive to all members of that category" (Ashcroft, Griffiths, & Tiffin, 2000, p. 77). Within postcolonial theory there has been a tendency to assume that all women of a certain cultural group share the same experience of oppression, ignoring diversity and differing degrees of agency (De Souza, 2004). Proposed ways to avoid this include considering the historical understanding of the context, and carefully examining socio-political processes by which certain values and practices have been deemed central components of a culture (Narayan, 2000).

The postcolonial feminist perspective was used in the current research to identify the different ways in which the intersections of race, gender, and class relations affect social, cultural, political, and economic factors, which can subsequently impact the lives of women with refugee backgrounds. Ultimately, research is political, as it can reveal power relations and offer a new vision of producing knowledge for social justice and freedom (Anderson, 1991). This perspective provides an analytic lens to understand the impact of contextual factors upon women with refugee backgrounds' mental health, to generate transformative knowledge about women with refugee backgrounds' mental health care experiences, and to increase the understanding of needs of this population within resettlement countries (O'Mahony & Donnelly, 2010).

When working with women from refugee backgrounds, a postcolonial feminist lens reveals how racism and political, economic, and cultural impacts of colonialism can interact with experiences of forced migration (Wachter & Snyder, 2018). Women with refugee backgrounds are often forced to relocate themselves internally as well as relationally in resettlement countries. This foregrounding of internal realities, feelings, and perspectives of women in policy and research with forced migrant populations is referred to as “centering subjectivities” (Wachter & Snyder, 2018).

Centering subjectivities allows researchers to situate experiences within historical as well as contemporary contexts. Resultantly, the impacts of war, conflict, displacement, and experiences in resettlement countries upon women’s internal and relational lives can be considered. For example, when subjectivities are centered, the notion of “refugee” itself can be examined, as can the ways in which structural oppressions have affected women and how women may have internalised the classifications and labels that facilitated their forced migration.

Postcolonial feminism invites questions regarding the construct and label of “refugee” for women during the post-migration period. For example, what does being labelled a “refugee” mean to women, and does this potentially impact on their access to health care, employment and education? It also considers women’s belonging, and how they make sense of and contextualise a life that was once lived elsewhere, and how their lives might have changed as a result of resettlement.

The approach recognises the colonial legacies and the impacts of war, forced migration, and displacement on disrupting women’s lives and connections. Furthermore, it allows exploration of how women negotiate intersecting identities and experiences that continue on from different countries and contexts (Wachter & Snyder, 2018).

The aim of this perspective is not only to represent and portray women’s experiences, but also, ultimately, to improve the conditions in which participants live and access mental health care and services (O’Mahony & Donnelly, 2010). Adopting such a politically driven approach challenges the oppressing forces that shape women’s lives and looks for opportunities to neutralise these forces. In other words, this perspective “recognizes the need for knowledge construction from the perspective of the marginalized female subject whose voice has been muted in the knowledge production process” (Kirkham & Anderson, 2002, p. 10).

Researchers who conduct post-colonial feminist research are critical of the traditional social sciences and in particular, their ontological and epistemological underpinnings. They argue against the objectivism and value free epistemology of traditional scientific enquiry. They theorize that knowledge is socially constructed, as well as value-laden, and that the researcher’s race, class, gender and culture shape the research process (O’Mahony & Donnelly, 2010). This approach is therefore reflexive, and the researcher’s social position is acknowledged and incorporated into the analysis. By highlighting and acknowledging positionality, the researcher is aware of their own subjective experience in relation to that of the participants, and this is essential in acknowledging the limits of objectivity (Deutsch, 2004).

The postcolonial feminist perspective is oriented to exploring how race, gender, and class relations influence social, cultural, political, and economic factors. These contextual factors all subsequently influence the lives and mental health experiences of women with refugee backgrounds. Thus, instead of viewing each woman as being solely responsible for her health care, researchers examine how health care institutions and policy affect women’s health and health care (Donnelly & McKellin, 2007).

In this research I examine how racism, gender roles, and expectations, as well as class hierarchical relations, shape participants’ resettlement experiences and help-seeking behaviours relating to mental health services. Critical theory allowed me to explore and further understand how the complex relationship between the participants and the environment in which they live may influence their mental health experiences and help-seeking behaviours. This interpretive lens helped to illuminate how social injustices may contribute to unequally distributed resources and inaccessibility of services for women with refugee backgrounds. Further understanding how gender and culture influence refugee women's mental health care access may lead to more effective service development and treatment and care for this population.

3.4 Role of the researcher

Howard Becker (1996) argued that there is no tangible procedure for the production of high-quality qualitative work. Therefore, in the absence of an evaluative checklist, researchers should practice a certain degree of reflexivity in order to assess the validity of knowledge generated through qualitative methods (Day, 2012).

Reflexivity refers to the researcher's continuous, internal, and critical self-evaluation of their role, actions, and positionality, and to the active recognition that the position of the researcher may influence the research process and the outcome (Bradbury-Jones, 2007; Guillemin & Gillam, 2004).

3.4.1 Managing power relationships

In feminist reflexivity, a primary concern has been the problematizing and effects of power in the research relationship (Zavella, 1996). In other words, how are researchers implicated and located within power relationships in qualitative methodology? For some scholars, reflexivity involves questioning role performance whilst conducting qualitative research (Watts, 2006). Others question the co-construction of identity throughout the research process (Best, 2003). Additionally, Reinhaz (1997) argues that reflexivity is a practice of understanding how the multi-positioned self becomes meaningful within qualitative studies.

In relation to the co-construction of identity during the research experience, scholars may question how their gender, race, and class were made meaningful in and through the research relationships. In the case of my own positioning during the research that formed the basis of this thesis, I acknowledge my background as a young, Australian-born, white, educated, middle-class, English-speaking, and as such, privileged, woman.

As aforementioned, language is an important mediator between social and personal worlds and allows us to communicate cultural values and meaning (Kleinman, 1980). As such, language is acknowledged as a significant source of power. In particular, English-speakers (especially native speakers) hold significant power given the language's wide-spread and increased use in international settings.

Within interviews, discursive exchanges should be considered "in the contexts of shifting positions, storylines and power relatiosn" (Ritchie & Rigano, 2001, p. 749). The relations of power dynamics within interviews are enacted by who asks what, when, how, and in what language, and the researcher is the one who holds the power to make these choices. I, as an Australian-English speaker asked the questions and participants (in all cases, English as second language speakers) were expected to respond. Evidence of this dynamic became apparent when some participants made comments such as "my English is not so good", or asked for clarification of meaning of questions. Additionally, the findings of the research were published in English. As such, my English-speaking background was a significant factor in the power dynamics throughout all stages of the research process.

In interviews, participants were asked to disclose information about their own demographics and past stories. Therefore, some participants also asked about my background and the purpose of the research, making my own identity salient. My own privilege was evident in these moments as I described that I was completing a PhD, and that I had had the opportunity to undertake long-term study, including an undergraduate and postgraduate degree. My identity as a researcher was co-constructed by participants and myself, as participants each interpreted my interest in refugee mental health and reasons for doing the research slightly differently.

I found my position as being that of both an “insider” and “outsider” simultaneously. I was considered an insider because of my gender as a woman, but also an outsider due to my race and difference in religious beliefs. Being a woman and working with women allowed me to connect and build rapport with participants. Participants sometimes referred to their experiences as something that I would also understand, as I identified as a woman. For example, some women disclosed personal female health issues and stories of traumatic childbirth that may not have been discussed with a man.

Pre-constructed ideas about positions as researchers can affect the types of research relationships that are subsequently experienced (Acker, 2000). I was often required to re-negotiate my position (Gordon et al. 2005) and manage the power imbalance between the research and participant (Finaly, 2002).

Harding (1988) has argued that knowing the researcher’s position and place makes the research understandable. Reflecting upon and explaining one’s positionality gives context to the researcher’s voice, rather than reproducing a de-contextualised voice of authority (Day, 2012). Indeed, knowing what kind of position and context the author is coming from allows the reader to better understand what is being said. In this case, I, as the author, came into the research with my own political position regarding refugee and immigration policy. These beliefs would have influenced the way in which I constructed research questions initially, as well as how I interpreted the interviews.

One's role performance in the research process is considered "doing", and is performative (Brekhus, 2008). In interviews, the interaction was predominantly one-way, in that I was doing the asking and the participant was doing the responding. To counteract this power dynamic, I ensured that the questions were open-ended, and that participants had adequate time to tell their stories and guide the interaction.

A researcher typically presents themselves in a certain way, either as having a level of credibility, legitimacy, and authority (Watts, 2006), or being student-like and being in need of a participant's explanation or validation (Hoffman, 2007).

Researchers also can perform emotional labour, playing various, and at times inconsistent, roles in managing the emotions of participants as well as their own (Hoffman, 2007).

The role of research participants can also be analysed as performing in a certain way to fit the model or the script that is expected by the audience (in this case, myself as a researcher) (Murray, 2003). However, research relationships can change throughout the research process. I became friends with some participants – visiting them to conduct interviews and to check interpretations, but also staying to have conversations. For others, I was viewed as an advocate as the research process went on. In some cases, I felt as if participants viewed me as an academic researcher, and we only interacted for the interview, as they did not wish to engage further. I had a connection with one community leader before the research process, and so my relationship with him changed to a working and collaborative relationship rather than a friendship. These experiences demonstrate the fact that my role performance necessarily changed because the research relationships themselves also changed in the field. My relationships and the roles that they entailed were thus dynamic throughout the research process.

Taking the point of view of those that we study has an epistemological foundation that truthful knowledge about social life can be achieved by going to the source of those who truly experience it, with the assumption that “the nearer we get to the conditions in which [people] actually do attribute meanings to objects and events the more accurate our descriptions of those meanings are likely to be” (Becker 1996, p. 58). Thus, underlying this epistemology is the assumption that there is a distance to be overcome between the researcher and the researched “other”.

Feminist epistemology takes the perspective that this distance between knower and known can be improved by considering the ways in which hierarchical research relationships have the potential to objectify research participants (Day, 2012; Wolf, 1996; Shope, 2006). Additionally, feminist theorists have suggested an epistemological reorientation by including experiential accounts in the production of knowledge about social life (Day, 2012). Thus, reflexivity has come to mean a deeper consideration of the subjectivity and role of the researcher in the research process and process of knowledge production.

3.4.2 Reflexive practice

What is interpreted or “seen” in qualitative studies must be reflexively thought of as “what we think we see”, continuously questioning the foundation upon which interpretations have been made. Ultimately, this practice involves considering how one’s own conceptual categories are implicated in observations and subsequent analyses.

As one theorist explains, “questions are always loaded with the questioner’s prejudices” (Minh-ha, 1989, p. 69). Thus, it is important to recognise that the approach to the research and the research process itself has been influenced by my own conceptual categories and assumptions about what issues these two communities may face. This includes for example, my choice of the research topic, creation of research questions, and the interview guides. Although I formed interview guides with the input of community leaders, ultimately my own position as a researcher within an academic institution, and as a white, middle-class woman would have influenced their framing and inclusion.

These questions about the extent to which a researcher's own conceptual categories affect the production of knowledge are fundamental, especially when considering these conceptual categories as a product of my own situation as a researcher within a disciplinary field and academic institution (Bourdieu, 2004). It is important for researchers to be aware that the interpretations that we make based on what we know (in this case being an academic or student who is surrounded by a field of knowledge – psychology) do not impede upon our participants' knowing, and also their lived experiences (Frosh & Emerson, 2005).

I wished to incorporate and practice reflexivity throughout this project due to my desire to use a CBPR approach, as well as address dilemmas concerning assumptions about the production of knowledge, what is considered legitimate knowledge in the first place, and what role power has within the research process.

For researchers conducting CBPR projects, the work as been described as involving "learning as much about ourselves as it does about 'the other'" (Carter, Banks, Armstrong, Kindon & Burkett, 2013). As suggested by Nowell, Norris, White & Moules (2017), an audit trail and a reflexive journal were kept to document insights, feelings, and emotions that were generated throughout the research process, particularly following interviews and throughout data analysis. At times I felt emotionally drained following interviews and interactions with participants – especially if the nature of their story contained traumatic elements. Recording my reactions following interviews helped me to process my own emotions and thoughts that arose when I listened to participants' stories. When I reviewed these reflections, I altered and adjusted some of the interview questions, depending on how the interview went, the quality of rapport established, and participants' responses to questions.

Drawing on a CBPR approach, I also consulted with community leaders and bi-cultural workers regarding culturally appropriate language and what topics were relevant to communities.

3.4.3 Dual role: activist and academic

Historically, university campuses were sites of political and social activism, for example, the student protests during the anti-Vietnam war movement (Grey, 2013). However, more recently some academics have questioned how the role of academic-activist can exist, given the academic demands of creating peer-reviewed articles and political, institutional, and bureaucratic restrictions on involvement in community and political organisations (Grey, 2013).

Activism involves deliberately and consciously dissenting against hegemonic discourses (Grey, 2013). "In a free society, a university has a moral purpose, combining an intellectual purpose of free and open inquiry and a social purpose as source of social criticism independent of political authority and economic power" (Tasker & Packham, 1990). Within psychology, the term scholar-activist has been defined as the tradition of exposing, subverting, and challenging social injustices through a combination of various forms of scholarly work and activism (Murray & Poland, 2006). However, academics who connect themselves to social and political causes are often viewed as being at odds with academic notions of objectivity. Jones, Galvin & Woodhouse (2000, p. 9) have argued that:

> the dissemination of knowledge requires academic freedom, and this in turn demands the highest standard of integrity. The requirement of integrity is crucial whether the dissemination of knowledge is within one's own discipline or into the public realm more broadly

If we conceptualise social movements as collective challenges of established authority, as ideologically controlled action (Zald, 2000), and as creators of new knowledge (Eyerman & Jamison, 1991), then it makes sense and is logical for academics to be involved. From this perspective, activists bring about social and political change through the production and reproduction of knowledge (Grey, 2013). Whilst Jacobsen & Landau (2003) highlighted the concern that refugee research can be politically charged, and as a consequence may not be reliable or valid, others have suggested that researchers who work with refugees need to stand in solidarity with participants, and fulfil advocacy-type roles (Hartley, Pedersen, Fleay & Hoffman, 2013; Mackenzie, McDowell, & Pittaway 2007).

Ultimately, researchers must find a balance between "rigor, advocacy, benefit, and inclusion in the research process" (Ziersch et al., 2017, p. 14). Hartley et al., 2013 have emphasised the importance of "bearing witness" involving listening and observing the experiences of others and then taking some form of social action. As such, I approached the research reported in this thesis as occupying a dual role of activist and academic. My goal was to bear witness to, and bring women's experiences to the forefront and then disseminate the findings to relevant organisations and the public. I also aimed to contribute to the growing literature in refugee mental health and place pressure on policymakers, as well as highlight implications for service development.

Chapter 4: Community-based participatory research and methodology

This chapter outlines how the principles of CBPR were used to ensure that the research was not only extracting information, but also benefiting the community, that participants with refugee backgrounds were involved throughout the research process, and that the research was delivered in a culturally sensitive manner.

I then present the method of recruitment, data collection, analysis of the data, and ethical challenges that I encountered.

4.1 Community-based participatory research (CBPR)

Historically, research conducted in minority communities has not always included community members and leaders in a participatory manner (Hacker, 2013). Instead, research has often been conducted *on* communities, not *with* them. Consequently, researchers have been negatively perceived as extracting information without involving relevant community members and finishing projects without assisting communities. This approach risks leaving members of the community feeling taken advantage of, exploited, or forgotten.

As such, participatory approaches have been gaining momentum as they challenge the heirarchies of researched and researcher (Kindon & Elwood, 2009; Brulin, 2001), seek to maximise participant control and honour the views and voices of those whose voices are often unheard (Kindon, 2005; Pain, 2004), and prioritize conducting research with communities (Pain, 2004; Collie, Liu, Podsiadlowski & Kindon, 2010).

CBPR is a participatory approach with a goal to ensure that the research is relevant to the lives of the people in the communities being investigated. This involves ensuring that participants' voices are heard and that community leaders have input in identifying issues and shaping topics and questions for investigation. Ideally, CBPR should involve mutual respect between researchers and community members and work to benefit both parties (Hacker, 2013). Ultimately, CBPR is committed to work in partnership with community members to reduce or eliminate inequities that have been sef-identified by community members themselves (Jull, Giles & Graham, 2017). Furthermore, CBPR aims to combine knowledge with action and then “achieve social change to impove health outcomes and eliminate health disparities” (Kellog Foundation, 1992).

CBPR has an emphasis on partnering and collaborating with communities and recognises the importance of working with and involving members of a study population as active partcipants. The knowledge of community members is identified as legitimate and expert in nature (Fletcher, 2002). Community members are involved in all stages of the research process, including formulating research questions, defining research design, field work or data collection, analysis and interpretation of data, and writing reports and disseminating the results and outcomes (Holkup, Tripp-Reimer, Salois & Weinert, 2004).

Israel, Schulz, Parker & Becker, (2001) described CBPR as focusing on social, structural, and physical environmental inequiteies through active involvement and participation of community members and researchers in every part of the research process (Israel et al., 2001). Israel et al. (2001) further outlined the main characteristics of CBPR as: 1) recognising the community as a unit of identity, 2) building on the strengths and resoures of the community, 3) promoting colearning among research partners, 4) achieving a balance between research and action that benefits both the research aims and the community, 5) emphasising the relevance of community-defined problems, 6) disseminating knowledge gained from the CBPR project, and 7) recognising the necessity for long-term commitment on behalf of all research partners. By involving community members in the research process, trust can be established between researchers, institutions, and comunities (Israel et al., 2001; Holkup et al., 2004).

Principles from a CBPR approach were used in this research project. Each research step built upon the last, and research questions were established based on assessed needs, and as potential avenues of exploration opened up as the research progressed.

Although women with refugee backgrounds from South Sudan and Afghanistan are typically a hard-to-reach population, a CBPR approach allowed community leaders to be involved in the dissemination of study information. This resulted in the information about the project being delivered and advertised in a more culturally sensitive manner.

A CBPR approach also ensured that the research not only extracted information, but also benefited the community in some way. In this case, the close involvement of community leaders and regular consultation ensured that the research was relevant and important to the communities and more closely met their needs, for example, the prioritisation of resettlement stressors over help-seeking, and the exploration of experiences of domestic violence and racism. Following analysis, the findings of the research were summarised into two-page reports (see Appendix K & L) and delivered to participants, as well as organisations, including the African Women’s Federation of South Australia, The Muslim Women’s Association of South Australia, and the Australian Refugee Association.

In CBPR there is an emphasis on honouring the voices of participants, and to be led by what is important for communities. As such, my research agenda shifted from an initial focus solely on barriers to help-seeking to an expanded focus on resettlement stressors and challenges. Making these women's voices heard may also empower other women with refugee backgrounds and provide more exposure and insight to their stories for mental health practitioners and policymakers.

4.2 Participants

Inclusion criteria for refugee participants included whether they had been in Australia for more than three months, ensuring some level of familiarity with the Australian health care system (given the initial focus of the study on help-seeking), and were over the age of 18 years. Inclusion criteria for service providers included if they worked with women from refugee backgrounds, in particular South Sudanese or Afghan women, in a mental health or wellbeing capacity.

From the Afghan (Hazara) community, 11 female community members participated in the research, and no women identified themselves as community leaders. Participants were aged between 18 and 60 years of age (*M* = 30), and had lived in Australia between 4 and 16 years (*M* = 6.8). Participants spoke English, Hazaragi, Dari, Urdu, and Hindi. The occupations of the Afghan women included childcare worker, students, unemployed, and /stay-at-home caregivers/mothers. All identified as Shia Muslim.

From the South Sudanese community, two male community leaders, four female community leaders and three female community members participated in the research. South Sudanese participants' ages ranged from 25 years-65 years. These participants had lived in Australia for between 7 and 18 years. All participants identified their religion as Christian. In regard to cultural groups, 6 participants were from the Dinka group, 2 were from the Ma'di group, and 1 was from the Jurchol group. Participants' occupations included Community Chairman, government worker, aged care nurse, disability support worker, students, and two were unemployed.

It has been well established that it is imperative for interview questions to be administered with an interpreter or translation where participants do not speak English (Kabranian-Melkonian, 2015). However, confidentiality concerns can arise when using interpreters from the same ethnic group, particularly if communities are small, and when discussing sensitive topics (e.g. domestic violence or sexual health) (Gartley & Due, 2016). All community participants were offered interpreters in whatever language they felt most comfortable speaking. However, no participants wished to have an interpreter. Two of the older Afghan women preferred to have their daughters interpret for them, and this may have impacted upon the answers to certain questions. For example, there may have been things that mothers did not want their daughters to know, or to hear about their experiences. Furthermore, given the topic of mental health, there may have been feelings of shame or stigma that resulted in these participants feeling uncomfortable about disclosing information in front of family members.

Ten service providers were also recruited from mental health services that specifically worked with refugee women in South Australia. The occupations of these participants included senior social worker (child protection), two social workers, two case managers, one general practitioner, and four bi-cultural workers.

4.3 Recruitment and access

A purposive sampling and snowball sampling of women from refugee backgrounds from two specific communities (South Sudanese and Afghan) was used in this research. Purposive sampling refers to the process of deliberately selecting individuals based on their particular knowledge of a shared or collective experience

(Morse & Field, 1995). Snowball sampling involved participants already recruited for the study recruiting other participants who they knew fitted the criteria for the target population (Bloch, 2007; Morse, 1989). Altogether, 30 participants were recruited for the research from three different groups.

Service provider participants were predominantly recruited through responses to emails and through existing contacts. Refugee participants were recruited through responses to posters and fliers distributed through education institutions, community centres, and other organisations. My volunteer work at the Emergency Relief Refugee and Migrant Centre run by Saint Vincent de Paul and The Australian Refugee Association assisted me to network and gain support from these organisations to facilitate recruitment through distributing fliers and posters. I also met with the African Women's Federation of South Australia and the Muslim Women's Association of South Australia and explained my study, and they distributed information to anyone who may be interested in participating.

Interested participants made contact with myself or my secondary supervisor via phonecall or email. Once participants had made contact, we set up a time to meet in a place that was most convenient for them. This was usually the participants' homes, a library, or a room at a university campus. The interviews with service providers took place at the service providers' workplaces, or over the phone.

The research data included information gathered from in-depth, semi-structured interviews (see Appendix F & G), and field notes. Data saturation, referring to the point at which no new data emerges through data collection (Morse, 2000), was reached in each participant group by 11 participants with women from the Afghan community, 9 participants with women from the South Sudanese community, and 10 service providers.

4.4 Interviews

In regard to the service provider group, an interview guide was used that included questions such as “What do you perceive to be barriers that your female clients face to seek help for mental health issues?”, “What do you perceive to be enablers and facilitators for your female clients to seek help for mental health issues?”, “What do you think is the biggest issue that your female clients face?”, “What challenges do you face working with your female clients?”, “What strengths do you see in your female clients?” and “How do you think services for your female clients could be improved?” (see Appendix G). Interview questions were developed by drawing on the findings of previous literature (e.g. Jewson, Lamaro, Crisp, Hanna & Taket, 2015; Prosselt, McDonald, Procter, de Crespigny & Galletly, 2017; De Maio, Silbert, Stathopoulous, Rioseco, Jenkinson & Edwards, 2017) and identifying a lack of studies focusing on women with refugee backgrounds.

In regard to the two participant groups of women with refugee backgrounds, an interview guide was used that included questions such as “What do you think are some of the difficulties that women face in your community?”, “When women in your community feel unhappy how do they get help?”, “What kind of things might stop women from getting help in your community?”, and “What keeps women in your community strong?”. These guides served as an *aide memoire*, and participants predominantly guided interviews facilitated by prompts (see Appendix F). Interview questions were developed by initially considering literature in the field of barriers to help-seeking (e.g. Drummond et al., 2011; Ellis et al., 2010; Colucci, Minas, Szwarc, Paxton & Guerra 2012; O’Mahony & Donnelly, 2013) and identifying the need for further exploration with women from refugee backgrounds. Following this, consultations were had regarding the relevance, importance, and wording of interview questions with community leaders and bi-cultural workers from each community. Following initial interviews with participants, I consulted once more with a South Sudanese female community leader and bi-cultural worker who worked with Afghan clients in order to add questions to reflect participants' priorities (in this case, resettlement challenges, experiences of domestic violence, and experiences of racism).

Tables were constructed to represent how research questions were answered and interview questions were developed (see Appendix I & J) drawing on Castillo-Montoya's (2016) Interview Protocol Refinement Framework. These tables demonstrated the relationship between the research agenda and purpose, the research questions, and the subsequent development of the interview guide for both service provider and refugee populations (Castillo-Montoya, 2016).

Interview questions were reviewed following each interview and adapted in some cases, especially at the beginning of the study, following consultation with community leaders (McGrath, Palmgren & Liljedahl, 2018). For example, when participants discussed issues of racism throughout the initial interviews with South Sudanese participants, I discussed this with a community leader and added a question specifically asking about experiences of racism (see Appendix F).

Idioms of distress, for example "thinking too much", instead of rigid psychiatric or medical language were used during interviews, as they have been shown to be used across all major world regions (Kaiser et al., 2015). In response to these challenges as well as the identified issues regarding applying mental health literacy cross-culturally, I avoided the professional definitions of mental disorders, as they may have limited validity in certain populations when working cross-culturally (referred to as the category fallacy by Kleinman, (1987)).

4.5 Method of data collection

Semi-structured, in-depth interviews were used as the method of data collection to explore help-seeking for mental health services, and resettlement challenges and stressors. This method of data collection was selected, as in-depth interviews allow a detailed exploration of participants' experiences, perspectives, thoughts and behaviours (Boyce & Neale, 2006; McGrath et al., 2018). This method also lends itself well to giving voice to minority groups (Reeves et al., 2015). Face-to-face interviews with participants allowed them the opportunity to thoroughly describe their experiences and tell their stories in detail.

All interviews were audio-recorded with the consent of participants. In some cases, the participants had young children or babies present in their homes. Breaks were taken at times throughout the interviews for mothers to attend to their children, or if participants became upset or overwhelmed with emotion whilst telling their story. If this happened, all participants were given the opportunity to end the interview or withdraw from the study, but this did not occur in any of the interviews. Following a brief period of time, participants resumed the interview. At the beginning of each interview contacts were given to participants for counselling and support services (see Appendix D), and these were reiterated at the end of an interview, particularly when participants became emotionally distressed.

Interviews were conducted between October 2016-May 2017. At the beginning of each interview I explained the project, spoke about why I was interested and passionate about the issues, and discussed consent to participate in the study. In regard to informed consent, I explained the nature of the questions that would be asked, gave an estimate of the duration time of the interview, gave information regarding confidentiality, and explained how the interview data would be used. I also gave participants opportunity to ask me questions before the interviews began. Interviews started with socio-demographic questions and then progressed to the interview guide. Each participant was interviewed once, except for one female community leader who participated in a second interview along with another female community leader. In this case I had interviewed one woman independently, and she then invited her friend to her house on a second occasion to speak with me. The two women expressed that they both wished to speak with me together, as they had come to Australia together and had many shared experiences and opinions regarding the interview topic.

The duration of interviews was approximately 60-90 minutes. The length of the interview was predominantly determined by the participants, with an open-ended question at the end inviting participants to share any further stories, thoughts, or comments. At the conclusion of the interview a $20 shopping voicher was given to participants from the two community groups, as well as a thank-you letter to all groups (see Appendix H).

Once interviews had been transcribed, member reflections (Tracy & Hinrichs, 2017), an alternative method of member checking (Creswell, 2007; Braun & Clarke, 2013), were attempted. Member checking refers to taking back the findings to the participant to check or determine the accuracy of initial qualitative findings (Creswell, 2007; Braun & Clarke, 2013). Instead of member checking, I used member reflections, as this was more in line with a CBPR approach because it involved active participation from members of the community (Tracy & Hinrichs, 2017). Member reflections were deemed particularly important due to the position of the project in relation to "giving voice" to participants' experiences. Specifically, I wanted to ensure that there was overall a good fit between my initial interpretations and the representation of the participants' experiences. The process of gaining members' reflections was done by emailing participants copies of their transcripts and initial interpretations of the data and inviting them to meet for a second brief interview and discussion. Overall, members from both participant groups stated that they had been represented well. However, it was difficult to ascertain whether this was the case for both populations, as only two participants (South Sudanese women) requested to meet to discuss the data, with other participants responding to emails. It would have been ideal to be able to discuss the findings with each participant in order to gauge that they truly felt that they had been represented accurately, but again, it was decided that respecting participants' wishes superseded the researcher-led agenda of needing to member check all participants.

4.6 Data coding, analysis and interpretation

The interviews were audio-recorded and then transcribed verbatim as soon as possible following the interview, using a "Jeffersonian Lite" transcription method. I also recorded any significant thoughts or observations that I had throughout the interview. To ensure accuracy following initial transcription, interview recordings were listened to again and checked against the transcripts. Throughout the data collection process as well as throughout the analysis, I would revisit the audio recordings to gain a deeper level of understanding. I also found this to be a helpful and powerful way to fully comprehend the participants' complex narratives and experiences.

Thematic analysis (Braun & Clarke, 2006) was used to analyse the data. Thematic analysis refers to a method to identify, analyse, and report patterns or themes within data (Braun & Clark, 2006). Thematic analysis was used as a "contextualist" method (Braun & Clark, 2006), as it was characterised by the theory of critical realism (Willig, 1999). In this sense, thematic analysis was used to explore the ways that individuals made meaning out of their experiences and also the way that the social context within which they lived impacted upon that meaning.

As the data was being collected, I recorded my initial impressions and thoughts regarding codes and themes. As I reached saturation in each participant group, from listening to the audio-recorded interviews I coded the transcripts and formulated a list of code categories to organise the data.

According to Boyatzis, (1998, p.1) a “good code” captures the qualitative richness of the phenomenon. Research questions guided the formulation of interview questions, but after the data was generated, I took an inductive approach to coding. The coding process involved recognising important points in the data and coding them before interpretation (Boyatzis, 1998). The identified codes were refined as more data was collected, and these codes helped to determine when I had reached saturation. The research process was not linear, but instead reflexive and iterative (Tobin & Begley, 2004), involving frequent re-reading of previous stages of analysis and re-listening to audio-recordings of interviews. There was significant overlap between codes, and data in certain codes were often seen as interconnected to, and relevant for, other code categories. I had regular supervision meetings throughout the data collection and analysis stage, which I found helpful to reflect upon the interviews, including my own emotions and initial thoughts regarding themes and codes.

The interpretation of the codes and themes was conducted by a process of reading and re-reading, as well as reference to relevant literature and discussion with my supervisors. Once the coding was complete, the data was examined and compared within and across transcripts in order to highlight any differences or commonalities across code categories. Again, it was observed that many codes were inter-related and interconnected, especially for the two community groups (South Sudanese and Afghan), and this is discussed in the results and discussion sections.

A theme was considered a theme if it was patterned within the dataset and it captured something important about the data in relation to the research question (Braun & Clarke, 2006). Boyatzis (1998) has defined a theme as “a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon” (p. 161).

4.7 Ethical considerations

Ethical approval was obtained by the University of Adelaide Human Research Ethics Committee (H-2016-130), as well as the Royal Adelaide Hospital Human Research Ethics Committee (HREC/17/RAH/114) and the Central Adelaide Local Health Network (R20170309).

Numerous ethical considerations have been raised when conducting research with people from refugee and asylum seeker backgrounds (Birman, 2006; Block, Warr, Gibbs & Riggs., 2012; Carter et al., 2013; Liamputtong, 2010). People with refugee and asylum seeker backgrounds have been classified as a hard-to-reach, “vulnerable” population (Liamputtong, 2010). Accordingly, research must be designed and conducted in a way that empowers, respects, and “does no harm” to communities (Kia-Keating, Yusuf, Lincoln & Nur, 2007; Hugman, Pittaway & Bartolomei., 2011).

Beattie & VandenBosch (2007) highlighted important factors in preparation for working with vulnerable populations, including: a) knowledge of the population; b) knowledge of other research with the population, in particular research that has been problematic; c) appreciation of multiple vulnerabilities and being prepared in advance for issues regarding recruitment and retention of participants; d) identifying and building strong relationships with key members of the group to understand norms and assist with problem-solving issues related to the research process. These factors overall align with the CBPR approach and were factors that I took into consideration when selecting the populations with which I would conduct the research.

Indeed, participatory research methods have been championed as best suited for working with refugee populations, as researchers work collaboratively with community leaders and members throughout all stages of research design (Hugman et al., 2011; Hanza et al. 2016; Due, Riggs & Augoustinos, 2014; Higginbottom & Liamputtong, 2015). Close community collaboration is necessary to ensure that research results are valid, and that community understandings of constructs such as mental health are taken into account (Pittaway & Bartolomei, 2003; Ellis et al., 2007; Hugman et al., 2011; Ziersch, Due, Arthurson & Loehr, 2017).

Participatory research methodologies enable trust to be developed, encourage knowledge translation, incorporate community perspectives into the research, ensure cultural relevancy, work to reduce power imbalances, and promote social justice (Wallerstein & Duran, 2006; Ziersch et al., 2017; Pittaway & Bartolomei, 2003). A community-based participatory research approach was drawn upon for this study’s research design (Hacker, 2013). Efforts were made to provide comprehensive information regarding the research design, methodology and data collection process to maintain transparency regarding the research process (Jacobsen & Landau, 2003).

Throughout the research, I was aware and mindful about the extent to which I became involved in participants’ lives, (Vervliet, Vanobbergen, Broekaert & Derluyn, 2015) as this can lead to confusion of the researcher’s role, resulting in challenges at both a personal level and within the research itself (Ziersch et al., 2017; Due et al., 2014; Verviet et al., 2015). Clear protocols and referral pathways for participants were established at the beginning of the research process, so that there were clear guidelines to follow if participants become distressed or re-traumatised by interview questions (Ziersch et al., 2017).

Many people from refugee backgrounds may be hesitant to sign consent forms due to previous negative experiences with authorities, or signing documents (Liamputtong, 2010; Kabranian-Melkonian, 2015). Participants should be given the opportunity to provide ongoing consent and be able to withdraw at any time (Mackenzie et al., 2007). Furthermore, the ability to give informed consent may be influenced by power relations between the researcher and participants.

Free and informed consent preceded all interviews. Each participant was given a full explanation of the study and their rights, as well as information for further support if they became distressed during or following the interview. Some participants may not understand that participation is voluntary (Ellis et al., 2007), and participants from more collectivist cultures may be reluctant to decline their participation in order to benefit their broader community (Ellis et al., 2007). Every effort was made to ensure that the participants were aware that they could withdraw from the study voluntarily and were not obliged to respond to any questions that they felt uncomfortable answering or found distressing during the interview.

Participants were asked to give informed consent by signing a form after the study information was provided, and after I was confident that the participant had understood the implications of participating in the study. A copy of the consent form and information sheet was given to each participant.

Recording interviews with voice recorders may also prove difficult for some participants, as they may be concerned that what they disclose will be held against them. Thus, I had to balance being able to report participant’s experiences authentically, and the need to respect and respond to reluctance about being recorded (Ziersch et al., 2017).

Individual interviews were recorded with participant permission and occasional notes were taken. Given that the communities that I worked with were small, it was important that I ensured the anonymity and confidentiality of each participant. Anonymity was protected by using a pseudonym and code to identify participants within the data, and storing all information, consent forms, recordings, and transcribed data in a locked cabinet, or in a locked and password-protected computer, both of which were in a locked office at the university. At the completion of the study all final reports do not include identifying information. Audio recordings will be destroyed seven years after the completion of the study.

Building rapport and trust with communities is an essential stage in the research process. Not only do relationships with community leaders and members enable access to participants, but they also provide crucial cultural information about social norms and rules (Ziersch et al., 2017). Careful attention must be paid to the relationships between different ethnic or language groups within communities (Lee, Sulaiman-Hill & Thompson, 2014), especially if there is ongoing political tension in the country of origin.

I already had a pre-existing relationship with a community leader from the South Sudanese community who initially approached me expressing interest regarding research in mental health with his community. Once my supervisors and I had decided upon the populations to work with, I familiarised myself further with the historical, social, political, and economic situations that each community faced. I also sought guidance from people that worked with these communities, including the African Women’s Federation of South Australia and the Muslim Women’s

Association of South Australia. I was conscious of the fact that social, economic, migration, and political difficulties may exist, and to address this I paid careful attention to the ways in which interactions occurred, including body language, tone of voice, and even physical positioning within the interview space. For most interviews I followed the lead of the participant and sat with them either on the floor or on couches in their living rooms or at tables in their kitchens.

I was attentive to the fact that some of the topics we discussed and the stories that women told covered sensitive issues which may be distressing. Many women expressed that they found telling their stories and discussing the issues raised in the interview to be satisfying, empowering, or that it made them feel good to be heard. In an effort to balance the power dynamic between researcher and participant, I spent time drinking tea and having conversations before beginning interviews, I sat at the same level as the participant (e.g. on the floor), and wore casual, conservative clothes.

Chapter 5. Study 1

5.1 Help-seeking for mental health services among Afghan women from refugee backgrounds in South Australia

Study 1 explored barriers to help-seeking and resettlement stressors for women with refugee backgrounds from Afghanistan. This was the first of two studies (with women from Afghanistan and South Sudan) exploring help-seeking and resettlement stressors with community members. Interviews with women from both communities were conducted between October 2016 and May 2017, with most of the interviews with Afghan participants occurring between October 2016-February 2017. Following Study 1, Study 2 - conducted with women from the South Sudanese community - is presented in Chapter 6.

This study is under review with the *The Australian Community Psychologist.* The paper is presented here with the same typeset as the rest of the thesis.

Statement of Authorship

Title of Paper: Help-seeking for mental health services among Afghan women from refugee backgrounds in South Australia

Publication status: under review

Principal Author

Name of Principal Author (Candidate): Rose Burford-Rice

Contribution to the paper: Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data analysis. Drafted, wrote and submistted article, then revised and responded to reviewer comments. Acted as corresponding author.

Overall percentage(%): 80%

Certification: This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.

Signed: Date: 28/01/2020

Co-authors

By signing the Statement of Authorship, each author certifies that:

i. The candidate's stated contribution to the publication is accurate (as detailed above);

ii. Permission is granted for the candidate in include the publication in the thesis; and

iii. The sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author: Professor Martha Augoustinos

Contribution to the Paper: Input regarding study design and sampling. Supervised development of the work and input regarding analysis of data. Provided guidance on the preparation of manuscript and editorial and structural feedback on the paper.

Signature: Date: 28/01/2020

Name of Co-Author: Dr. Clemence Due

Contribution to the Paper: Input regarding study design and sampling. Supervised development of the work and input regarding analysis of data. Provided guidance on the preparation of manuscript and editorial and structural feedback on the paper.

Signature: Date: 28.1.2020

There are currently over 25.9 million people currently classified as refugees, who have been forced to leave their home countries due to persecution or conflict (UNHCR, 2019). Of these, approximately 2.7 million have fled Afghanistan, most recently as a result of years of conflict (UNHCR, 2019), including the Soviet-Afghan war during the 1980s, civil war, invasion by the United States, and current political instability. In particular, the Shi-ite Hazara minority have endured increased levels of violence during the theocratic rule of the Taliban from 1996-2001 (Saikal, 2012), and over 13,000 people from a Hazara background have resettled in Australia between 2010 and 2014 (more recent figures unavailable; Department of Social Services, 2014). Although people with refugee or asylum seeking backgrounds often show extraordinary strength and resilience in the face of extreme adversity (Hutchinson & Dorsett, 2012), meta-analytic studies suggest that refugee populations suffer poorer mental health status when compared with other groups of migrants and the general populations of Western and non-Western host countries (Porter & Haslam, 2005; Fazel, Wheeler, Danesh, 2005; Lindert, Ehrenstein, Priebe, Mielck, Brahler, 2009; Kirmayer et al. 2011). Although few studies have assessed mental health outcomes among Afghan refugees resettled in Western countries specifically, of those that have, results consistently suggest high levels of mental health disorders, ranging from 25.4-35% for Post-Traumatic Stress Disorder (PTSD) and 54.7-57% for depression (Gernaat, Malwand, Laban, Komproe, de Jong, 2002; Gerritsen et al., 2006). A recent Australian study found that 44% of a sample of 150 Afghan refugees presented with clinically significant PTSD symptoms, and 14.7% had symptoms of depression (Slewa-Younan et al. 2017).

Poor mental health outcomes amongst refugee populations more generally have been linked to pre-migration trauma (including torture, loss of family members, witnessing or participating in conflict, and imprisonment) as well as post-migration stressors (adjusting to a new culture, racism and discrimination, resettlement stress, and loss of social support) (Porter & Haslam, 2005; Alemi et al., 2014). A recent meta-analysis of Afghan refugees' mental distress supports these findings (Alemi et al., 2014). Women may be at particular risk of psychological distress due to extra risks they face on their journey to a resettlement country, including sexual violence, rape, unwanted pregnancies, harassment, health issues, and separation from children and loved ones (Kastrup, 2006). In addition, many Afghan women have experienced human rights violations under the Taliban regime (Scholte et al. 2004), with one cross-sectional survey finding that Afghan women living in Kabul or refugee camps during the Taliban rule in 1998 reported significant symptoms of major depression (97%), and anxiety (86%) (Rasekh, Bauer, Manos & Iacopino, 1998). After arrival in a resettlement country, mental health issues may be heightened due to the erosion of traditional and cultural values within the family and the negotiation of gender and social roles in host countries, particularly among elderly women (Alemi et al. 2014). Previous research has suggested that refugees from war-affected countries may suffer from mental health issues years after resettlement, and that this may be compounded by post-migration socio-economic factors (Bogic et al., 2015). A study with 150 Afghan refugees who had lived in Australia for a mean of approximately 6 years revealed that 44% of participants suffered from significant PTSD symptoms, and 14.7% had significant symptoms of depression (Slewa-Younan et al., 2017).

Despite the well-known high levels of psychological distress in refugees and asylum seekers, these populations are significantly underrepresented in relation to the utilization of mental health services in resettlement countries such as Australia (Minas et al., 2013; Posselt, McDonald, Procter, de Crespigny & Galletly, 2017). Although there is a growing body of literature addressing health and mental health service utilisation by non-English speaking people and immigrants (McDonald & Steel, 1997; Trauer, 1995, Bruxner, Burvill, Fazio & Febbo, 1997; Hassett & George, 2002; Boufous, Silove, Bauman & Steel, 2005), few Australian studies have specifically investigated contributory reasons behind the apparent low up-take of mental health services in culturally diverse refugee communities. This gap warrants an examination of community factors influencing help-seeking behaviours and uptake of services. Help-seeking behaviours have been defined as “any communication about a problem which is directed toward obtaining support, advice or assistance in times of distress” (Gourash, 1978, p. 413). This is particularly important, since previous research has identified low rates of help-seeking amongst people with refugee backgrounds in resettlement countries such as Australia (Kayrouz et al., 2015), including refugees from Afghanistan living in South Australia (Slewa-Younan, 2017)

In a systematic review of the literature concerning the impact of primary health care delivery for refugees in resettlement countries, Joshi et al. (2013) identified strategies that improved access to services, which included using teams of multidisciplinary staff, use of interpreters, outreach services, free transport to appointments, more generous consultation times, and gender-sensitive health providers. In regard to refugee populations, some identified barriers to help-seeking for mental health services in the literature include lack of services that take into account cultural knowledge and healing (Ellis et al., 2010), discordant health beliefs and divergent expectations of healthcare systems (Pavlish, Noor & Brandt, 2010), difficulties regarding interpreters, lack of trust of services (Colucci et al., 2012), language difficulties (Colucci et al., 2015; Sheikh-Mohammed et al., 2006; Franks, Gawn & Bowden, 2007), and institutional racism (Fernando, 2017). Specifically, for Muslim immigrants, identified barriers include social stigma surrounding mental health problems and cultural mistrust of mental health workers (Amri & Bemak, 2012). Identified barriers to help-seeking among immigrant and refugee women include gender hierarchies within the family and relationship dominance, as well as precarious visa status (O'Mahony & Donnelly, 2013). Specifically, for Afghan women with refugee backgrounds, lack of awareness of services, husbands as gatekeepers, access to interpreters (Rintoul, 2010), and low mental health literacy (Yaser et al., 2016) have been identified as potential barriers. Only minimal research thus far has examined how cultural beliefs and culturally-specific concepts of mental illness may affect help-seeking in this population.

Using qualitative research methods, this study will explore the use of mental health services within the Hazara refugee community in South Australia, with a focus on women. Specifically, it aims to: 1) contribute to the literature concerning culturally specific knowledge about conceptualizations of mental health within this population, 2) explore preferred strategies for coping with mental health problems, 3) explore perceived efficacy of Australian mental health services, and 4) better understand and recognise barriers to help-seeking behaviours.

Theoretical perspective

Andersen's model of health service utilisation was used in this study as an interpretive lens to examine any social inequalities in access to health services. The model addresses the concern that minority groups may receive less health care provision compared to the rest of a population (Andersen & Newman, 1973). It conceptualises access to services as a result of decisions made by the individual, which are constrained by their position in society and the subsequent level of accessibility and availability of health services (Andersen, 1995; Andersen & Davidson, 2007).

According to this model, an individual’s likelihood of access to health services is considered to be a function of three individual and contextual characteristics. ***Predisposing factors*** are socio-cultural characteristics that include demographic factors, social structure, and health beliefs. Social characteristics include how supportive the community is towards health and access to health services, educational level, ethnicity, employment level, and crime rate, as these are existing conditions that predispose people to engage or disengage from service use (Andersen, 1995). ***Enabling factors*** are the logistical aspects of obtaining care, including whether an individual has a regular source of care, ability to transport oneself, health insurance, and knowledge of health care services. It also includes whether there are available health facilities within their community (Andersen, 1995).

Need factors include functional or health issues that promote the need for access to health care (e.g. level of discomfort of symptoms). Need factors are considered the most immediate cause of service and are the conditions that laypeople recognise as requiring healthcare (Andersen, 1995).

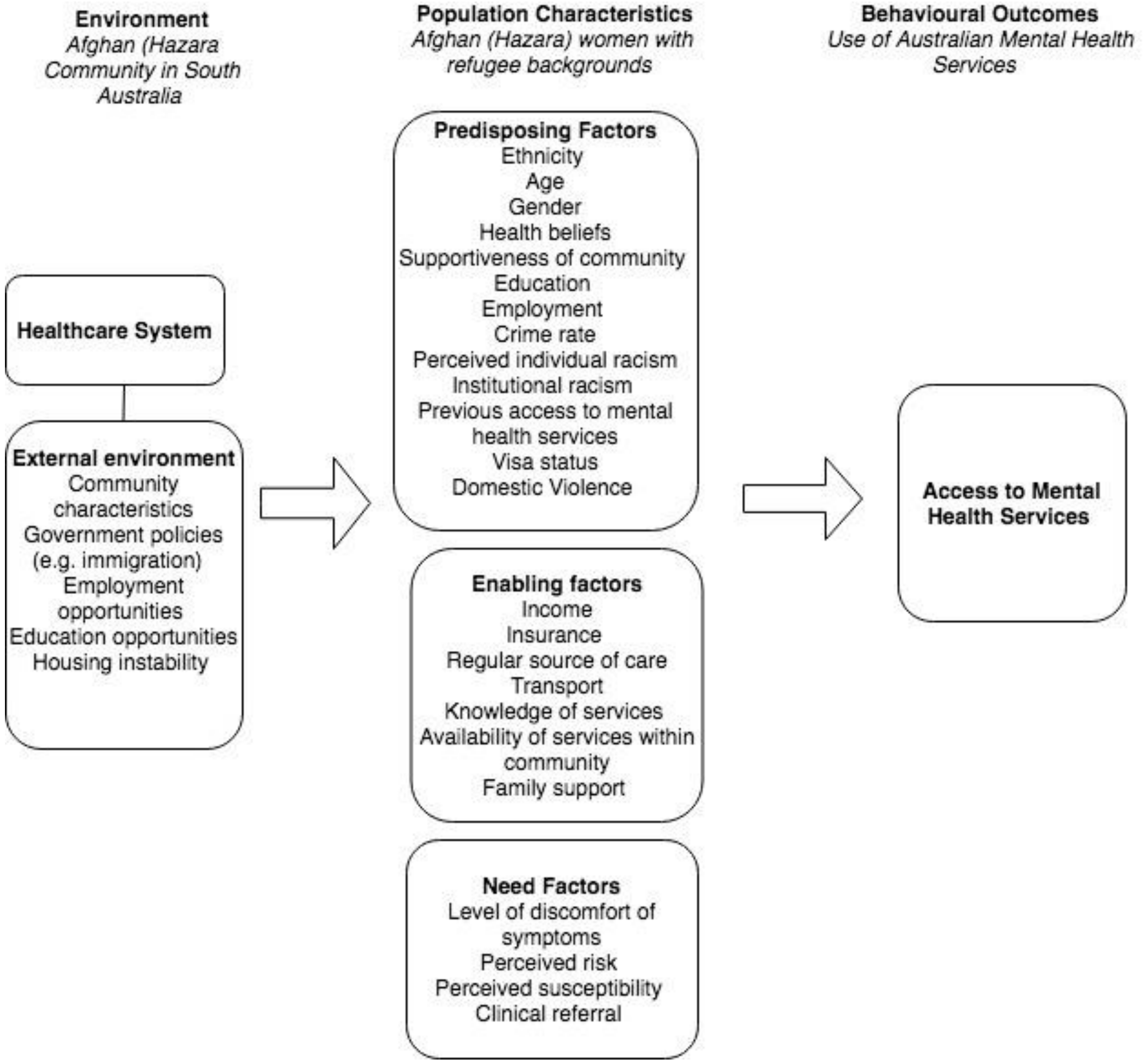

Figure 1: Adapted version of Andersen's Model of Health Service Utilisation (Andersen, 1995)

The model has been employed as a theoretical basis for studies investigating health-seeking behaviours in refugee populations by numerous international researchers (Ruiz-Rodriguez et al., 2006; Portes, Kyle & Eaton, 1992; Seagal & Elliott, 2012). However, there are as yet no Australian studies that use the Andersen model to consider barriers to mental health services for Afghan women from refugee backgrounds.

Method

Participants

Participants for this study were 11 Hazara women with refugee backgrounds from the Afghan community who lived in Adelaide, South Australia. Participants were recruited through responses to posters and fliers (in English and Dari) distributed around South Australian universities, a Technical and Further Education institute (TAFESA), community centres, and organisations. A combination of convenience and snowball sampling was used to maximise participation. Eligible participants had to have been in Australia for more than three months to ensure some level of familiarity with the Australian health care system, and be over the age of 18. It was not a requirement for participants to speak English, as interpreters were offered in whatever language women felt most comfortable speaking. The mean age of participants was 30 years, and the mean length of time spent in Australia was 6.8 years.

Table 1: Participant demographic information

Pseudonym	**Age**	**Visa Status**	**Time spent in Australia**	**Language**	**Occupation**
Parisa	30	Temporary Protection Visa (785)	4 years	Hazaragi, English	Student
Laila	18	Permanent Protection Visa (866)	4 years	Dari, English	Student
Jamilah	59	Permanent Protection Visa (866)	4 years	Dari	Unemployed (Stay at home mother)
Qamar	31	Woman at risk visa (204)	4 years	Dari, English	Student
Naila	60	Woman at	4 years	Dari	Unemployed

		risk visa (204)			(Stay at home mother)
Giti	23	Permanent Protection Visa (866)	9 years	Dari, Urdu, Hindi, English	Student
Mahlia	32	Australian Citizen	11 years	Dari, Hazaragi, Urdu, English	Student and childcare worker
Saba	21	Australian Citizen	10 years	Dari, Irani, Hindi, English	Student
Rana	20	Refugee Visa (200)	5 months	Dari and Persian	Student
Lila	18	Australian Citizen	16 years	Dari and English	Student
Azadah	18	Australian Citizen	9 years	Hazaragi, Urdu, English	Student

Ethical considerations

Refugees and asylum seekers have been classified as a hard-to-reach, “vulnerable” population (Liamputtong, 2010). Accordingly, research must be designed and conducted in a way that empowers, respects, and “does no harm” to communities (Birman, 2006; Block et al., 2012; Ellis, Kia-Keating, Yusuf, Lincoln & Nur, 2007; Hugman et al., 2011; Ziaian et al., 2018).

In the current study, women were recruited from multiple institutional and community sources, creating multiple starting points from which to snowball in order to ensure a diverse sample (Bloch, 2007). Moreover, clear protocols and referral pathways for participants were established at the beginning of the research process so that there were guidelines to follow if participants became distressed or re-traumatised by interview questions (Ziersch, Due, Arthurson, & Loehr, 2017).

It was made clear to participants that participation was voluntary (Mackenzie et al., 2007), as those from more collectivist cultures may be reluctant to decline their participation in order to benefit their broader community (Ellis et al., 2007). In an effort to balance the power dynamic between researcher and participant, and to build rapport, author RBR spent time having casual conversations before beginning the interview (Mackenzie et al. 2007). Quotations used in this paper have been stripped of identifying information, and pseudonyms were used. All field notes, audio files, and audit trails were kept on a password-protected computer in a locked room at the university.

Procedure

Qualitative, semi-structured, face-to-face interviews were conducted between October 2016 and May 2017 by the first author. On average, interviews lasted 60 minutes and were conducted at locations that were convenient for the participants. A $20 shopping voucher was gifted to each participant upon completion of the interview in appreciation of their time. Written consent was obtained from each participant. The project was approved by The University of Adelaide Ethics Committee (H-2016-130).

Initially, efforts were made to recruit female community leaders in order to triangulate the data. However, it proved difficult to find women who identified as community leaders. Instead, two female Afghan bi-cultural workers were consulted to formulate research questions and provide relevant cultural information. Of the community-member participants, nine had a competent level of English, and two women did not speak English. The two women who could not speak English were offered professional interpreters but preferred to have a female family member interpret for them.

Interviews

An interview guide was used that included questions such as "What do you think are some of the difficulties that women face in your community?", "When women in your community feel unhappy how do they get help?", and "What kind of things might stop women from getting help in your community?". This guide served as an aide memoire, and participants predominantly guided interviews, facilitated by prompts from the first author.

Data Analysis

Braun & Clarke's (2013) six-stage thematic analysis was used to analyse transcripts verbatim. After familiarization with the data, interviews were initially inductively coded. Codes related to factors contributing to mental distress and barriers to help-seeking were sorted into themes and codes for barriers to help-seeking; these were condensed into two broad, overarching themes. The codes within these themes were then deductively analysed using Andersen's model, and identified as either "predisposing", "enabling", and "need" factors, with discussion provided about this categorization throughout each of the inductively identified themes.

Overall, two main themes were identified, and within these, multiple sub-themes were described. The overarching theme of "social & cultural" factors includes the sub-themes: stigma, cultural conceptualisations, racism, domestic violence, husband as gatekeeper, and informal help-seeking preferences. The overarching theme of "structural & organizational" factors includes the sub-themes: lack of knowledge of services/lack of appropriate services, English language proficiency, financial concerns, and transportation problems. Many of these sub-themes and themes interacted with each other and are presented in a way that reflects their importance as identified by participants in interviews.

Although participants in this study identified factors such as financial constraints, lack of transport, mental health literacy, and lack of knowledge of services as barriers to service access, these have been well-documented in previous literature (Colucci et al., 2012; Sheikh-Mohammed et al., 2006; World Health Organization, 2018; Franks et al., 2007; Chuah, Teng Tan, Teo & Legido-Quigley, 2018). Therefore, this paper will focus on the more unique findings of this study: specifically, social and cultural barriers to help-seeking for mental health services for Afghan women with refugee backgrounds.

Findings and Discussion

Social and cultural barriers to help-seeking

Theme 1: Stigma. Family reputation was described as highly valued in Afghan culture, with women responsible for caring for her children and husband. As a result, a woman's reputation also reflects her family's reputation within the community. If a woman is perceived to be derelict in fulfilling her role, she may be at risk of social disapproval, often in the form of gossip. We can see how Afghan women oriented to this concern in the following extracts.

> They will think oh if everyone else in the community finds out, what will they say about me? […] our family will have a bad image […] the question is what will people say? […] How will the community react to my condition, or to my health issues – Azadah (18 years)

> [if a]woman has serious mental issues they end up not to share it in public because it is good that it is confidential because it would be a fun stuff for them like spread out […] the family don't appreciate to share it out so they just keep it within the house –Mahlia (32 years)

Expressing personal problems may be detrimental not only to a woman’s social status, but also that of her husband and children. Participants reported not wishing to cause undue stress for their children, or not wanting to be a burden on other family members due to the stigma and social repercussions that may ensue from seeking help for their mental health concerns. In these accounts, a woman’s identity is equated with that of the family’s – they are intricately linked. This may cause a woman to reconsider seeking help, as it risks reflecting poorly upon her family members. For example:

> ….other people will not blame that girl, they will blame the family.[…] that’s the thing that stops people to go to any service or anywhere to help them. – Parisa (30 years)

Having a mental health issue and seeking help from a professional may be viewed as controversial within the community, as it would probably involve discussing family matters or marital issues. Fear of the social consequences thus prevent women from seeking help.

> They will think that if they go to any service for help, other people will think wrong about her and her reputation will be very bad in my community. For example, if people see that this woman is going to the other service they will think why she going? Is she mad? […] people backbiting about her. That’s the reason to stop women from going to any service. – Parisa (30 years)

Theme 2: Cultural conceptualisations of mental health. In addition, and sometimes contributing to stigma, were cultural understandings of mental health, with age playing a role in these understandings. In particular, participants reported that older women in their community thought the act of visiting a psychologist was extreme, and that a person would have to be "mad" or "crazy" to do so, again reflecting the stigma often associated with understandings of mental health.

> Afghani people talk "if you go to the psychologist" the Afghani people say "you are mad, you are crazy" and maybe they can't make friend with you […] if my mother go there people said my mother is nuts or crazy and the meaning of crazy and mad in my culture is very bad.[…] the psychologists has very bad name in my culture – Rana (20 years)

> You know in my country some people are going to mental health they say oh this is crazy because mental health is just for crazy people and their brain is not working. – Qamar (31 years)

Such beliefs are predisposing factors (Andersen, 1995) and discourage women from engaging with professional services. Cultural conceptualisations of people with mental health issues as "mad" or "crazy" serve to discourage help-seeking behavior, as also reflected in the previous section concerning stigma.

While younger women reported that mental illness was seen in a negative light in their community, they noted that views on mental health within their generation were gradually changing. This was predominantly due to younger women in the community growing up in Australia and receiving education about mental health, as well as forming support networks within the broader Australian population. These younger women were more likely to have knowledge about confidential services that were available to them if they needed mental health support. Consequently, these experiences served to lessen the impact of mental health stigma within the community.

> I don't think I would care about what the community thinks because in this generation no one really cares anymore, in this younger generation […]The longer you stay here, or the more educated you are, you'll think that way. But it also depends on the family you come from so if you're a bit more uneducated or if your family isn't as open minded, maybe you won't be willing to talk about it –Azadah (18 years)

Finally, in relation to cultural understandings of mental health, it was noteworthy that some women reported that mental health issues may be conceptualized as contagious, and that those who physically exhibited symptoms may be isolated.

> …they think like if this person has a mental health tomorrow I will I get in the same situation, […] like I get mental health tomorrow, so they think like that. Sort of like flu you know. – Lila (18 years)

Mental distress was often related to physical symptoms such as headaches. Medical treatment was reported as being a preferred treatment for some women rather than talking therapies or counselling.

> In Afghanistan […] they will say oh I’m not feeling well, I’m sick, I’m headache I need someone to talk to they will say oh you’re okay take this medicine you will be okay. Like even they don’t know what the medicine is, they have to take it –Parisa (30 years)

These reports are consistent with previous literature that highlight the frequency of refugee women in general (Kastrup, 2006), and specifically Afghan women resettled in Australia (Rintoul, 2010), presenting with emotional distress that manifests as non-specific somatic complaints such as headaches and pain.

As these participants’ accounts demonstrate, health beliefs and supportiveness of the community towards access to health services are predisposing factors for service use (Andersen, 1995). Thus, women who share these underlying values, beliefs, and sense of stigma towards mental health care may be less likely to access mental health services from the professional sector.

Theme 3: Racism A common theme throughout interviews was how negative depictions of people of Islamic faith, or reports of overt displays of racism towards Muslims in the Australian media impacted upon women from the Afghan community.

One participant reflected upon how recent global events (in this case referencing the 2017 Westminster attack in London) was impacting upon the collective treatment of Muslims in Australia.

> There is a lot of conflicts happening because of Islam and in the name of Islam it’s not because of Islam and I would say the Australian system has been taking it a little hard on Muslims. – Mahlia (32 years)

One participant highlighted the overt racist treatment portrayed in the media of a Muslim woman despite the fact that she was an Australian citizen.

> I hear on the news that Muslim lady has been targeted, her scarf has been ripped off of her head, there’s people on the bus saying get out of this country, where they’re a part of the country – they’re a citizen of this country or they were born into this country. – Azadah (18 years)

Similarly to Mahlia, Azadah demonstrates her awareness of the pervasive stereotypes associated with her identity as a Muslim woman and the real risks that she faces of experiences of racism in Australia.

Consistent with previous studies indicateing that perceived racism is negatively correlated with intentions to seek help for mental health concerns (Kim, Kendall & Chang, 2016; Mosley, 2014), one participant described the impact that media representations may have upon people from her community accessing services.

> oh sorry I can’t go (to a service) because they might think wrong about me cos of what they heard about me, cos of what they heard in the media that might affect us. Saying like we can’t help you because you are from the Muslim or from that group of people. You know? They might be racist to you and harass you – Saba (21 years)

Theme 4: Domestic Violence. Women spoke about violence towards women that occurred in Afghanistan as a factor that causes mental health issues for many community members. Importantly, domestic violence (or violence more generally) was not initially mentioned explicitly in interview questions; however, violence was often brought up spontaneously by participants when asked what the most significant issues for women were, or what would stop a woman from seeking help.

> In my country the way that they experience is probably cos abusement and violent and mens there they don't care about if you get […] killed in general. Or if you get […] a disease or a mental health problem, they just don't care about you. So whatever they do to you is like pleasure for themselves, it's different cos most of those mental health problems are from abusement and from hitting– Saba (21 years)

Questions relating to domestic violence were added to interviews after these issues were raised in the first two interviews following consultation with a bi-cultural worker. Previous research indicates that gender-based violence is not uncommon in Afghanistan, with studies of women in shelters in Kabul identifying experiences such as being subjected to violence when attempting to leave abusive relationships, inability to leave the house without male supervision, forced virginity exams, and threats of honour killing (Stokes, Seritan & Miller, 2016). Participants in the current study related psychological distress to experiences of violence that occurred in Afghanistan. Many of these accounts also point to the cultural differences and change in gender roles that women experienced in Australia.

> …they were treated really badly like they would be violent, they would be hitting them. Try to fight with them. So we had no quality as womens […] there was no actual value for womens as here cos here we are same as men, we have the same rights whereas they have no rights. You cannot be standing next to a man’s right. You’ll be always down, you’ll be always second. So we had nothing there like women were valued as nothing. They were just valued as something like an item, whenever they like to use it they use it, when they are done with it they just throw it away or trash it. – Saba (21 years)

Experiences of domestic violence and associated mental health issues were spoken about as something that many women were expected to endure and remain silent about.

> If they are facing domestic violence, they will keep with themselves, they will not go for help to go to the police, to go to the doctor or any other service that will help them, they will never go. […] if something happened to my mum she would never raise her voice because she has grown up in that environment – like you are brainwashed. She will never go to police, she will never go to any other person. She will like keep it with herself – Parisa (30 years)

Related to the earlier sub-theme of stigma, participants highlighted that seeking help for domestic violence remains highly stigmatised and would attract significant opprobrium from the community. For example:

> If for example an older woman go all through this, they think oh yeah maybe sick, maybe has something wrong with her, they will not say something. But for example, if a woman has been through all domestic violence and she has raised her voice then people will say something about her" – Parisa (30 years)

Theme 5: Husband as gatekeeper. In addition to threats posed by domestic violence, husbands were perceived more generally as potential barriers to help-seeking. Women mentioned that a spouse would most likely perceive a woman seeking help for mental health concerns as a negative reflection upon them and their relationship, or their family life.

> Their partner – unless there has been problem they don't appreciate them to go share, because they would definitely stop them. The partner would think if you share that they have this problem and it may look probably unusual for others because they think your woman's crazy […] think you would be a joke. – Mahlia (32 years)

> There's always mens that are too strict, or just say that ohh sorry you can't you are stuck with this you have to live with it, I don't wanna waste money on you – Saba (21 years)

Importantly, there were differences in the way that participants discussed the issue of husbands as barriers or gatekeepers to services, which were based upon the age of both the participant and the men they were discussing. Participants highlighted that older men were more likely to impede help seeking than younger men, although again, this is possibly more related to time in Australia than age as such.

> If the husband be young maybe he lets her for going to the psychologist but if her husband is old man maybe not let because old men is for a long time be in the Muslim country and there isn't any psychologists in there and maybe different between the old woman and the young woman. – Rana (20 years)

Theme 6: Language and communication. As previous studies with refugee communities have illustrated (Colucci et al., 2012; Colucci et al., 2015; Sheikh-Mohammed et al., 2006; Franks et al., 2007), lack of English language proficiency remains an enduring barrier to help-seeking for mental health services. Notably, there appears to be a paradoxical challenge for women with no English skills in relation to help seeking. That is, while women are required to attend English classes, mental distress restricts their ability to learn English, which in turn limits their ability to seek help for mental health. Notably, the two older women in the study reported having headaches, thinking about traumatic past experiences, worrying about separated family members, and finding it difficult to concentrate during English classes. Both women dropped out of classes within one year and stated that they had not attempted to learn English again. Both of these older women were accompanied by their daughters as translators/interpreters.

> When I talk to them they say we can't learn at this age, and then I say you can! […] But they are negative, they said we can't. And I guess they cannot because their minds are not here. […]See my mum is here, her mum is there,

> she thinks about her. […] She thinks about her past. She thinks, what is happening there? – Laila (18 years) interpreting for Jamilah (59 years)

> when she's going to the class she is getting headache, her foot is not well, one of them is hurting, and she went language class one year but did not learn anything [..] she's saying it's not like I'm not concentrating exactly, I will be thinking ohh what happened at home? Lots of things going in her mind […] it's hard for her to concentrate, I think it is not time for her to study –Giti (23 years*)* interpreting for Nailia (60 years)

These findings align with those of another study with Iraqi refugees in Australia (Slewa-Younan et al. 2015), which highlighted the impact that psychological distress may have on refugees enrolled in English language classes. In participants' examples their low levels of English and lack of ability to engage in English language classes compounded their ability, opportunity, and subsequent decision to access mental health services.

Theme 7: Informal help-seeking preference.

Social support. Aligning with the aforementioned social support literature (Faccincani et al. 1990; Fleury et al., 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik et al., 2009; Sherbourne, 1988), participants in the current study reported a preference for relying on social supports instead of accessing specialised services. Women reported that discussing shared experiences including being separated from family members would relieve some emotional distress. However, often participants reported that this was a short-term solution. Confiding in friends seemingly worked as a barrier to service use, as women regularly relied on this informal, temporary relief of distress instead of seeking professional help.

> they find their friend or woman like herself and talk together and remove the bad events in their mind or anything that bad effect in their memory – Rana (20 years)

Participants also reported turning to family members for help, and older women in particular relied primarily upon on their adolescent or adult children. Some younger participants spoke about the stress that this carer role can cause.

> …it's basically the kids who help the parents in terms of when they find a health issue or anything that is happening with their parents because they might be having depression – Mahlia (32 years)

Religion. Religion was also reported as something that women may turn to when they are feeling overwhelmed, instead of seeking professional help.

> My mum has always told me that if you have a problem, go pray. Pray because that connection with God will really help you. If you have a stronger faith that will really help you. And she says that if you turn to God he will always answer your questions – Azadah (18 years)

In these accounts, mental health issues were conceptualised as something that may subside once "answers" from God were sought. Although religious belief can encourage an internal locus of control (associated with well-being), and may have positive effects such as enhancing acceptance and resilience (Behere, Das, Yadav, & Behere, 2013), relying solely on religious practices may lead women to avoid professional services and therefore not get the assistance they need.

Faith in God and regular religious practice was mentioned as coping strategies for many women within the community. Again, older women relied more heavily on this informal strategy. One participant outlined what had happened to her own mother as a result of solely relying on her religion as a coping mechanism for her grief and anxiety.

> My mum believes strictly that if I am in a bad situation God will show my way. So in this few days she was sick, she was crying for one relative that has been killed on the way to Afghanistan she was crying all the days, about her mother who is sick. She is crying and then she ends up in hospital – Laila (18 years) interpreting for Jamilah (59 years)

Another young, highly educated participant who had grown up in Australia questioned the effectiveness of turning to religion for support with mental health issues.

> Maybe that faith will help you but at the end of the day I think you need to approach someone, you can’t just rely on God. Sure he will help you, he’ll answer your questions but he won’t say something to you, you know what I mean? Maybe that faith, that connection will make you feel as if he’s there for you and he’s looking out for you but in reality you need a person if you really

> want that help, you have to approach someone, you have to talk to someone – Azadah (18 years)

Although informal coping strategies such as family and religion may serve as barriers to professional help-seeking, their effectiveness and value is not to be dismissed. Aligning with previous research with refugee populations regarding resilience and coping strategies, women drew strength and positivity from their social connections within the community (Correa-Velez & Gifford & Barnett, 2010; Schweitzer et al., 2006) and their strong faith in their religious beliefs. (Schweitzer et al., 2007; Khawaja et al., 2008; Sossou et al., 2008; Lusk, Terrazas, Caro, Chaparro & Antunez, 2019).

Discussion and Recommendations

Interconnected, complex social and cultural barriers to help-seeking exist in varying degrees, dependent upon predisposing (Andersen, 1995) and demographic factors for women from this community. Participants' age influenced reported experiences and perceptions throughout every theme. Older women were reported to be most disadvantaged in terms of service access, due to the increased likelihood that they face barriers such as low levels of English, isolation, stigma surrounding mental illness, domestic violence, and restrictive gender roles. In relation to stigma and following Kleinman's (1980) arguments concerning social realities, there is the potential that older women may have internalised societal stigma surrounding mental health care as a system of meaning, which in turn has governed their help-seeking behaviour.

In the current study, the mean length of time spent in Australia was 6.8 years, and both women over 55 years had lived in Australia for 4 years, suggesting that although people may be experiencing mental health issues (Slewa-Younan et al., 2017), enduring barriers to services may still exist years after resettlement.

Although domestic violence is a phenomenon in all cultural and faith groups (Devries et al., 2013), in this cultural context, due to the reported high levels of stigma, domestic violence issues could be a major restraint to women's help-seeking for both domestic violence support and mental health concerns. Furthermore, complex intersecting factors relevant to the experience of domestic violence exist for women from refugee communities, including migration pathways, traumatic pre-arrival experiences, social isolation, and resettlement stressors (El-Murr, 2018). Previous research has suggested that women from culturally and linguistically diverse backgrounds (CALD) face inter-linked and overlapping barriers to accessing support for domestic violence, including limited knowledge of rights/services, lack of cultural safety, and family and community factors (Ghafournia, 2011; Harris, 2018; Vaughan et al., 2016). For participants in the current study, experiences of domestic violence worked as a predisposing factor for service access (Andersen, 1995). Women directly related experiences of violence to mental health issues, and if they are fearful to disclose this abuse, then they may not be receiving adequate psychological care. Therefore, it is necessary for service providers in this area not only to understand the general barriers to service access for this population, but also realise that women from refugee backgrounds may be affected by experiences of domestic violence in different ways that subsequently influence help-seeking strategies (El-Murr, 2018).

Differences in cultural understandings of mental health risk being interpreted as low mental health literacy, which subsequently results in low levels of help-seeking. However, Western notions of mental illness may make little sense in the context of the lives of many women with refugee backgrounds from Afghanistan.

Nadeau and Measham (2006) suggest that working with clients, family members, and cultural brokers to develop a shared understanding of the issue is necessary. The results of this study further support these recommendations and highlight the need for service providers to understand the unique cultural ways in which individuals think about and prioritize mental health concerns in their lives.

Participants highlighted issues of interpersonal as well as institutionalised racism and discrimination, both of which have been noted in previous research with refugee populations more broadly (Fozdar & Hartley, 2013). Participants described how the negative representation of Muslims in the media impacted upon women from their community. Rather than racism being specifically linked to their Afghan (Hazara) cultural background, women associated experiences of racism to their Muslim faith. Women demonstrated their awareness of the potential risk of experiences of overt racism from the Australian public, especially when their faith was physically observable (for example, wearing a headscarf). Women stated that they may reconsider accessing services for fear of being discriminated against.

Utilising social support networks was a preferred strategy to seeking professional help from services, aligning with previous literature reporting that higher levels of social support are often correlated with lower service use for mental health services (Faccincani, et al. 1990; Fleury et al. 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik et al., 2009; Sherbourne, 1988). However, social support may include coping and healing strategies that from a Western perspective are deemed “informal”, but which could operate as formal healing practices within communities. Previous studies have recommended developing community-based mental health services that work to maintain and enhance the protective effect of individuals’ social support networks (Faccincani et al. 1990). The social support networks that women reported using spoke the same language and often shared the collective refugee experience. If women more easily trust and relate to people of their own culture, then training community members as mental health professionals would ensure that Afghan women have the option of choosing services that are more culturally appropriate and that they may feel more comfortable using.

Women reported significant barriers to help-seeking in relation to language and communication. Some women reported trouble learning English due to their inability to focus and concentrate or due to thinking of past experiences or estranged family members. It has been well-documented that past traumatic experiences can affect concentration as well as ability to learn within migrant and refugee populations (Schmidt, 2019). Unfortunately, English is often necessary for women to learn about and access available services in their resettlement country. As such, English classes for women from refugee backgrounds need to be trauma-informed (Schmidt, 2019) and delivery of information regarding available services needs to be done in more accessible ways. It is likely that outreach English language classes and mental health support may be more effective. Necessarily, these services would require teams of teachers, bi-cultural workers, mental health workers, and interpreters who are culturally competent to work with Hazara Afghan women. Education sessions are necessary to inform women about the Australian health care system and available services. Importantly, English language classes could be an avenue for teaching women about helpful services for mental health and domestic violence support. Female-only, group sessions for education and therapy may be more effective, given the collectivist culture and frequent gender-segregated practices (Gondek et al., 2015; Murdoch Children’s Research Institute (2015) “Healthy Happy Beginnings”; Felsman, 2016). Similarly, given the fact that the Muslim faith was portrayed as being highly significant in many participants' lives, there may be an opportunity to incorporate mental health literacy into religious practices or Khutbahs (Islamic sermons) as a way to draw attention to, educate about, and reduce stigma surrounding help-seeking for mental health services.

While this study has provided important information concerning mental health and help seeking for women with refugee backgrounds from the Hazara community, it is not without its limitations. A small sample size and snowball sampling within a tight-knit community means that results may not be generalizable. Instead, these findings should serve as a basis for future research. It proved difficult to find female community leaders. While multiple participants were significantly involved with their community, they did not identify themselves as leaders. When asked who the leaders were in the community, it was reported that they were men, and attempts to contact them were unproductive. The use of family members as translators may also be problematic. Although we chose to respect participants' preferences for family interpreters, this may have meant that they felt uncomfortable discussing certain topics.

Conclusion

It appears that some women, especially older women from the Afghan community, are a somewhat silent population in terms of presentation to services. Service providers may not be seeing those women most in need due to a range of barriers, including differences in ways of conceptualising mental illness, husbands acting as gate keepers, and stigma surrounding reasons for presentation. Young women from this community expressed concern that their mothers and grandmothers required further support. For future projects of this type a research team, including bi-cultural workers and interpreters, is required to ensure that the voices of those who do not speak English are included. Indeed, as this research suggests, older Afghan (Hazara) women with no/low English proficiency may be those with the greatest unmet needs, with many facing domestics violence as a key barrier to accessing care. The National Plan to Reduce Violence against Women and their Children (Commonwealth of Australia, 2016) and the Intimate Partner Violence in Australian Refugee Communities review (El-Murr, 2018) highlight the prevalence of domestic violence in CALD communities, and the importance of early intervention and for services to practice in a culturally safe manner. Women also reported interpersonal as well as institutional experiences of racism as impacting upon their community as well as their decisions to access services. Considering this, as well as the findings of the current study, it is necessary for service providers in this area to understand that women from refugee backgrounds face multiple barriers to service use, including domestic violence, and that these experiences may also be compounded by other systemic and structural intersections of oppression such as restrictive gender roles, racism and migration status.

Chapter 6. Study 2

6.1 Resettlement stressors and challenges for South Sudanese women with refugee backgrounds: a South Australian study

Study 2 predominantly explored resettlement stressors for women with refugee backgrounds from South Sudan, as barriers to help-seeking were not prioritised in participant's accounts. This was the second of two studies (with women from Afghanistan and South Sudan) exploring help-seeking and resettlement stressors with community members. Interviews with women from both communities were conducted between October 2016 and May 2017, with most of the interviews with South Sudanese participants occurring between February 2017- May 2017. Throughout Study 2, the impact of experiences of racism and the negative portrayal of South Sudanese community members in the media was a salient theme. As such, Study 3 explored this theme further, presented in Chapter 7.

This study is under review with the *The Australian Psychologist*. The paper is presented here with the same typeset as the rest of the thesis.

Statement of Authorship

Title of Paper: Resettlement stressors and challenges for South Sudanese women with refugee backgrounds: a South Australian study

Publication status: under review

Principal Author

Name of Principal Author (Candidate): Rose Burford-Rice

Contribution to the paper: Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data anaylsis.

Drafted, wrote and submitted article, then revised and responded to reviewer comments. Acted as corresponding author.

Overall percentage(%): 80%

Certification: This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.

Signature: Date: 28/01/2020

Co-authors

By signing the Statement of Authorship, each author certifies that:

i. The candidate's stated contribution to the publication is accurate (as detailed above);

ii. Permission is granted for the candidate in include the publication in the thesis; and

iii. The sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of Co-Author: Professor Martha Augoustinos

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Signature: Date: 28/01/2020

Name of Co-Author: Dr. Clemence Due

Contribution to the Paper: Input regarding study design and sampling. Supervised development of the work and input regarding analysis of data. Provided guidance on the preparation of manuscript and editorial and structural feedback on the paper.

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Ongoing conflict in South Sudan means that it is still one of the leading countries from which people are seeking asylum (UNHCR, 2016). The population of people from South Sudan who have been resettled in Australia reached over 20,000 several years ago (Marlowe, Harris & Lyons, 2014). Although people with refugee backgrounds, such as those from South Sudan[1], often show strength and resilience in the face of extreme adversity (Hutchinson & Dorsett, 2012), research indicates they are also frequently vulnerable to psychological distress, particularly if they have been exposed to high levels of violence, trauma, and displacement (Shawyer et al., 2017; Schweitzer et al., 2006; Porter & Haslam, 2005). Poor mental health outcomes amongst refugee populations generally have been linked to pre-migration trauma (including torture, loss of family members, witnessing or participating in conflict, and imprisonment) as well as post-migration stressors (adjusting to a new culture, resettlement stress, and loss of social support) (Porter & Haslam, 2005; Steel, Chey, Silove, Marnane, Bryant & van Ommeren, 2009; Alemi et al., 2014; Schweitzer et al., 2006; Reiner, 2010). Previous research has also indicated that many people with refugee backgrounds may access mental health services at lower levels than the general populations of resettlement countries (Minas, 2013; Posselt, McDonald, Procter, Galletly & de Crespigny, 2015).

Background and previous literature

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[1] By way of definition, a refugee is an individual outside their country who has a well-founded fear of persecution due to their race, religion, nationality, membership of a particular social group, or political opinion, and is unable or unwilling to return to their country due to fear of persecution (UNHCR, 2011). An asylum-seeker is an individual whose request for sanctuary has yet to be processed (UNHCR, 2018). All participants in this study were classified as 'from a refugee background' as they had all arrived in Australia as 'refugees', but some had since become permanent residents.

South Sudan has witnessed of one of the world's worst humanitarian crises, a 21-year armed conflict ending in 2005 (Ayazi, Lien, Eide, Shadar & Hauff, 2014), ongoing political instability, and ethnic conflict (primarily between the Dinka and Nuer tribes), resulting in thousands of deaths and mass displacement (Adaku et al., 2016). This enduring instability has resulted in high levels of trauma and psychological distress (Ayazi, Lien, Eide, Majok & Hauff, 2012). In an Australian interview study involving 63 resettled Sudanese refugees, Schweitzer et al. (2006) found that previous experiences of trauma and post-migration stressors (including employment difficulties, family separation and acculturation) were important predictors for psychological wellbeing, particularly for females. Although previous studies with different refugee communities have found that mental health outcomes can improve over time spent in a resettlement country (Steel, Silove, Phan & Bauman, 2002; Montgomery, 2010), Schweitzer et al. (2006) found the contrary, revealing increased living difficulties and a trend toward poorer mental health over time for refugees from Sudan living in Australia. Similarly, Khawaja & Milner (2012) suggest that post-migration stressors for refugees from South Sudan can have ongoing negative impacts on social relationships and wellbeing. They considered the role of acculturation stress on marital relationships, finding that management of finances, a lack of social support in Australia, adherence to cultural gender roles, a lack of cultural understanding amongst law enforcement, and a lack of pre- and post-migration information all impacted on wellbeing for their participants. South Sudanese women may be at particular risk of psychological distress due to extra risk factors they face on their journey to a resettlement country, including sexual violence, unwanted pregnancies, harassment, health issues, and separation from children (Kastrup, 2006). Once they have arrived in a resettlement country, women, especially mothers, may face the challenge of navigating different gender roles and changes within family dynamics (Hebbani, Obijiofor & Bristed, 2009; Fisher, 2013). Furthermore, women from refugee backgrounds may face additional interpersonal barriers to help-seeking for mental health services post-resettlement – particularly in relation to shame and stigma (Drummond, Mizan, Brocx & Wright, 2011). A study by Schweitzer et al. (2006) revealed that women from Sudan resettled in Australia overall experienced greater depressive symptoms, greater PTSD symptomology, and greater anxiety symptomology than Sudanese men. Although studies have alluded to the fact that there may be unique and important stressors impacting upon mental health outcomes for South Sudanese women (Schweitzer et al., 2006), minimal research has specifically explored the challenges that this population face following resettlement. Given that research has revealed that refugees from Sudan may face increased risk for living difficulties and mental health issues over time spent in Australia (Schweitzer et al., 2006), that there is stigma surrounding mental health issues, and that the conflict in South Sudan is still ongoing, there is a need to ascertain the challenges faced by women from this community.

Thus far, Australian studies have explored challenges and coping strategies with refugees from both Sudan and South Sudan collectively (Schweitzer et al., 2006; Khawaja, White, Schweitzer & Greenslade, 2008), with few studies focusing specifically on the South Sudanese community (Khawaja & Milner, 2012). However, South Sudan and Sudan have significantly different political, religious and historical backgrounds, and thus these groups may present with different challenges and collective stressors. Additionally, South Sudan is made up of over 600 ethnic groups who speak many different languages (Wal, 2004). As highlighted by Schweitzer et al. (2006), different groups experience profoundly different difficulties in adjustment to a new resettlement country. Furthermore, to our knowledge there are no studies that explore post-resettlement challenges and stressors for South Sudanese women with refugee backgrounds living in Australia. This study therefore aimed to examine existing challenges and coping strategies for women from this community.

Method

Participants

Participants for this study were two male community leaders, four female community leaders, and three female community members from the South Sudanese community who lived in Adelaide, South Australia. Participants were between the ages of approximately 20 years –70 years; some participants did not know their exact year of birth and others did not wish to disclose their age, so approximate ages are given. For female participants, the mean length of time spent living in Australia was 13 years (see Table 2).

Table 2: Participant demographics

Pseudo-name	**Community status**	**Tribe**	**Approximate age**	**Years in Australia**	**Number of children**	**Religion**	**Occupation**
David	Male Community Leader	Dinka	40-50 years	15	3	Christian	Community Chairman
Mark	Male Community Leader	Ma’Di	40-50 years	18	2	Christian	Government Worker
Grace	Female Community Leader	Dinka	50-60 years	15	3	Christian	Aged Care
Susan	Female Community Leader	Dinka	60 + years	15	4	Christian	Unemployed
Hope	Female Community Leader	Dinka	40-50 years	12	6	Christian	Student
Anna	Female	Dinka	50-60 years	15	8	Christian	Student

	Community Leader						
Chloe	Community Member	Dinka	30-40 years	12	2	Christian	Unemployed
Mary	Community Member	Ma’di	20-30 years	16	0	Christian	Disability Support
Leah	Community Member	Jurchol (Luo)	30-40 years	7	2	Christian	Student

Procedure

At the beginning of the research project, the first author was approached by a male community leader expressing concern about general mental health issues and recent suicides in his community. He advocated for research to be conducted with an aim to improve access to services and encourage dialogue within the community about mental health concerns. Following further consultation, it was decided that, given the gender of the first author, it would be most culturally appropriate for the participants to be female for this research project. As well as female community members, 4 female community leaders were also recruited to serve as key facilitators and to develop appropriate research questions. Following institutional ethics approval (H-2016-130), participants were recruited through responses to posters and fliers distributed through education institutions, community centres, and other organisations. Given that this population was hard to reach, a combination of convenience and snowball sampling was used to maximise participation. Participants were eligible if they had been in Australia for more than three months, ensuring some level of familiarity with the Australian health care system, and if they were over the age of 18. It was not a requirement for participants to speak English; interpreters were offered in whatever language women felt most comfortable speaking before the day of the interview. However, no participants requested to use an interpreter. Researchers respected participant’s wishes and decisions not to use interpreters, but due to the complex nature of the topics discussed, this may be a limitation of the study.

Qualitative, semi-structured, face-to-face interviews were conducted between October 2016 and May 2017 by the first author. On average, interviews lasted 60 minutes and were conducted at convenient locations for the participants. A $20 shopping voucher was gifted to each participant in appreciation of their time. Best practice ethical guidelines for research with refugee and asylum seekers were followed (Birman, 2006; Block et al., 2012; Hugman et al., 2011; Ziersch, Due, Walsh & Arthurson, 2017), including clear protocols and referral pathways for participants if participants became distressed. Identifying information has been removed from interview extracts.

Measures

The semi-structured interviews included questions that asked participants about difficulties that women faced in their community, how women sought help for mental health concerns, what kinds of things might stop women from getting help, and what participants have found has helped them through hard times in their lives. In accordance with the CBPR approach, research questions were formulated through consultation with two community leaders: one male (who approached the first author initially) and one female. From these discussions the first author formulated a semi-structured interview guide and then consulted with the female community leader again. Interview questions included how women sought help for mental health concerns, what might stop women from getting help, and what participants found had helped them through difficult periods in their lives. The interview guide served as an aide memoire, and participants predominantly guided the interview (Braun & Clarke, 2013, p. 84).

Data Analysis

Thematic analysis (Braun & Clarke, 2013) was used to analyse interview data. Interviews were initially coded inductively for themes relating to factors contributing to mental distress and barriers to help-seeking, in line with the research questions. Although there was an initial focus on barriers to help-seeking, participants primarily discussed practical stressors and challenges that their community faced in Australia. As such, codes for stressors and challenges were condensed into two overarching themes: “Resettlement Stressors” and “Social and Cultural Factors”.

Results and Discussion

Theme: Resettlement stressors

Responses to interview questions specifically regarding help-seeking were often steered to discussions about resettlement stressors by participants, suggesting that seeking professional help for mental health concerns may be a low priority for some women from South Sudan. The following sub-themes are specific stressors that were flagged as particularly salient.

Family separation

Separation from family members has been identified as having a negative impact on the mental health of Sudanese refugees living in Australia (Savic et al., 2013). The following accounts illustrate the impact of family separation of women from relatives remaining in refugee camps or dangerous areas. Not only does this separation cause emotional distress, but also frequently results in financial strain for resettled families, as they regularly send remittances back to family.

> when you live together with family it doesn’t happen all the time to be sad. […] But here, it’s sad is more. You thinking about your background, your family in Africa. – Hope (30-40 years)

> I have sisters and brothers (back home) […] it’s really stressful cos most of the time they can stay hungry […] and if you don’t send money it’s very hard on them because they don’t have better jobs. – Chloe (25-30 years)

Community divide

South Sudan has approximately 600 different ethnic groups, and 400 different languages are spoken (Wal, 2004). The ongoing conflict between different ethnic groups in South Sudan was reported to have far-reaching impacts upon social relationships in Australia. One woman reported severe isolation in a time of crisis due to the fact that she was in an abusive relationship and that her membership of a minority ethnic group was used against her.

> I remember back then Ma’di would not let Dinka go to their things, […] if you’re Dinka you can’t come to that. So they have this conflict. – Leah (25-30 years)

> they killing my family or they killing my relative why would I be good with them you know. It is happening especially with Dinka and Nuer – Leah (25-30 years)

Although community divide was reported as something that the South Sudanese community is working to overcome, in some circumstances it still has the potential to detrimentally affect women's mental health. In particular, if a woman is from a smaller ethnic group, this may serve to isolate her further.

Social determinants of health

Housing, employment, and social isolation are important social determinants of health and may particularly impact the wellbeing of people with refugee backgrounds, causing resettlement stress (World Health Organization, 2018). These were all noted in the current study. For example, finding appropriate and affordable housing is a common resettlement stressor for refugees (Ziersch et al., 2017). Similarly, women in the current study expressed concerns about finding appropriate, affordable housing for their often-large families.

> Someone will be looking for a house for six months, nine months, she didn't get a house. […] When you look to buy them, can't manage, no work. […] In my country everyone is having property but in Australia it's very hard to manage.' – Hope (30-40 years)

Moreover, the majority of women in the current study reported that they had multiple children whom they supported on a low income.

> we have one of our sisters […] She wants to kill herself cos of the bill for her kids' school […] they need that bill $7000, nothing. So sometimes she just locks her door and cry, cry, cry and thinks I want to kill myself you know? – Grace (50-60 years)

Finally, isolation was reported as a resettlement stressor itself that was often caused by other stressors. For example, a lack of English language skills may discourage some women from engaging with others. One woman described her life in a South Sudanese rural village, where community members were consistently connected to each other, as a stark contrast to her Australian experience.

> in Sudan you go to a place every Sunday to reflect as a group of women. But in Australia the South Sudanese are not getting in a group of women […] When you sit by yourself morning, afternoon, and not go out, it's very sad, I'm not happy– Hope (30-40 years)

The feeling of isolation was also reported as being akin to not feeling like Australia was home, and a lack of social connection made one woman feel alienated even though she had lived in Australia for seven years.

> So I believe here is home, fifty percent […] I'm still not into much friendship, I don't have a lot of people, or connected with a lot of Australians. […] I came here alone […] I've gone through all this stress on my own – Leah (25-30 years)

Theme: Social and cultural factors

Cultural factors can significantly affect the manifestation, diagnosis, subjective experience, and prognosis of mental disorders, social responses (including discrimination and racism), and help-seeking patterns (Gopalkrishnan & Babacan, 2015). South Sudanese culture is generally considered collectivist (Khawaja & Milner, 2012) but also hierarchical, patriarchal, and authoritarian, with strict gender roles and expectations (Hebbani, Obijiofor & Bristed, 2009).

Cultural conceptualisations of mental health and stigma

Qualitative studies with South Sudanese refugees indicate that mental health problems are often broadly viewed as 'madness' or as problems of "thinking too much" (Kaiser et al., 2015). Other research has noted how in illness narratives the self, identity, and the body are perceived to be inextricably linked, leading to the use of terms such as "the heart", "blood" and "body construction" to narrate social and cultural losses (Coker, 2004). The accounts in this project similarly demonstrate specific cultural conceptualisations of mental health issues. One young participant reported on the beliefs of others in her community and hometown in Africa regarding treatment of people with mental illness.

> when I was in Africa in 2014 I seen […] how people with mental illness get treated. Like oh its witchcraft, oh he's crazy, or oh his family has been cursed or all that kind of rubbish […] I see how people getting treated is getting tied up on a tree because you're crazy. And you're given medicines because that's what they believe in, […] South Sudanese, we believe that medication can heal, or prayer heal– Mary (18-25 years)

She also suggested that some women believe that their suffering is part of "God's plan"; this belief may serve as a barrier to help-seeking, as they may believe that only God has the ability to help them recover, or that they are being taught a lesson.

> they usually say if I am sick and they can't do anything about it, pfft, I'm gonna stop seeking for help because […] maybe it's god's choice for me to be like this […] so sometimes […] if they find out that a person has mental illness, they won't bother, because they'll probably think oh if she has it, I probably have it, so I won't even go to seek for help. […] God's plan, everything comes back to god' – Mary (18-25 years)

A female community leader reported that some women would call her and report their mental health symptoms, or even their suicidal thoughts. Contradicting the previous account that "medications can heal", this woman was concerned that many of the women in her community do not believe that mental illness is a "sickness" that warrants treatment. Instead of seeking professional help, they either hide their symptoms or call community leaders.

> people they not thinking that you are sick - they put it in a different way […] even me, I didn't know it was a sickness. […] But here now we are sick. We are sick. Because if you're mental it's not good. Or sometimes you scream, you don't know that you're screaming. You do something different […] it's scary. So that's a sickness but we don't know, they won't talk about it. – Grace (50-60 years)

She reported that she had only recently learnt about Western definitions of mental health; indeed, other participants noted that a lack of ability to recognise mental illness symptoms that warrant treatment could lead to severe outcomes, including suicide.

Ayazi and colleagues (2014) found a high level of stigma towards the mentally ill in South Sudan, particularly in rural areas, where participants were more likely to believe that people with mental illness “suffer from an evil spirit or are possessed” (Ayazi et al. 2014). Similarly, the following accounts suggest stigma for mental illness exists within the South Sudanese community.

> that’s still going on you know judging, put-downs, gossiping, all that kind of stuff. Straight away they will just say that person’s crazy, or that person’s witchcraft, like that’s person’s cursed”– Mary (18-25 years)

> when you’re crazy, or become crazy - not all Sudanese but especially Dinka it’s shame,[…] when you’re crazy, when you do strange or funny thing […] even when you have TB coughing some sickness that will eat your lungs […] it’s shameful because it’s coming to your family, and to your creator, your great grand mother, father – Grace (50-60 years)

Privacy was reported to be highly valued, and if a woman had a problem it was expected to stay within the family. It was especially important to keep matters between husband and wife private.

> if a woman […] got an issue with her husband and she wanna share it with her friends that friend will not keep that secret, she will go and talk around […] so

> a lot of women better just keep their problems within […] Sudanese community cos they still really low education and when you have problem you lost respect in the community and people will just ignore you, look at you like you're nothing because you don't know how to keep your problem within – Leah (25-30 years)

As a consequence, one community leader expressed her concern that many women may be suffering, but remaining silent.

> sometimes they need help and they don't say, […] they need help and they are hiding their problems. We feel like its shame […]. So when you keep quiet and are hiding your problem it's hurting you, and it's hurting others. – Grace (50-60 years)

The level of stigma surrounding mental health issues between younger and older members of the community is different. One young woman reported that young people who had spent a substantial amount of time in Australia experienced fewer barriers accessing mental health services.

> for us young ones we okay because we have been brought up into this country where they are saying […] there's this service you can go to or there's these people you can talk to, we have that knowledge […], but our parents don't know […] and they still have the mentality where if I tell you you're probably going to tell another person. – Mary (18-25 years)

Racism

It is well documented that refugee populations in countries of resettlement experience racism and discrimination after resettlement in a host country (Humpage, 2001; Gowayed, 2019; Buccitelli & Denov, 2019; Kirmayer et al., 2011). In a study by Khawaja et al (2008), six Sudanese participants reported experiences of racism, for example, difficulties attaining employment, increased attention from police, and even verbal abuse. In the current study, a common theme throughout interviews was how the Australian media generated predominantly negative stereotypes and generalisations of refugees from South Sudan. These stereotypes were predominantly associated with media reporting of so-called South Sudanese youth “gang” violence in cities such as Melbourne, reports that were often repeated and reinforced by political leaders and the police force. Such negative portrayals work as a form of institutionalised racism which functions to perpetuate and reinforce negative public sentiments towards South Sudanese Australians, including those with refugee backgrounds. The women from the South Sudanese community in Adelaide reported feeling the negative effects of this publicity and worrying about their own children who may be vulnerable to discrimination.

> One day in channel 7 there’s a report saying there is another Sudanese man who stole something from the liquor shop which he didn’t so it was wrong, and then they apologise and they say oh it wasn’t him it was another one, that is definitely wrong. – Leah (25-30 years)

> it’s only Sudanese now you know it’s Sudanese, Sudanese, Sudanese and we are thinking we are very good in our background, we are coming to Australia for studies, for food, for medication for everything - Grace (50-60 years)

A female community leader, Grace, expressed how these negative portrayals of a select few members of their community were impacting upon their lives in Australia. Specifically, she emphasised her frustration at how the selective reporting of negative stories about a small minority in the South Sudanese community functions to depict the entire community in a negative light. For some women, experiences of racism and negative depictions of young people from their community were compounded with their gender and cultural roles as mothers, elders, and caregivers.

> we are coming from refugee camp to here, Australians brought us here to share good life, the children to go to school here, to get the job in Australia we’re doing something good for Australia, not criminal. It’s now they doing criminal we are very shocked. The elders they sit now they have high blood pressure, high sugar, mental problem, everything! We unhappy, not happy – Susan (60-70 years)

> now even they cannot consider some people working they say oh Africans they just taking Centrelink money but not, not all. And that’s what they say in our language, one onion all smell [..] because some South Sudanese they are working hard but not good enough […] they judge all of the community and it’s not fair.. So we just even ask God who bring us here to help us. – Grace (50-60 years)

Not only were women from the South Sudanese community faced with experiences of racism from the Australian community, but some accounts suggest that they are also at risk of being discriminated against within their community.

> there is also a bit of racism amongst ourselves as well […] the violence that's been happening back home in South Sudan that's caused a lot of issues, to the point where now it's like because I'm Sudanese but yet I am Equitorian, and then we have the Dinka people, and then we have the Nuer people.[…] And now it's causing issues between us because we are Equitorian and they are Dinka, and they are saying oh you don't belong in South Sudan it's like you can't even say that because we're all South Sudanese. So there is a bit of racism out there.' – Mary (18-25 years)

Given the salience of reports regarding the impact of racism and negative media portrayals of South Sudanese youth, this theme will be explored further in the next study.

Lack of trust

A recent Australian study found that South Sudanese participants reported a very low level of trust in others in Australia, with only 4 per cent of participants agreeing that 'most people can be trusted' (Markus, 2016). Women in the current study reported a similar phenomenon within their own community, as well as with service providers. Some women described the need for a reason for them to trust someone, and a certain amount of fear surrounding disclosure of personal problems.

> it’s really, really hard for a person who comes from a different background, especially the refugee background to disclose some information because it’s like what makes you think that I can trust you for me to talk about this kind of stuff? Some of the South Sudanese, majority of the people out there they don’t believe in counselling, or psychologists, they say all I’m going to be doing is talking to that person, how is that going to help me? […] There’s certain things that you went through in life and you just don’t want your family to know. […] and if I tell you, you’re probably going to tell that person […] where I come from sometimes it’s really hard to tell a person something because they go disclose it to your family member. […] Keeping things confidential they don’t know about that. – Mary (18-25 years)

This reported lack of trust also transferred to fear – reducing the likelihood that some women would engage with Australian services outside of their community.

Control and power

In South Sudanese culture, women tend to be primarily responsible for caring for family members and running the household (Wal, 2004; Hebbani, Obijiofor, & Bristed, 2009). In interviews, a woman’s expected role was consistently described in this way.

> in South Sudan – a good woman is like a full time house work. […] Listening to her husband, cleaning, washing, doing everything in the house, taking care of her husband and her kids, that’s a good wife I believe – Leah (25-30 years)

As in Khawaja & Milner's (2012) study, the difference in gender roles after resettlement in Australia was reported to cause tension in some families, particularly as women began to change their role (e.g. through gaining a driver's licence or employment).

> men are the ones that want to take control of the money, I have seen a lot of that in the Sudanese community - where the men want to control everything and now womens also have the power to do things and they feel like less of a man, because now the womens are stepping up on the table and trying to work and trying to provide as well. – Mary (18-25 years)

One woman perceived family breakdown as inevitable if a woman stepped outside her expected domestic role.

> I noticed a lot of people that when they become educated in Australia and tried to do better for their family, their family breaks down. Cos the good woman who was back home, she's no longer still a good woman here, so she's busy with her other jobs […] and some men they don't really want that, they want their women to just be home and not even drive so that he can control her – Leah (25-30 years)

Participants reported that women who transgressed their expected gender roles, including gaining control over money and transportation, challenged men's control and power. These changes in gender roles may elicit spousal conflict, which could result in family breakdown and isolation and cause significant distress for women already having many family responsibilities (Khawaja & Milner, 2012).

Domestic Violence

For refugee women, the rupture of forced migration often results in women having to redefine their gender roles within their families, which can subsequently result in family conflict or domestic violence (Fisher, 2013). Women related the changes in social, cultural, and gender roles to experiences of family violence following resettlement.

> Domestic violence is huge problem, that’s what I know because I’ve been through it as well. So I know there’s women that can’t speak for themselves, and there’s women that need help you know. – Leah (25-30 years)

Hope described how older, respected family members addressed issues of family violence in her home country.

> Sometimes the man beat the women and then she be sick. This one is not good. Even in my country when you do like that the father comes to take you away from this man – Hope (30-40 years)

These participants described how some women within her community had decided to leave abusive relationships, but that older women may be at a higher risk of experiencing family violence but not being able to leave, especially if they came to Australia with their partner.

> And it depends you know a lot of people are getting out of it, and many of them they can't. Cos it's already been their issue for quite a long time. It's hard to get out of it cos umm and one of the reason why a lot of reason are now single, they live single because they decided to say no, enough. And for the oldest one – and for those older ladies that they can't do anything at the moment. And they've already been through it you know and it's hard now you have to get out of it. – Leah (25-30 years)

> we have inside problems and we have outside. Because like in the house, the men and women, the women who came here with men they have problem between them – Grace (50-60 years)

Husband as Gatekeeper

South Sudan is predominantly a patriarchal society (Hebbani, Obijiofor & Bristed, 2009), and the women in this study emphasised the degree to which men acted as barriers to help seeking.

> if you are a married woman they're very strict –you can't go out, only something that your family knows or your husband. […] Most of the times the struggle is to look for jobs because you have to look after kids […] you only go to community parties, you can't go out with friends –Chloe (25-30 years)

However, community leaders felt that it was their role to mediate spousal conflict, potentially encouraging women to remain silent in an effort to reduce experiences of shame.

> I am a leader woman and in the community something happens for a man and a wife I am going to solve that, I am calling the elders to go there to solve these two’s problem and they come together. – Anna (50-60 years)

Discussion

Participants primarily discussed practical stressors and challenges that their community faced in Australia, despite the research question focusing on help-seeking preferences. Accessing mental health services was a low priority for many women, who prioritised practical concerns and resettlement stressors rather than psychological issues. Moreover, accessing Western formal support services may be perceived as unhelpful, as many resettlement stressors (e.g. family separation) can only be addressed at the government level. The initial research agenda of exploring help-seeking for mental health services seemed somewhat less critical when women began speaking about such experiences.

Similar to the findings from the previous study with Afghan women, these findings here reiterate the interconnectedness of the local and global in the collectivist South Sudanese culture. Women in this study reported concerns within their local resettlement experience in the form of stressors that could not be separated from global factors, including immigration policies, family separation, cultural conceptualisations of mental health, and experiences of racism and discrimination. These challenges represent contextual and social factors (Andersen, 1995) that can work to impede access to services, or even render some services unhelpful or irrelevant.

Within the current political climate, the often unheard voices of the South Sudanese women as represented in this study are extremely important, and demonstrate the need to consider how marginalized communities are being represented, and the effect that this has upon the wellbeing of community members.

Community leaders currently act as a helpful avenue of support for many women who do not engage with professional services, but they may require more support and training if they are to continue in these roles. If unsupported or feeling ill-equipped to adequately support other women, they may have a heightened risk of fatigue or burnout. There is a need for a focus on the strengths and value of existing community supports, and for mainstream services to learn from the female community leaders already supporting their communities with limited resources.

The population for this study was hard to reach and the sample was relatively small. However, as recommended by previous researchers, as the interviews were in-depth, the sample size was still above the minimum number for thematic analysis and research involving hard-to-reach, vulnerable research populations (Baker & Edwards, 2012; Braun & Clarke, 2013).

Conclusion

Participants in this study were strong, articulate South Sudanese women who voiced the challenges and stressors that they faced in resettlement. The current findings suggest that women faced enduring stressors that are interconnected and exist both on a local and global level. Participants were articulate in discussing community needs and were experts on the cultural context and complexities that addressing these needs would entail. Not only did women face resettlement stressors such as family separation and social determinants of health, but they also had different conceptualisations of mental health and face community stigma when presenting to services for mental health concerns. These women cared deeply about their community and were significantly concerned about how it was being represented in the broader Australian community – concern that will be elaborated upon further in the next study.

Results highlighted the complex intersectionality between gender, race, and refugee status faced by participants. For example, a woman's membership to a particular South Sudanese ethnic group (for example, Nuer), may compound with experiences of family violence (based on her gender) and create multiple challenges or barriers for her own empowerment and advancement within her community. Participants described the way in which racism, patriarchy, economic disadvantages, and their refugee status (even years after resettlement) created layers of inequality that structured the relative positions of women and men in their community and the broader Australian society.

Although female community leaders were already working to unite the generations for meetings to discuss the concerns raised in this study, they did unanimously voice that they required further resources. Indeed, it is well documented that in general a more holistic approach to mental health care, including home visits, psycho-education, support and advocacy, and English classes may benefit refugee women (Murray & Skull, 2005; Khamphakdy-Brown, Jones, Nilsson, Russell & Klevens, 2006). However, recent budget cuts in Australia have seen a cut to refugee resettlement services (Baker, 2019). Furthermore, concerns have been raised regarding structural and staffing issues for the Adult Migrant English Program (AMEP) English language program that provides 510 hours of free language classes for migrants and refugees (Scanlon, 2019). These structural policy constraints currently directly impact on Australian refugee populations and the women in this study. Women from this community will benefit greatly from government investment in refugee services, more easily accessible, free, and trauma-informed English classes, parenting skills workshops, and women’s health information seminars.

Chapter 7. Study 3

7.1 “That’s what they say in our language: one onion, all smell”: The impact of racism on the resettlement experiences of South Sudanese women in Australia

Study 3 presents further analysis of the salient accounts from South Sudanese participants regarding experiences of racism and negative portrayals of the South Sudanese community in Australian media. In accordance with suggestions by reviewers from the *Journal of Language and Intercultural Communication*, the analysis in this study was informed by principles from discursive psychology. The analysis focuses on how the issues of racism and negative portrayal of the community were constructed by participants, and on the impact of these issues on their resettlement experiences. Finally, Study 4 explores the issues raised in studies 1-3 from the perspective of service providers who work with these populations, presented in Chapter 8.

This study was accepted for publication with the *Journal of Language and Intercultural Communcation* 20(2). The paper is presented here with the same typeset as the rest of the thesis.

Statement of Authorship

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Contribution to the paper: Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data anaylsis. Drafted, wrote and submitted article, then revised and responded to reviewer comments. Acted as corresponding author.

Overall percentage(%): 80%

Certification: This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractural agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.

Signature: Date: 28/01/2020

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By signing the Statement of Authorship, each author certifies that:

i. The candidate's stated contribution to the publication is accurate (as detailed above);

ii. Permission is granted for the candidate in include the publication in the thesis; and

iii. The sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

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Humanitarian refugees from sub-Sahara Africa constitute one of the newest cultural groups to permanently settle in Australia. Since 2000, over 50,000 people from this region have been resettled in Australia under the Humanitarian Entrant Program. However, this refugee resettlement program has attracted significant political and public dissension in Australia, with the then (conservative) Federal government reducing its refugee intake from South Sudan in 2007, claiming that South Sudanese refugees were failing to integrate into the so-called “Australian way of life” (Pearlman, 2007). These government claims, along with heightened media attention on crimes purported to be linked to South Sudanese “youth gangs”, have increasingly politicised the issue of refugee resettlement in Australia (Augoustinos, 2010; Due, 2008; Every & Augoustinos, 2008; Hanson-Easy & Hanson-Easy & Augoustinos, 2011; Nolan, Farquharson, Politoff & Majoribanks, 2011; Nunn, 2010; Windle, 2008). Negative media depictions are a form of institutional racism, which has been linked to negative mental health outcomes (Goodall et al., 1994; Wodak, 1989). However, little research has directly considered the impact of sustained negative media reporting on the lives of the South Sudanese Australian community. This paper aimed to explore this issue within a sample of women with refugee backgrounds from South Sudan living in South Australia.

Background and previous literature

Refugees from the African continent have been increasingly maligned by the Australian media and public discourse in recent years. For example, in an article published in 2005 in a mainstream Australian newspaper, Associate Professor Andrew Fraser suggested that: “an expanding black population is a sure-fire recipe for increases in crime, violence and a wide range of other social problems” (Dick, 2005). Fraser argued that refugees from South Sudan were inherently more likely to commit crimes and were less intelligent than other Australian immigrants (Dick, 2005). In the same year, the now chairperson of The Australian First Party (an Australian far-right political party), Dr Jim Saleam, claimed that refugees arriving to Australia would cause widespread social upheaval, arguing that they come from “utterly fractured societies where the use of the gun and the knife is the common way to settle disputes” (ABC News, 2005). During 2006, Australian media outlets reported that a number of African refugees had arrived in Australia carrying communicable diseases such as hepatitis C and HIV, and right-wing politicians soon adopted discourses of “diseased Africans” to legitimate their opposition to Australia’s African refugee intake (*The Australian*, 2006). In the same year, the city council in Tamworth - a regional town in the state of New South Wales - ceased a settlement programme for South Sudanese refugees, which they stated was due to “general settlement problems” (The 7.30 Report, 2007).

Despite such claims associating “African” culture with violence, there is little evidence that refugees from anywhere in Africa are more likely to commit a crime than any other group of people – including those who have been the target of particularly sustained attacks from the mainstream media (Windle, 2008). On the contrary, an Australian report concerning South Sudanese refugees’ experiences with the Queensland criminal justice system found that young South Sudanese participants, rather than being a threat in public spaces, actually felt vulnerable due to increased policing and surveillance (Coventry, Dawes, Moston & Palmer, 2014). Similarly, several authors have suggested that the intense media scrutiny of refugees from Africa in Australia has significantly contributed to their racialised “othering” and associated high levels of discrimination (Baak, 2011; Budarick, 2018; Mansouri, 2018; Tuffield, 2018; Windle, 2008).

Media representations of recently arrived groups in Australia also play an important role in the politics of belonging. For example, Nolan, Burgin, Farquharson and Marjoribanks, (2016) thematically analysed letters to the editor concerning Sudanese Australians in three Victorian newspapers in 2007 and demonstrated that the letters worked to reiterate a culture of “integrationism”, and to criminalize South Sudanese Australians for their failure to “integrate”. These public concerns - combined with government claims that refugees from South Sudan were failing to integrate into the Australian “way of life” - functioned to justify government policy restricting the humanitarian refugee intake from South Sudan in 2007. Previous literature has identified the phenomenon of “crimmigration” (see Stumpf, 2006) regarding the acknowledgment of the convergence of criminal and immigration laws to control migrants and refugees globally. Researchers have noted an increase in ideas of deterrence, heightened policing, condemnation, and punishment in the absence of clearly identifiable criminal activity (Gerard & Pickering, 2014). Indeed, ongoing negative media coverage of refugees from South Sudan could be considered a form of systematic racism and discrimination directed to control this group of people.

A broad range of research has highlighted the relationship between racism and negative mental health outcomes for the population in general (Paradies, et al., 2015; 2006; Williams, Neighbors & Jackson, 2003; Williams, Priest & Anderson, 2016). Furthermore, there is a growing consensus in international research that experiences of discrimination can compound with pre-migration trauma, leading to increased negative mental health outcomes (Beiser & Hou, 2016; Ellis, et al. 2010; Molsa, Kuttinen, Tiilikainen, Honkasalo & Punamaki, 2017; Noh et al., 1999; Stark, Plosky, Horn & Canavera, 2015).

The impact of negative representations of South Sudanese in Australia

South Sudanese Australians have been the subject of negative representations and racial politics in Australia for decades. Since the interviews reported in this paper were conducted in 2016 and 2017, the issues surrounding the negative portrayal of South Sudanese Australians have not subsided. Examples of recent political discourse reflect the same sentiments: in 2018 then-Home Affairs Minister Peter Dutton stated that “there is a major law and order problem in Victoria…. we don’t have these problems with Sudanese gangs in NSW or Queensland” (Crowe & Grace, 2018). Then Prime Minister (PM) of Australia, Malcolm Turnbull did not dispute Dutton’s claims, but rather, when questioned, agreed that there were “real concerns about Sudanese gangs” (Crowe & Grace, 2018). Simultaneously, former PM, Tony Abbott called all African immigration into Australia into question, stating that there was “an African gang problem” and questioned “why do we store up trouble for ourselves by letting in people who are going to be difficult, difficult to integrate?” (Koziol & Cunningham, 2018).

There is now a growing body of research examining how public anxiety concerning South Sudanese refugees has been represented in political and media discourse (Due, 2008; Hanson-Easy & Augoustinos, 2010; Hanson-Easy & Augoustinos, 2011). Overall, former refugees from South Sudan who live in Australia have been socially constructed as different, deviant, and a danger to the Australian national identity (Baak, 2011; McMaster, 2001). There has also been an increase in popularity of right-wing politicians, anti-immigration policies, and “reactionary identity politics” (Ang, 2000) that largely stems from a fear of threat to the British-derived, white homogeneity that has historically defined Australian national identity (Ang, 2000; Baak, 2011). Fewer studies, however, have explored the effects or impact of this public discourse upon the South Sudanese community in Australia and New Zealand. Baak (2011) analysed the ways in which, following the murder of a young man originally from Sudan, media reports served to exacerbate feelings of lack of belonging for Sudanese community members. Marlowe (2013) conducted an ethnographic study involving the documentation of narratives of 24 South Sudanese men that highlighted difficulties developing inter-community relationships whilst maintaining important cultural and social histories. Participants reported the struggle to represent themselves and have their voices heard over those in positions of power who depict their community in a negative and racist fashion, including political leaders (Marlowe, 2013). Phillips (2013) highlighted the issues of labelling South Sudanese as African-Australians, including the fact that this label does not capture the specific elements of South Sudanese culture and unique pre-migration experiences. Moreover, Baak (2019) identified experiences of racism and Othering in the school environment, including racist bullying from other students and peer and teacher exclusion, through interviews with primary school Sudanese children. Baak (2019) argued that these experiences in school environments were enabled and perpetuated by racist political and media discourses surrounding refugee and minority groups in Australia.

As many researchers have argued, this “othering” of South Sudanese refugees has impacted on their sense of belonging in Australia. In a qualitative study with 21 South Sudanese men and women in Canberra, women and men reported differences in their sense of belonging (Willie, 2013): men’s sense of belonging depended more upon having their agency acknowledged and participating in Australian society, whereas women emphasised language barriers, employment, and lack of childcare and family support as significant barriers to resettlement.

The present study

The above review of existing research clearly indicates that South Sudanese refugees in Australia have had to confront significant challenges, not the least of which has been the pervasive and systematic representation of their community as problematic. However, there has been less research examining the impact of this negative portrayal on the health and wellbeing of the community. Using principles from a community-based participatory approach, this study reports on interviews with South Sudanese women in South Australia who were initially recruited to speak about barriers to help-seeking for mental health services, but who consistently highlighted the impacts of these negative depictions of their community on their psychological health and well-being during interviews. It is this issue that we specifically examine in this paper.

Method

Principles from a community-based participatory research (CBPR) approach were used in this project. CBPR is a social justice approach for working with vulnerable and minority groups (Banks et al. 2013). The main goal of CBPR is to ensure that research is relevant to those in the communities being considered, including partnership with communities and community involvement in all stages of the research design.

One of the main principles of CBPR is the promotion of knowledge sharing between communities, universities, and service delivery institutions. Ultimately, this process can aid in improving service design and policy making, as well as improving and developing skills of staff who work with communities. CBPR is based on a set of values that includes the promotion of equal partnerships and shared learning experiences, and it generally requires some degree of active involvement from community stakeholders (Banks et al., 2013). Thus, CBPR requires particular attention to be paid to the ways that ethics are negotiated around power relations between different parties, an approach that is notably different to that of traditional approaches in psychological research, and which we detail below.

Procedure

Nadimpalli, Van Devanter, Kevathe & Islam (2016) have highlighted challenges encountered during CBPR research, including the author's ability to be included into the community partnership, forming relationships with community partners, finding appropriate spaces to collect data, funding of the project, and presenting results to the community. Other researchers have similarly noted ethical challenges that can arise regarding the ownership of the collected data in a CBPR research project (Holkup, Tripp-Reimer, Salois & Weinert, 2004). In light of these issues, considerable time was spent by the first author developing relationships within the South Sudanese community in Adelaide. This included regular phone-call conversations with community leaders, meetings with The African Women's Federation of South Australia, and allowing extra time at visits for rapport building before interviews. At the beginning of the research project, the first author was approached by a male community leader expressing concern about general mental health issues and recent suicides in his community. He advocated for research to be conducted with an aim to improving access to services and encouraging dialogue about mental health concerns. As a result of this request, a project was developed with several community members involved in the project design and development of interview questions.

The project was approved by The Human Research Ethics Committee at The University of Adelaide (H-2016-130). Best practice ethical guidelines for research with refugee and asylum seekers were followed (Hugman et al., 2011; Ziersch, Due, Walsh & Arthurson, 2017). In the current study, women were recruited from multiple institutional and community sources, creating multiple starting points from which to snowball in order to ensure a diverse sample. Moreover, clear protocols and referral pathways for participants were established at the beginning of the research process if participants became distressed or re-traumatised by interview questions (Ziersch et al., 2017). Specifically, participants were informed verbally of relevant services and provided with a complaints and contacts sheet at the beginning of the interview.

Drawing on previous research (Hebbani, Obijiofor & Bristed, 2013; Mackenzie et al., 2007), people may be reluctant to decline a request to participate in research in order to benefit their broader community. As such, it was made clear to participants that participation was completely voluntary (Mackenzie et al., 2007). The ability to give informed consent may be influenced by power relations between the researcher and participant (Mackenzie et al., 2007). In an effort to redress this potential problem, and to build rapport between researcher and participant, the first author spent time with participants before beginning the interview, including offering time to further consider involvement, in order to build trust and rapport.

Participants

Participants for this study were seven women and two men from South Sudan with refugee backgrounds who lived in Adelaide, South Australia. Four women and the two men identified themselves as community leaders. Participants described community leaders as people who were involved in bringing their community together, organising events, representing the best interests of their community, and often meeting to discuss important issues. Participants were recruited through responses to posters and fliers distributed through education institutions, community centres, and other organisations. Participants were eligible if they had been in Australia for more than three months, ensuring some level of familiarity with the Australian health care system (given the initial focus of the study on help-seeking), and were over the age of 18. A combination of convenience and snowball sampling was used to maximise participation. Participants were between the ages of approximately 25 –70 years (see table 4). Some participants did not know their exact year of birth and others did not wish to disclose their age, so approximate ages are given. The average length of time spent living in Australia was 13 years. Participants were not required to be fluent in English; interpreters were offered in whatever language the women felt most comfortable speaking. However, none of the participants requested or required an interpreter.

Table 4: Participant demographics

Pseudo-name	**Community status**	**Tribe**	**Approximate age**	**Years in Australia**	**Number of children**	**Religion**	**Occupation**
David	Male Community Leader	Dinka	40-50 years	15	3	Christian	Community Chairman
Mark	Male Community Leader	Ma’Di	40-50 years	18	2	Christian	Government Worker
Grace	Female Community Leader	Dinka	50-60 years	15	3	Christian	Aged Care Worker
Susan	Female Community Leader	Dinka	60 + years	15	4	Christian	Unemployed
Hope	Female Community Leader	Dinka	40-50 years	12	6	Christian	Student
Anna	Female Community Leader	Dinka	50-60 years	15	8	Christian	Student
Chloe	Community Member	Dinka	30-40 years	12	2	Christian	Unemployed
Mary	Community Member	Ma’di	20-30 years	16	0	Christian	Disability Support Worker
Leah	Community Member	Jurchol (Luo)	30-40 years	7	2	Christian	Student

The interviews

Qualitative, semi-structured, face-to-face interviews were conducted between October 2016 and May 2017 by the first author. At the time of interviews, there were widespread reports of violence related to the so-called “Apex gang” after police launched a Taskforce to monitor the group in November 2015. Extensive media coverage of an incident at the Moomba Festival in March 2016, and then again in March 2017 where 53 people were arrested (Wahlquist, 2018), sparked the use of terminology such as “African gangs”, both by the media (for example, see Bolt, 2016, SBS News, 2015) and federal government leaders, including PM Turnbull.

On average, interviews lasted 60 minutes and were conducted at convenient locations for the participants. All interviews were conducted in a one-on-one setting, except for one interview that was conducted with two female community leaders present (Grace and Susan). A $20 shopping voucher was gifted to participants in appreciation of their time. In accordance with the CBPR approach, research questions were formulated through consultation with two community leaders: one male (who approached the first author initially) and one female. From these discussions the first author formulated a semi-structured interview guide and then consulted with the female community leader again. Interview questions included how women sought help for mental health concerns, what might stop women from getting help, and what participants found had helped them through difficult periods in their lives. This guide served as an aide memoire, and participants predominantly guided the interview (Braun & Clarke, 2013, p. 84). As the interviews were conducted the interview guide was modified according to what was most important for participants to speak about.

A clear issue identified through the initial interviews was that of experiences of racism and discrimination, and it is noteworthy that these arose without prompts. As such, questions regarding racism and discrimination were added in subsequent interviews after again consulting with the female community leader concerning cultural appropriateness and wording.

Each interview was transcribed verbatim using the “Jeffersonian lite” transcription method (Potter & Hepburn, 2005), in which detail beyond the actual words spoken is provided, including pauses and volume. See table 5 for transcription conventions used in this study (Potter & Hepburn, 2005).

Table 5: Transcription conventions

Symbol	**Definition and use**
(.)	Brief interval
Wo::rd	Colon indicates prolonged vowel or consonant
Word-	A dash indicates a cut-off
>word<	Right and left carats indicate increased speaking rate
.hhh	Inbreath – Three letters indicate normal duration. Longer or shorter inbreaths indicated with fewer or more letters
W(h)ord	Indicates abrupt spurts of breathiness, as in laughing when talking
(word)	Parentheses indicate observed physical action
<u>Word</u>	Underlining indicates emphasis
‘word’	Single quotation marks indicate reported speech
↑↓	Marked shift in pitch/intonation, up (↑) or down (↓)

Consistent with a CBPR approach, each transcript was returned to participants either through email and a follow-up phone call or a home visit to discuss interpretations and to provide further approval for the project (Holkup Tripp-Reimer, Salois & Weinert, 2004). Extracts from interviews that appear in this paper have been stripped of any identifying information (aside from the interviewer), and an approximate age of the participant and pseudonyms are used. The interviewer has been included in most extracts to emphasise the interactional nature of the interview (Potter & Hepburn, 2005).

Thematic discourse analysis (Braun & Clarke, 2006; 2013) was used to analyse data. Interviews were initially coded inductively for themes relating to factors contributing to mental distress and barriers to help-seeking, in line with the aims of the original project. However, during analysis, it became clear that significant portions of the interview were devoted to discussing experiences of racism and the impact of negative media reporting of Sudanese refugee communities in Australia. The analysis in this paper specifically focuses on how these issues were constructed by participants and the impact of these issues on their everyday lives. The analysis is informed by principles from discursive psychology (Hepburn & Wiggins, 2005). Specifically, that discourse is action-oriented, and that discourse is situated within the unfolding of the conversation (Potter, 2012).

Results

Three recurring themes were identified: 1. The overwhelming negative stereotyping of South Sudanese Australians within media and public discourse in Australia, 2. Direct experiences of racism, and 3. The impact of negative media representation upon intergenerational relationships and wellbeing.

Stereotypes of Sudanese Australians: “One onion all smell”

A common theme throughout interviews was how the Australian media generated predominantly negative stereotypes and generalisations of refugees from South Sudan. These stereotypes were largely associated with media reporting of so-called South Sudanese youth “gang” violence in cities such as Melbourne, reports that were often repeated and reinforced by political leaders and the police force. Such negative portrayals work as a form of institutionalised racism which functions to perpetuate and reinforce negative public sentiments towards South Sudanese Australians, including those with refugee backgrounds. In Extract 1, two female community leaders expressed how these negative portrayals of a select few members of their community were impacting upon their lives in Australia

Extract 1:

Grace: now even they cannot consider some people working >they say oh African they just taking Centrelink money< [government welfare] but not (.) not all (.) and that’s what they say in our language (.) one onion all smell [...] because some Sudanese they are working hard but not good even […]

Susan: the other one work in different buildings not to steal like this one looking on the TV not good (.) the government to help us for this to help these children we happy (.) we happy.

Grace: the government I think they try to help but the problem for me here they abusing us (.) you know like the Sudanese (.) not all Sudanese (.) young people,

Susan: young (.) young people

Grace: some of them (.) when they Sudanese we feel bad you know?

Interviewer: yeah it’s a judgement

Grace: they judge all of the community and it’s not fair yeah (.) so we just even ask God who bring us here (.)

Susan: to help us-

Grace: to help us (.) that’s all because (.) we try what to do we don’t know

In this extract Grace and Susan construct individual and group identities through the use of “we” and “us”, referring to themselves individually and their group identity as “Sudanese” (7, 8, 10, 15, 16, 17, 18). They also construct the group identity of the Australian government and the media through the use of “they” (1, 2,10, 15). Grace uses reported speech (1: “they say”) to construct the general public’s attitudes toward members of the South Sudanese community. Grace’s onion metaphor makes reference to the negative stereotyping endured by the South Sudanese community. Specifically, both women express their frustration at how the selective reporting of “bad news” stories about a small minority, specifically “young people” (11-12) functions to depict the entire South Sudanese community in a negative light. The failure of the media and other institutional authorities to present alternative frames within which to view this community (4-5: “some Sudanese they are working hard”; 6: not to “steal”) is presented here as unfair and unrepresentative.

Similarly, in Extract 2, Mary speaks of how the unlawful behaviour of some youth affects the entire South Sudanese community, and moreover attributes the racism they are experiencing to this unrepresentative behaviour.

Extract 2:

1 Mary: there’s a lot racism that’s going on because of (.) what (.)
2 young people are doing (.) the young ones are pretty much
3 wrecking it for the– (.) especially the South Sudanese you hear-
4 (.) you know, like- the things that they are doing is not good, (.)
5 and they’re out there causing issues and stuff .hhh and that
6 kinda comes back to us again like >‘oh you’re Sudanese, South
7 Sudanese’< straight away you know? (.) it’s stereotyping-
8 ‘these guys are violent’ (.)

9 Interviewer: yeah
10 Mary: and coming from a place that is violent and >then coming to
11 Australia to seek help< and then next minute – some people
12 out there that are doing silly things and not realising that (.) it's
13 coming back to the actual community (.) it's coming back to us
14 as South Sudanese.

Mary also uses reported speech to reference the negative attitudes of the general public that have been fostered by negative media coverage (6-7). Mary includes herself in the group category of "South Sudanese" (13-14) and describes how the media's use of the category "Sudanese" to refer to some young people then reflects upon the whole community (6-8). As in the previous extract, Mary laments the automatic stereotyping of the Sudanese community as "violent" (8). Indeed, she emphasises how the category "South Sudanese" immediately positions their community negatively. As Baak (2011) argues, it also racializes the community as an "Other": foreign, failing to integrate, and inherently violent, given their background of war trauma and low levels of education.

In Extract 3 Leah expresses conflicting views on media representations of her community. Although she is disapproving of antisocial behaviour by some young people in her community, she also complains that media reports are quick to conclude that perpetrators of crimes are South Sudanese Australians without sufficient evidence. Again, as seen in other extracts, Leah indicates that such media portrayals had negative repercussions for the entire South Sudanese community.

Extract 3:

1 Leah: I'm really stressed about seeing those things happening (.) it's
2 just stressful (.) >because< it makes us look – >I don't know

how to call myself<, but all the young kids whatever they are doing it's ↓wrong (.) they shouldn't be doing that even though- because I know there's problems everywhere (.) even the Australian people they are um there's issues that are happening with their young people (.) well I think what they are doing is beyond (.) trust me it's beyond (.) I watched in channel 7 one day- ah, there is bad and good within us, but >coming from as a refugee to another country you need a better life<. (.) and you need to fix everything that happened to you (.) and I >don't believe those kids are going through any mental health<, .hhh I don't believe that (.) because they came here young or they even born here

Interviewer: mmm

Leah: they didn't come here (.) they can't say 'oh mental issue' unless they caused it themselves with drug addict and stuff like that.

Interviewer: do you feel that those media reports reflect badly on the whole of the South Sudanese community?

Leah: ↑>at the moment yes<. trust me, .hhh because now even my voice can never be heard because (.) I'm not in any support of all what the kids are doing (.) the media, (.) ↑I cannot say the media is bad or anything because there's bad and good (.) there's one day in channel 7 there's a report saying there is another Sudanese man who stole something from th::e liquor shop >which he didn't< so it was wrong (.) and then they came and apologise and they say 'oh it wasn't him it was another one'

28 (.) that is definitely wrong (.) but if there is something with
29 evidence of course ↑why not to believe?

Leah repeatedly emphasises how ‘stressful’ (1: “really stressed”) it is for her to see and watch “bad things happening” by members of her community on television (8-9). Leah’s distress can be evidenced throughout the extract by numerous paralinguistic features in her speech. For example, she emphasises the words “stressed” and “us” (1 & 2) and emphasises as well as drops her intonation (4) on the word “wrong”. Her speech quickens and is also emphasised as she makes the point that a South Sudanese man did not steal (26). While acknowledging the unacceptability of bad behaviour by Sudanese youth, describing it as “beyond” (8), she also appeals to the commonsense idiom that “there is bad and good” (9) people within her community, just as there is in the wider Australian community. Two categories of youth are constructed – those who behave in a “socially acceptable” manner and those who do not. As Goodman (2017) notes, this contrast structure works to normalise the South Sudanese community as being like any other community. It also functions discursively to position Leah as someone providing a fair and balanced evaluation of her community before continuing her argument that she is not supportive of “what the kids are doing” (22). It is notable that Leah also uses this contrast structure to categorise the media into “bad and good”, and thus avoids attributing blame to all sectors of the media for depicting her community in a negative light.

Leah’s repeated appeals to the interviewer to trust her (8 & 20) function discursively to assert the sincerity and independence of her accounts and views (Edwards & Fasulo, 2006). It is of significance that her complaint “now even my voice can never be heard” (20-21) is prefaced by this expression of sincerity, and can be heard as reflecting her perceived position of helplessness and lack of agency to change how her community is being represented.

Experiences of racism: "oh that's normal… that's just life"

It is well-documented that refugee populations in countries of resettlement experience racism and discrimination after resettlement in a host country (Kirmayer et al., 2011; Montgomery & Foldspand, 2008). In addition to negative media portrayals, participants in this study similarly spoke of their own personal experiences of overt racism.

Extract 4:

Interviewer: Mmm, what about racism from um people from outside your community? >So people< like from the (.) Caucasian um like what you see in the media things like this

Grace: you mean like Australians >or something like that<?

Interviewer: yeah

Grace: oh that's normal you know? (laughter) .hhh that's just life. There are bad people and there are good people. (.)So sometimes like that (.) sometimes it affects young people

Interviewer: yeah okay

Grace: (.) not us

Interviewer: younger people

Grace: yeah younger people like (.) ah my daughter (.) the second one (.) she was working in healthcare and then she was doing the cleaning and an appointment with the old man (.) and then the old man expected to see a wh(h)ite girl (.) when the old man come he sees a black one and he says 'ohh no I don't want to

17 see her (.) cos she’s black’ (.) and so she was upset (.) and she
18 was crying, .hhh but the good manager talk to her and then they
19 called me. (.) I said ‘no (.) you know you have to face (.) you
20 have to be (.) you have to face because there are bad people and
21 there are good people’ – so we have to live with that you know
22 in our life (.) but it’s good for (.) not for us (.) like for me I
23 face, but I can handle (.) but for young people (.) it’s hard for
24 them also because (.) that’s life, we can’t do anything because
25 they will live like that (.) I think it is a very big issue because
26 you can’t do anything about it.

When asked about general experiences of racism, Grace initially responded with “no we love each other in our community”. In response to the interviewer’s direct question about experiences of racism from outside the South Sudanese community (4), Grace seeks clarification as to whether she is referring to “Australians” and responds with laughter, describing such racism as normal (6: “that’s just life”). Here, racism is constructed by Grace as a normal part of everyday life that older people like herself have learned to live with, but one which younger people find more difficult to accept. Again, we see the use of the common-sense trope and contrast structure that “there are bad people and there are good people” (7 & 20-21) to argue that racism is an everyday experience that must be endured, and that is ultimately “life” (6 & 24).

In Extract 5, she continues to report on the experiences of her children (son) and their emotional response to racism. While acknowledging how difficult it is for younger people to cope with racism, she emphasises again it is something they need to “learn to face” but at the same time ignore (16).

Extract 5:

Grace: like my son last year (.) he went to play football yeah I used to
take him to basketball, football (.) but that day I was working
so he drive himself so he's playing (.) the man not even the
man come and throw him a bottle in his car and he is young
how can (.) he is going to feel (.) he will fight or will he
respond and that's not good (.) and he called 'mum, mum, mum'
I said (.) 'don't do anything just go into the car and come back'
(.) so from that he did not go (.) he did not go and play football
nope (.) so it affected him .hhh and um yeah so that's what like
I said (.) it's the young people that are affected (.) but they love
to mix with the Australians because they are Australian (.) and
one day they will come good (laughter) they will bring
something good – like goal or something for Australia – cos
they are not playing for Sudan they are playing for Australia (.)
but not all people just some people yeah (.) so we have to face
and we have to (.) ignore them (.) just ignore them just let them
talk (.) but for young people it's hard for them .hh when in my
place some people say 'Nooo you're black' I said 'yes, bad
luck' (laughter) I said 'bad luck, I'm black but I'm helping you'
(laughter) >'if you like it or not just calm down<, .hhh I'm
h(h)elping you' (.) and then they said nothing. (laughter
continues) you know nothing you can do

Grace positions herself as a mother (6) guiding her son through an overt experience of racism. Notably, she positions South Sudanese youth as "Australians"

(11), but she does not include herself in this national category. Grace describes her son having to negotiate his participation in a local football team (ingroup) whilst also being perceived by others as belonging to an outgroup (South Sudanese young person) and experiencing racism. Grace argues that South Sudanese youth are no longer playing for Sudan but rather playing for "Australia" (12-14), reflecting her general sentiment that her family has lived in Australia for a significant period of time, so they should be identified as Australians. Although Grace describes two overt experiences of racism experienced by her son as well as herself, she does not attribute blame to all Australians (15: "not all people just some people"). These descriptions work to position Grace as a protective, strong, guiding maternal figure, as well as someone who endures explicit racism in her place of work as an aged care worker. Grace's laughter in her telling of racist incidents is a recurring feature in this extract. As Potter & Hepburn (2010) argue, laughter may have a range of interactional functions that can be quite separate from jokes or humour. Specifically, the laughter in this extract may function to emotionally de-escalate descriptions of two arguably extreme and confronting experiences of racism.

Studies investigating the help-seeking attitudes and behaviours of groups of people subjected to racism and discrimination have indicated that perceived racism is negatively correlated with intentions to seek help for mental health concerns (Kim, Kendall & Chang, 2016; Mosley, 2014). Here, participants similarly indicated that racism was a barrier for some women seeking help for health issues and employment. Mary below describes these problems, with her perception that South Sudanese Australians are automatically assumed to be "trouble" (3).

Extract 6:

1 Mary: if I go to someone and say ‘I’m South Sudanese’ they’ll be like
2 (.) (gives disapproving look) >without knowing me< they’ll
3 just be like- straight away they’ll be like ‘oh, (.) okay trouble’ (.)
4 you know? (.) straight away (.) >and I think that’s why<
5 sometimes it’s very hard for us to seek for help (.) even
6 employment itself job itself (.) because of your name, your last
7 name (.) sounds weird

Mary uses both reported speech and body language (2-3) to imply prejudicial attitudes and behaviour from those whom she might seek help or employment. Specifically, the spontaneous association of South Sudanese with “trouble” makes her and members of her community reluctant to seek services and assistance. Like other participants, Mary demonstrates her awareness of the pervasive stereotypes associated with her identity as South Sudanese. Below we demonstrate the effects of this everyday racism on participants’ wellbeing and relationships.

Negative media representations, intergenerational relationships, and wellbeing

While the perceived causal reasons behind negative and racist depictions of the South Sudanese community in the media were attributed primarily to the actions of a small number of youth, participants also expressed concerns regarding their lack of control over the youth within their community. Indeed, participants expressed considerable distress over intergenerational tension and conflict. Tensions between parents and their children can typically arise post-resettlement in a new environment with different parenting practices, languages, and cultural barriers (Deng & Marlowe, 2013). In terms of parenting, in South Sudanese families it is usually the mother’s role to care for the children and teach them language and cultural practices until a certain age (Deng, 2016). Family structures in South Sudan are larger, more inclusive, and determined by complex social as well as biological factors (Baak, 2016). As such, women from the South Sudanese community may have multiple connections to, responsibilities for, and relationships with children or young people to whom they are not necessarily biologically related (Deng, 2016).

Negative media reports about South Sudanese youth served to exacerbate these concerns, leading to reports of physical and mental health effects, especially among elderly women. One community leader directly related the behaviour of some young people - as well as drug and alcohol use within her community - to higher incidents of physical and mental health issues. In these accounts, women attributed their wellbeing concerns (unhappiness and feelings of shame in particular) to the behaviour of some young people in their community. In Extract 7 Susan describes the shock and disappointment of the entire community with the anti-social behaviour of the few.

Extract 7:

Susan: we are coming from refugee camp to here (.) Australians
brought us here to share you good life (.) the children to go to
school here >to finish the school< to get the job in Australia
we're doing something good for Australia not criminal

Grace: not criminal

Susan: it's now they doing criminal we are >very very shocked< the
others they sit now they have high blood pressure, high sugar,
mental problem, everything (.) we unhappy (.) not happy (.)

Grace: yeah it's a problem for family

Susan: it's a problem

Interviewer: do you think that would be the biggest issue in the community?

Susan: that one the >biggest, biggest< issue

Grace: because we are not happy

Susan: we are not happy

Grace: and we are not healthy

Susan: we are not happy, we are not happy >the children do not finish school, the children not to go to school they doing like this one not good<

Grace: it’s very shameful (.) we feel shame

Susan: we feel shame (.) shame in Australia

It is notable how unhappiness and shame feature as central emotion categories (Edwards, 1999) in this account, and how these negative emotions are linked to poor health (15*)* in the community. Although intergenerational conflict is unlikely to be unique to the South Sudanese refugee community – indeed it is likely to be a cross cultural phenomenon and enhanced by resettlement stressors (Dolezal & Lyons, 2017; Hebbani, Obijiofor & Bristed, 2012; McMichael, Gifford & Correa-Velez, 2011) – the intense public focus and institutional gaze that South Sudanese youth in particular have received has had a far-reaching impact on the entire community. As the role of adults in South Sudanese culture is to educate and pass down cultural values, norms, and language to younger generations (Pouch, 2006), if this is not perceived to occur there may be ramifications upon parents' wellbeing. Perceived misbehaviour or transgression on a child's behalf can reflect upon, or bring shame upon, a whole family (Bishop, 2011). Furthermore, the magnitude of collective shame described here (19-20) is likely to compound the usual resettlement difficulties.

Discussion

This paper has outlined the salience of negative media portrayals on the lives of women with refugee backgrounds from South Sudan, and highlighted the importance of listening to the voices of participants in research. In this case, adopting a CBPR approach encouraged researchers to honour participants' concerns and priorities as most important, instead of solely focussing on the pre-determined, and perhaps less relevant, research agenda of help-seeking. In this final section, we consider our findings relevant to previous literature, and reflect on the methodological process and its role in ensuring that research is oriented not only towards producing 'evidence', but also to listening to, and working with, community members.

Stemming from issues with media representations, participants highlighted a range of other concerns, including interpersonal and institutionalised racism and discrimination, as well as its impact upon wellbeing and intergenerational relationships and conflict, both of which have been noted in previous research with refugee populations more broadly (Fozdar & Hartley, 2013). Participants acknowledged a range of complex factors that contributed to intergenerational tension, including differences in parenting, and young people learning English more quickly than their parents. However, participants consistently indicated that negative depictions of young people from their community and intense media and political scrutiny compounded and exacerbated these intergenerational tensions and resettlement stressors. It was evident that although some women in this study were clearly distressed and may benefit from mental health support, their concerns were more collective and community-based (Okegbile, 2014). As indicated by previous research, although some individuals may have symptoms of mental health issues, overall functioning may not be reduced, with more concern often reported about current stressors, including family problems (Tempany, 2009). The initial research agenda of exploring help-seeking for mental health services seemed somewhat less critical when women began speaking about such experiences.

Media and political discourse has chosen to predominantly present depictions of South Sudanese youth associated with violence and “gangs” without more nuanced representation. Notably, racially and politically charged comments from influential and powerful Australian political figures, such as PMs and radio commentators, reflect deep-seated institutional racism and serve to increase racial anxiety amongst the general public (Baak, 2018). Ultimately, the negative depiction of South Sudanese youth, and subsequently the community, is complex and nuanced, involving methods of social control that are specifically targeted at the exclusion and criminalization of people from refugee or migrant backgrounds (Aas & Bosworth, 2013; Bosworth, Franko & Pickering, 2017; Bowling & Westenra, 2018). Negative media coverage, for example involving “African gangs”, serves to elicit fear in the general Australian public that then works to further marginalize targeted groups from wider society. Defining or categorising “suspiciousness” is interlinked with visible difference and people of colour are largely targets for surveillance and control (Bowling & Westenra, 2018), including the media. When groups of people are broadly classified according to their level of “dangerousness” (Weber & Bowling, 2008) we observe a level of dehumanization in order for minority populations to be effectively controlled or excluded (Zedner, 2013).

In the current study, although participants acknowledged the surveillance of their community and the negative behaviour of a minority of young people, they understood and argued that this is not representative of their collective identity. Women also described the detrimental effects that this had on their own wellbeing, perhaps due to the importance of community and raising children. The often unheard voices of the South Sudanese women as represented in this study are extremely important and demonstrate the need to consider both how marginalized communities are being represented, and the effect that this has upon the wellbeing of all community members.

Methodological reflections and limitations

In following the principles of CBPR, researchers in this project faced several ethical dilemmas. In particular, the multiple roles of researcher, academic and activist were evident, with the first author negotiating her dual role as researcher and community advocate/activist (Calderon, 2004). Throughout the project, participants viewed the first author in different ways: sometimes as an ally, a friend, an outsider, someone who could facilitate change, and an individual from an institution. Negotiating these expectations of roles proved challenging and required a high degree of transparency. Furthermore, in terms of stake and interest (Potter & Hepburn, 2005), and researching such a politicised topic, the first author’s political perspective is naturally evident, and interpretations of the data somewhat reflect these views. It is important to determine for whom and for what purpose the research is conducted (Phipps, 2017). This reflects Gramsci’s notion of the “organic intellectual”: a social agent that has an allegiance to a hegemonic class and is responsible for the formulation and spreading of “organic ideologies” (see Bates, 1975). Academia and activism have long been viewed as separate worlds that are driven by contrasting aims and imperatives (Eschle & Maiguascha, 2006). However, social researchers have recently argued that there are ways of bridging these two realms. In the current research, community consultation in relation to the research questions allowed exploration of issues relevant to the community. This raises the importance of participatory research approaches where interview guidelines are re-worked and modified depending upon community needs and priorities. In the current study, there was consultation with two community leaders at the beginning of the project regarding the purpose of the research. Both leaders highlighted the importance of starting conversations about mental health within the community.

In this particular project, the CBPR approach encouraged the researchers to honour participants’ priorities instead of solely focussing on the pre-determined research agenda of help-seeking, this leading to the foregrounding of women’s voices. Notably, within CBPR there is the capacity for complex ethical issues to arise due to the frequently encountered variety of stakeholders involved, and the negotiation of power-sharing throughout the research process. In this regard, Banks et al. (2013) have coined the term “everyday ethics”, which refers to the consideration of ethical issues within the context of the research as it emerges, encouraging researchers involved in CBPR to reflect on their status as active and embedded in the research process and in relationships with participants, and not as impartial deliberators. As such, everyday ethics encourages consideration of ongoing responsibilities, values, and commitments that frame and constrain ways of seeing, judging, and acting in particular situations that may arise during the research process, including the shaping of the research through issues of salience to communities, as in this project. Although our research reported here attempts to honour such commitments, we acknowledge that these efforts could have been strengthened by more collaboration and community involvement in each step of the research process.

Implications and conclusion

This article highlights the ethical implications and moral obligations of researchers working with minority groups, particularly when research findings deviate from the initial research agenda – in this case help-seeking – and the importance of participatory research methods when this does occur. This article highlights the negative impact that racist media portrayals is having upon members of the South Sudanese community in Australia. We argue that there needs to be an end to systematic racism in the Australian media and public discourse if we are going to have any success in working towards improved mental health outcomes and general well-being for such already vulnerable populations. There is a need for the Australian media to practice reflexivity and acknowledge that the current negative portrayal of the South Sudanese community is unhelpful and detrimental to the wellbeing of members of this community. Moreover, it is incumbent upon political leaders to behave ethically in the face of community anxieties about minority groups by not exploiting such vulnerable communities for their own political purposes.

Chapter 8. Study 4

8.1 Social determinants of women’s mental health and barriers to help-seeking: perspectives of service providers working with women from refugee backgrounds

In order to triangulate the data from studies 1-3 conducted with community members, study 4 involved interviews with service providers who worked with these communties. Findings are presented below and then further explored with reference to studies 1-3 in the Discussion, presented in Chapter 9.

This study has been prepared as a manuscript for submission to the *Australian Community Psychologist*. The paper is presented here with the same typeset as the rest of the thesis.

Statement of Authorship

Title of Paper: Social determinants of women’s mental health and barriers to help-seeking: perspectives of service providers working with women from refugee backgrounds

Publication status: prepared as manuscript

Principal Author

Name of Principal Author (Candidate): Rose Burford-Rice

Contribution to the paper: Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data anaylsis. Drafted, wrote and submitted article, then revised and responded to reviewer comments. Acted as corresponding author.

Overall percentage(%): 80%

Certification: This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractural agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.

Signature: Date: 28/01/2020

Co-authors

By signing the Statement of Authorship, each author certifies that:

i. The candidate’s stated contribution to the publication is accurate (as detailed above);

ii. Permission is granted for the candidate in include the publication in the thesis; and

iii. The sum of all co-author contributions is equal to 100% less the candidate’s stated contribution.

Name of Co-Author: Professor Martha Augoustinos
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Signature: Date: 28/01/2020

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Contribution to the Paper: Input regarding study design and sampling. Supervised development of the work and input regarding analysis of data. Provided guidance on the preparation of manuscript and editorial and structural feedback on the paper.

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Globally, there are currently over 25.9 million people classified as refugees, who have been forced to leave their home countries due to persecution or conflict (UNHCR, 2019). Although people with refugee or asylum seeking backgrounds often show extraordinary strength and resilience in the face of extreme adversity (Hutchinson & Dorsett, 2012), meta-analytic studies suggest that refugee populations suffer poorer mental health status when compared with other groups of migrants and the general populations of host countries (Porter & Haslam, 2005; Fazel, Wheeler, Danesh, 2005; Lindert et al., 2009; Kirmayer et al. 2011). Poor mental health outcomes amongst refugee populations more generally have been linked to pre-migration trauma (including torture, loss of family members, witnessing or participating in conflict, and imprisonment), as well as post-migration stressors (adjusting to a new culture, racism and discrimination, resettlement stress, and loss of social support) (Porter & Haslam, 2005; Alemi et al., 2014).

Women may be at particular risk of psychological distress due to extra risks they face on their journey to a resettlement country, including sexual violence, unwanted pregnancies, harassment, health issues, and separation from children and loved ones (Kastrup, 2006). Despite the well-known high levels of psychological distress in refugees and asylum seekers, these populations are profoundly underrepresented in relation to the utilization of mental health services in resettlement countries such as Australia (Minas et al., 2013; Posselt et al., 2017). Although there is a growing body of literature addressing health and mental health service utilisation by non-English speaking people and immigrants (McDonald & Steel, 1997; Trauer, 1995, Bruxner, Burvill, Fazio & Febbo, 1997; Hassett & George, 2002; Boufous, Silove, Bauman & Steel, 2005), few Australian studies have specifically investigated contributory reasons behind the apparent low up-take of mental health services in culturally diverse refugee communities. This gap warrants an examination of community factors influencing help-seeking behaviours (defined as “any communication about a problem which is directed toward obtaining support, advice or assistance in times of distress"; Gourash, 1978, p. 413) and uptake of services. This is particularly important, since previous research has identified low rates of help-seeking amongst people with refugee backgrounds in resettlement countries such as Australia (Kayrouz et al., 2015).

Despite the well-documented mental health risk factors for refugees, there remain gaps in our understanding of barriers to help-seeking, access to, and use of mental health services for refugees in Australia. This study focuses on refugee service providers' perceptions of the social determinants of refugee women's mental health and barriers to help-seeking in South Australia.

Previous literature has identified several barriers to help-seeking for mental health services, including lack of services that take into account cultural knowledge and healing (Ellis et al., 2010), discordant health beliefs and divergent expectations of healthcare systems (Pavlish et al., 2010), difficulties regarding interpreters, lack of trust of services (Colucci et al., 2012), language difficulties (Colucci et al., 2015; Sheikh-Mohammed et al., 2006; Franks et al., 2007), and institutional racism (Fernando, 2017). Identified barriers to help-seeking for immigrant and refugee women include gender hierarchies within the family and relationship dominance, as well as precarious visa status (O'Mahony & Donnelly, 2013).

Previous research has explored service providers' perceptions of issues that refugee populations face. Jewson, Lamaro, Crisp, Hanna and Taket (2015) interviewed 22 health and human service professionals from various refugee-specific and CALD organizations and services to explore service providers' perceptions, needs, and experiences regarding service provision for resettling refugees in Geelong (Australia). Service providers identified a number of structural, organizational, and cultural barriers to service access, including issues of prejudice and racism within the community as well as in the service sector, lack of cross-cultural training for service providers, rigid bureaucratic processes and lack of flexibility, a lack of coordination between services, inadequate resources and funding for sevices, and a lack of willingness or understanding about using interpreters. Participants also reported barriers at the client level to be language barriers, low levels of literacy, a general lack of understanding about Australian systems, cultural barriers, and a lack of willingness to access services.

Some research has explored the perspectives of service providers providing mental health services to refugee youth. Colucci et al. (2015) conducted 15 focus groups and five key informant interviews with 115 service providers from 12 mental health agencies that worked with refugee-background young people (13-25 years) in Melbourne, Australia to explore barriers and facilitators to mental health service access. The study identified eight main factors that worked as barriers or facilitators, including differences in cultural concepts of mental health, illness and treatment, service accessibility, distrust of services, working with interpreters (for example, confidentiality), engaging family and community, the style and approach of mental health providers (e.g. reliability, boundary-setting, nonverbal aspects of consultations), advocacy (attending to the needs and priorities of the young person), and continuity of care. Prosselt, McDonald, Procter, de Crespigny & Galletly (2017) interviewed 15 government and non-government social workers, psychologists, and mental health nurses from mental health and alcohol and drugs services providing care to young people with a refugee background in Australia. Fifty-six service providers from 26 relevant mental health and alcohol and drugs services also responded to a survey. Researchers also interviewed 15 refugee youth aged between 12-25 years from Afghan and African backgrounds. Overall, reported barriers to service use included organizational and structural issues (fragmented structure of services and need for partnership and collaboration), access and engagement (stigma surrounding mental health, language and communication difficulties, accessing services at a point of crisis, and fear and distrust of services), treatment and service delivery (policies and procedures of services preventing engagement, lack of flexibility in appointment options and lack of holistic care), and training and resources (lack of training for working with refugee populations) (Prosselt et al., 2017).

In regard to service provision for refugee women, in a mixed methods study by De Maio et al. (2017), service providers identified family and gender roles, awareness and understanding of the service system, a service's geographical location, and the flexibility of programs as barriers to service use. Overall, participants rated language as the most significant barrier to service access. They also suggested that barriers, rather than availability of services, were a more important issue faced by clients.

Social determinants of health

Migration

Migration has been conceptualised as cutting across the social determinants of health, as it often fuels health inequities and can also expose individuals to increased health risks, resulting in negative health outcomes (International Organisation for Migration, 2019). Displaced people often have to endure a myriad of cultural, economic, behavioural, and communication barriers that can negatively influence their physical, mental, social, and emotional wellbeing. Women, for whom the determinants are often more severe, are particularly vulnerable during the migration process (International Organisation for Migration, 2019).

Individual level

Gender

Gender has increasingly been recognised as a significant determinant of health for both men and women, given that gender roles, norms, and behavior impact upon how people access health services, and how health systems respond to their needs (Men, Frieson, Socheat, Nirmita & Mony, 2011). Gender refers to social differences rather than biological differences, and is relational. Gender roles and characteristics do not exist in isolation; rather they are defined through interactions and relationships (Vlassof, 2007). Ballantyne (1999) argued that gender could mediate the influence of socioeconomic status as well as social integration upon health – both of which are inextricably linked for many women. Furthermore, marriage may initially increase economic status and social support for women, but also reduce control over paid and unpaid work, subsequently compromising health status (Ballantyne, 1999). For refugee women, the rupture of forced migration often results in women having to redefine their gender roles within their families, which can subsequently result in family conflict or domestic violence (Fisher, 2013).

Education and literacy

Difficulties with language has consistently been identified as a barrier to service use in refugee populations. In the longitudinal *Building a New Life in Australia* study with 2400 humanitarian migrants, 93% in Wave 1, 91% in Wave 2 and 88% in Wave 3 reported that they required interpreting services. Whilst interpreting services are often available for clinicians, access to these services for both clients and clinicians can be challenging (Smart, De Maio, Rioseco & Edwards, 2017). Sixty-one percent of participants at Wave 1 reported that they "always" or "most of the time" had been able to gain access to interpreting services when required, 49% at Wave 2 were able to gain access, and 44% at Wave 3. Reasons behind this lack of assistance included not knowing how to access an interpreter, or interpreters not being available. Notably, at Wave 1, 17% of participants reported that they had been told that their English was good enough not to require an interpreter. The percentage of participants doubled to 41% at the Wave 3 interview, suggesting that need for interpreters may persist well into the resettlement journey.

Interpersonal Level

Culture

Culture is a complex and multi-layered concept that many scholars have attempted to define (see Hofstede, 1984; Linton, 1945; Tylor 1871; UNESCO, 2002). Drawing on various definitions, culture is composed of values, beliefs, norms, symbols, and behaviours, which are largely learned (Eshun & Gurung, 2009). Eshun & Gurung (2009) have summarised the definition of culture as a "general way of life or behaviours of a group of people which reflect their shared social experiences, values, attitudes, norms, and beliefs" (p. 4). They state that culture is "transmitted from generation to generation, and changes over time", and that "it has been conceptualised as something that is cyclical or self-reinforcing, consists of tangible and intangible behaviours, and is crucial for survival and adaptation" (Eshun & Gurung, 2009, p. 4). As such, cultural traits and norms affect how we think, how we respond to distress, and how comfortable we are expressing our emotions (Eshun & Gurung, 2009). Differences in cultural conceptualisations of health and mental health can therefore determine individuals' access, utilization of, and interaction with health and mental health care services (de Anstiss & Zaian, 2010). For example, de Anstiss & Zaian (2010) conducted a study with adolescents from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. Each participant held specific cultural conceptualizations and beliefs about mental health, and as such, assumed that the treatment offered in Australia would be substantially different to their country of origin. This resulted in participants reporting a distrust regarding the Western model of mental health treatment.

Racism and discrimination

Racism has been defined as structured systems within societies that produce and re-produce inequalities in power, resources, and opportunities across ethnic groups (Paradies, 2006). Racism can manifest through beliefs, attitudes, stereotypes, prejudices, or discrimination relating to ideas of "race". It can be overt, involving open threats or insults, as well as covert, involving phenomena deeply entrenched in social systems and established structures (Berman & Paradies, 2010; Paradies et al., 2015). The negative impacts of racism upon health and mental health are now well established, with racism being considered a social determinant of health (Paradies et al., 2015; Williams & Mohammed, 2013; Ben, Cormack, Harris & Paradies, 2017).

Paradies et al. (2015) conducted a meta-analysis examining 293 studies between 1983-2013 conducted predominantly in the United States. They found that racism was associated with poorer mental health, including depression, anxiety, and psychological stress, as well as poorer general health and poorer physical health. The impact of racism upon health can occur through various pathways (Gee, Ro, Shariff-Marco & Chae, 2009; Paradies, 2006; Paradies et al., 2015), including: diminished access to employment, housing, and education; adverse cognitive or emotional processes associated with psychopathology; allostatic load, or "wear and tear" on the body due to chronic stress; reduced engagement in healthy behaviours or increased engagement in unhealthy behaviours as coping mechanisms for stress; and physical injury as a result of racially motivated violence.

Not only may experiences of racism and discrimination influence health and mental health, but it may also impact upon access to, and the quality of, healthcare received (van Ryn et al., 2011). Experiences of racism both within the healthcare system, as well as in society more generally, may influence how individuals perceive the healthcare system, how they interact with service providers, and the patterns and quality of their healthcare access (Williams & Mohammed, 2009; van Ryn et al., 2011).

Organisational Level

Institutions and Organisations

Institutions and organisations play a significant role in influencing the refugee population's understanding of Australian healthcare systems (Stokols, 1996; Taylor & Haintz, 2018). This includes the degree to which refugee populations are aware of services, and how much healthcare information is translated into relevant languages and distributed within communities (Taylor & Haintz, 2018). Studies have revealed that many resettled refugees may not be aware of services or know how to use them due to the lack of appropriately translated health material (Clark, Gilbert, Rao & Kerr, 2014; Nicol et al., 2014). For example, one qualitative, community-based study using focus groups and interviews with 39 refugee women from nine different countries and 5 community health nurses revealed that community members, as well as service providers, believed that appropriate written information regarding health services was scarce (Nicol et al., 2014).

Policy Level

Restrictive government policies in host countries directly affect people with refugee backgrounds and can negatively impact on their health and mental health (Silove et al., 2017), especially those that foster uncertainty and hopelessness (Killedar & Harris, 2017). Refugee and immigration policies are ever-changing, depending upon the government in power. These policies have not only direct effects on the individual lives of asylum-seekers and refugees living in Australia, but also their families' and friends'. It is important therefore to consider their impact upon mental health. Government policies directly impact upon the lives of refugees living in Australia and not only directly determine access to healthcare and mental heath care, but also opportunities regarding housing, employment, and family reunification.

Frameworks of social determinants of health do not often include immigrant or refugee-specific determinants of health, except ethnicity. However, Malmusi, Borrell and Benach (2010) and Ingleby (2012) have argued that migration and health issues should be integrated within the health equity framework, as this population is one of the most marginalized within society. For the purposes of this paper, the social determinants of health are considered within the social-ecological model (SEM). The socio-ecological model (SEM) has been endorsed when exploring health and mental health issues with refugee populations

(Vaughan et al., 2015; Miller & Rasmussen, 2017; Taylor & Haintz, 2018). The SEM was used to interpret results of this study, as it allows analysis of the independent influence of social determinants of health, as well as their interactions (Stokols, 1996). SEM considers individual, interpersonal, environmental, organisational, and policy levels relating to health services. The World Health Organisation defines social determinants of health as “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (WHO, 2011). Social determinants of health are often responsible for health and mental health inequalities within and between countries (International Organisation for Migration, 2019). They generally include individual lifestyle factors, community influences, living and working conditions, socio-economic status, and cultural and environmental conditions that determine the general health and wellbeing of individuals. The health and wellbeing of a displaced person is determined by their psycho-social context and the experiences in their country of origin, as well as events that occur during transit and in the resettlement country. Social determinants of health encompass: 1) the social environment, including racism and discrimination, income, and gender; 2) the physical environment including place of dwelling; 3) access to quality health care and health insurance; and 4) structural and societal factors (Centers for Disease Control and Prevention, 2012).

Method

Participants

Participants for this study were 10 service providers working with refugee populations in Adelaide, South Australia. Purposive sampling was used and based on whether the participants worked in the general field of mental health and with women with refugee backgrounds. Participants were predominantly recruited through responses to emails. Service providers included caseworkers, case managers, social workers, a general practitioner, and bi-cultural workers (see table 6). Bi-cultural workers were from different communities – Julia was an African bi-cultural worker, Sarah was a Sri-Lankan bi-cultural worker, and Niki and Salma were Afghan bi-cultural workers. At times, service providers referred to participants in broad categories such as "Middle-Eastern" and "African" women, as they worked with diverse populations extending beyond Afghan and South Sudanese women and sometimes included other populations in their accounts.

Table 6: Participant Information

Pseudonym	**Occupation**
Amy	Senior Social Worker (Child Protection)
Laura	Social Worker
Samantha	Social Worker
Beth	Case Manager
Eva	Case Manager
Emma	General Practitioner
Julia	Bi-Cultural Worker
Sarah	Bi-Cultural Worker
Niki	Bi-Cultural Worker
Salma	Bi-Cultural Worker

Procedure

Qualitative, in-depth, semi-structured, face-to-face interviews were conducted between October 2016 and May 2017 by the first author. On average, interviews lasted 60 minutes and were conducted at locations that were convenient for the participants. Written consent was obtained from each participant. The project was approved by The University of Adelaide Ethics Committee (H-2016-130). Participation was voluntary, and transcripts were sent back to service providers for their feedback and reflection (Tracy & Hinrichs, 2017) post-interview. Quotations used in this paper have been stripped of identifying information, and a pseudonym was used. All field notes, audio files, and audit trails were kept on a password-protected computer in a locked room at the university.

Interviews

An interview guide was used that included questions such as “What do you perceive to be barriers that your female clients face to seek help for mental health issues?”, “What do you perceive to be enablers and facilitators for your female clients to seek help for mental health issues?”, “What do you think is the biggest issue that your female clients face?”, “What challenges do you face working with your female clients?”, and “How do you think services for your female clients could be improved?”. This guide served as an aide memoire, and participants predominantly guided interviews, facilitated by prompts from the first author. Interview questions were developed by considering the preliminary findings of the previous studies and also drawing on the findings of previous literature (e.g. Jewson, Lamaro, Crisp, Hanna & Taket, 2015; Prosselt et al., 2017; De Maio et al., 2017). The gap regarding a lack of studies focusing on women with refugee backgrounds was identified in relation to barriers to help-seeking. In order to triangulate the data, similar interview questions to the community populations were used, but altered to suit the perspective of service providers. Furthermore, the additional questions relating to experiences of racism and discrimination were also added to the service provider interview guides.

Data Analysis

Braun and Clarke’s (2013) six-stage thematic analysis was used to analyse transcripts verbatim. The six stages included familiarizing oneself with the data, generating initial codes, searching for themes, reviewing the themes, defining and naming the themes, and producing the report (Braun & Clarke, 2013). After familiarization with the data, interviews were initially inductively coded. Codes related to factors contributing to mental distress and barriers to help-seeking were sorted into social determinants of health. Codes for barriers to help-seeking were condensed into two broad overarching themes: socio-cultural barriers, and systemic and political barriers.

Findings and Discussion

In order to contextualise the findings, Table 7 below illustrates the identified themes and subthemes of the entire thematic analysis, including factors contributing to distress, as well as barriers to help-seeking. This paper will focus on the barriers to help-seeking rather than the factors contributing to mental distress as reported by service providers for refugee women.

Table 7: Themes and sub-themes

Categories	Themes	Subthemes
Contributing factors for mental health issues	**Economic**	Unemployment
		Housing
		Sending money home
	Socio-cultural	Racism and discrimination
		Social isolation
		Low levels of English
	Family	Domestic violence
		Single parenting
		Inter-generational conflict
		Children with carer roles
		Behavioural issues with children
	Psychosocial	Grief and loss
		Past traumatic experiences
Barriers	**Socio-cultural**	Stigma
		Social isolation
		Language and communication
		Conceptualisations of mental health
	Systemic and political	Government Policies
		Child protection concerns
		Missed opportunity for service provision
		Lack of accessibility
		Expectations of services

Socio-cultural barriers

Individual Level

Language and communication. Low levels of English language have been previously documented as a barrier to service-access for refugee populations (Salami, Salma & Hegadoren, 2018; Posselt et al., 2017; Colucci et al., 2012; Kohlenberger, Buber-Ennser, Rengs, Leitner & Landesmann, 2019). In the current study, Amy described the difficulties encountered especially by older women who are expected to learn English following resettlement.

> The older you are the harder it is […] we have had a lot of elderly women […] they just struggle to pick up English. They're beyond it to be honest with you, yet there's a huge expectation on them that they are going to learn English. It's just cruel. – Amy (Senior Social Worker)

These women may be a particularly at-risk group because difficulties learning English may be compounded by the effects of trauma on learning capacity (Schmidt, 2019). Service providers also identified that women may be dependent upon others, including their husbands.

> An issue is dependency on maybe your husband or whoever tends to speak better English. […] I was talking with a woman who I've tried to book an appointment with her and whenever I would ask a question she would say 'ohh can I put my husband on the phone he will have a better idea' and I said 'yes but you will be coming to the appointment' so every single question she would just say that 'oh no, no, no, I think I will talk with my husband and get back to

> you’ BOTH so you see that would be a big barrier in terms of reaching out for help or even attending appointments. – Beth (Case Worker)

Interpreters have been identified as a necessary and integral part of the provision of mental health care to refugee populations (Gartley & Due, 2017). Service providers referenced structural barriers regarding the availability and use of interpreters. They reported that some providers may be either missing opportunities to use interpreters, or assuming that a client’s English was good enough and an interpreter was unnecessary.

> (a client) has been linked in with mental health services and she’s on a particular medication that you have to get your bloods checked regularly and when we came into the support system no one had ever used an interpreter to read out the questionnaire […] it’s just handed to her and she learnt to tick it, she knew enough English but she didn’t really understand it. When we asked her for the first time do you know what you are ticking there? And she said nah I’ve just been ticking it. We realised that this is appalling there was this assumption […] that cos her English was reasonable […] She speaks English we don’t need an interpreter […] You’ll find that a lot in mental health services – that they will just – they will hear someone speak a bit of English and then they’ll think that’s fine you know? […] Oh she speaks English we don’t need an interpreter. – Eva (Case Worker)

In this example, decisions and assumptions were ultimately made for this woman regarding her level of English, disempowering her and also negatively impacting on her health care experience. Dependence upon others for language skills was also described as a gendered experience, as service providers indicated that it is usually the men who will speak on behalf of their families and who “have the front-line contact with the agencies” – Amy (Child protection). Further to this, if a service provider did identify the need to use an interpreter, there was often inadequate funding available, making it impossible for both the provider and the client.

> The psychologists don’t have access to interpreters. So there’s loads of psychologists out there who I’m sure would be very happy to see our client group but there’s no funding for interpreters. All very well to have mental health care plan, means nothing if you can’t speak English… - Emma (GP)

> If you want to book interpreters you have to pay yourself, so what do you say to the client on Centrelink? Oh this is how much the interpreter is going to cost you – they can’t access those services. – Samantha (Social worker)

These accounts demonstrate the interconnected nature of individual (language and gender), and organisational (lack of funding) factors of SEM working as enduring barriers. The importance of language concordance and the use of appropriate interpreters should not be underestimated, as research has suggested that language concordance is significantly associated with higher levels of reporting of psychological symptoms and past traumatic events (Bischoff, Bovier, Isah, Francoise, Ariel & Louis, 2004). Accounts suggested that older women may be a particularly at-risk group, given difficulties experienced when learning a new language and lack of educational opportunities. As such, the under-utilisation of interpreters may be working to further silence and discourage refugee populations from seeking support for mental health concerns. This would be a significantly disempowering experience to be a woman from a refugee background who may not have had the opportunity to learn English and are then denied a voice through lack of interpreter services.

Interpersonal Level

Stigma. Service providers acknowledged the weight of stigma attached to labels regarding Western notions of mental illness. External experiences of stigma stemming from family members and community members worked as a barrier that may deter clients from seeking support.

> there is a lot of stigma attached with mental health […] They'll tell me that they are not always willing to go to a professional and I think it's because they don't want to be seen as […] crazy or mad. And they do use that word – crazy – Amy (Senior Social Worker)

> Some CALD people just the name of mental illness they don't believe in that. – Julia (Bi-cultural worker)

Seeking help for mental health concerns was compared with a similar level of stigma that some women from refugee backgrounds might face when seeking help for women's health issues.

> Because of cultural issues women tend not to go and do their pap smear for example it's quite similar to mental health issues. […] People are unaware of mentally, maybe I need to see a psychologist, or it's just not in there at all. So I think it's a part of cultural practices, part of it is lack of education, part of it is the stigma. – Beth (Case Worker)

Overall, service providers found it difficult to distinguish between the impact of stigma and lack of education about mental health, or knowledge about services on help-seeking behaviours.

> There's family and that they don't want the community to know that they have mental health issues. They don't know what is mental illness […] they'll need more information to seek help. – Julia (Bi-cultural worker)

In this account, Sarah explains that stigma surrounding mental health issues can also foster fear and serve to isolate women from others within their community.

> (Mental illness) is probably something they don't understand quite well themselves, but is also quite fearful because its something that can potentially ostracize people from their community, so when people talk about mental illness they often talk about madness and going crazy so someone doing things that are bizarre and extreme sort of running through the street without their clothes or you know shouting and drawing attention to themselves. So these are things that people would conceive as mental illness and being crazy and they will say no I'm not like that. – Sarah (Community worker)

In an effort to combat stigma, service providers reported that they strove to normalize experiences when discussing mental health issues in an effort to alleviate clients' concerns and fears.

> We spend a lot of time normalizing their experience – talking about it's not about going crazy, this is a normal reaction to trauma. [….] People are really worried that 'I might be going crazy' or 'what does this all mean?' […] We don't talk a lot about mental illness as such. – Laura (Social worker)

In relation to Afghan clients, one bi-cultural worker reported that she finds that individuals from more rural areas with lower levels of education tend to be more secretive and worried that they will become "the laughing stock of their community" –Salma (Bi-Cultural Worker).

> they don't really like for the community to find out about anything that goes on with their health especially because they feel like the community will be looking down at them and will somehow be mocking them. […] clients from different regions in Afghanistan their mentality is a bit different in terms of understanding their mental health issues. – Salma (Bi-Cultural Worker)

However, there were varied opinions between service providers who worked with Afghan clients. One bi-cultural worker reported that she believed that stigma was no longer an issue that her clients faced, ranking isolation and lack of knowledge about services as a more significant barrier.

> What would stop a woman from reaching out? I wouldn't say shame because I think honestly that they have overcome that in Australia, because they are going through mental health as a community. I would say isolation, not knowing where to go, and even if they do go and complain about these issues

> to their doctor, maybe the GPs are not utilizing interpreters and it's not getting worked out […] definitely isolation, not knowing services or service providers, and language barrier which is the biggest hurdle. - Niki (Bi-Cultural Worker)

Conceptualizations of mental health. Previous literature suggests that understanding clients' conceptualisations of mental health is essential to understanding their access to and use of mental health care treatment (Bettman, Penney, Freeman & Lecy, 2015; Martin, 2009). Service providers stressed the importance of understanding that different populations will present in different ways with issues that could be related to mental health issues.

> People will not say oh I'm depressed, I'm anxious – they might not even have those words so sometimes they might also use different frameworks like dreams and all sorts of different things. It's trying to understand the systems, how people think from that cultural perspective about mental health. – Sarah (Community Worker)

Different language and cultural groups within communities were described as having different conceptualisations and perspectives on healing for mental health issues. As documented by de Anstiss and Ziaian (2010), participants indicated that depending upon congruence of beliefs about mental health with the dominant Western model, this could work to discourage access to Australian mental health services:

> It's gonna be different cos even in Africa you have different tribe, maybe my tribe will see it different to another tribe. So in my tribe it is more witchcraft you don't need medication for mental illness, you have to see a witch doctor

> who will give you some water or something to wash your body and some cream they will pray for it and you put on your body. – Julia (Bi-cultural worker)

This account highlights the importance of considering women’s historical context and of considering how the views and beliefs of women from refugee backgrounds may be influenced by their past experiences in their country of origin. Over-reliance upon the Western model of mental illness was deemed a barrier, as many clients considered that treatment for mental illness needed to be holistic and community-focused:

> About the Western model – people look at mental illness and health holistically from these communities. It’s about being healthy in your family, healthy in your community all those kind of things as well. I suppose when they think about health they think quite differently about illness, it’s a connection with community – all those kind of things also impact on health and people don’t feel healthy when they don’t have those things. So just kind of treating symptoms possibly will not actually assist them. – Sarah (Community Worker)

Clients were reported as more likely to seek help that was holistic, and involved connection with community, seeking console with family or friends, or spiritual healing. An incongruity between, for example, a more holistic view of health that does not differentiate between physical and psychological symptoms, and a Western biomedical approach may damage the therapeutic relationship (Martin, 2009) and result in termination of service use.

Isolation. Isolation was reported as a barrier to help-seeking, especially for Middle-Eastern women. Service providers who worked with both African and Middle-Eastern women consistently reported that they perceived their female Middle-Eastern clients to be more isolated than their female African clients. They reported that they felt as though African women were less likely to be isolated, as they were more "vocal", likely to up-skill, gain employment, organize social events, and socialise with their community. On the other hand, Afghan women were described as being more isolated and house-bound due to restrictive gender roles and responsibilities.

> They (South Sudanese) tend to be more socially organized in the sense of activities and events, when I do see that population group there tends to be social/community activities. Whereas, with the Afghanis it's a little bit trickier, the culture is actually more difficult particularly for the 204 (women at risk visa) reason, the single woman at risk. If they are not accompanied by a husband or male protector or escort within the family it really excludes them from doing what the rest of the community is doing. There is a lot of harassment as well from their own community. So the two groups are really very different in regards to how they settle and they just move on with life. – Samantha (Social worker)

> Africans are far more willing to voice – females. There is a role for women in the African community – there certainly is a patriarchal system operating, but it operates differently – African women are far more vocal and out there- and will take far more action around – in what is happening in their lives. They still play the role and to a degree subjugated through domestic violence – you know

> even when it happens, but generally the African women I think are far more vocal. But they're also quicker to get jobs. […] They're far more active, far more out there, they're not staying in their homes like a lot of the middle-eastern women are. – Amy. – Amy (Senior Social Worker)

Age was also described as a risk-factor for isolation in both Middle-Eastern and African client groups.

> A lot of them (elderly women) are isolated in their homes because they can't speak English. You know their daughters are out working, their grandchildren out working. They're often sitting on their own by themselves with no one to talk to. They can't talk to their neighbors because they haven't got the language – it's a really difficult issue. I've seen quite a few elderly African women in particular that this has happened to, and it's really sad. […] They are surrounded by English speaking white people who might not necessarily like that they are living there […] there's a fair bit of racism as well, absolutely no one to talk to all day long, which is the worst thing that can happen for an elderly person. – Amy (Senior Social Worker)

One participant identified a gap in service provision for elderly females with refugee backgrounds, especially those with low levels of English.

> Their health deteriorates after a while […] we've got a hell of a lot of services for young people and for families but there's very little for elderly female new arrival clients, very little. No one actually thinks of them until you've seen

> what I’ve seen, and it breaks your heart, it really is heart breaking[…] It would be really nice if there was some kind of visiting service or a day place where they can come during the day where they can talk their language with other older people, and have some activities – Amy (Senior Social Worker)

These accounts reflect similar themes found in previous research with service providers working with elderly refugees in Melbourne (Atwell, Correa-Velez & Gifford, 2007) who stressed the impact that isolation can have upon older refugees, who often endure the loss of social networks, language barriers, poor access to transport, and a lack of places to socialize.

One service provider suggested that women were more likely to be isolated than men, and that service providers would see men in services more than women. This aligns with previous research with Afghan women that indicated that husbands who may have arrived in Australia prior to their families were more likely to have their drivers license, be able to speak English, and accompany their wives to appointments (Rintoul, 2010). Service providers highlighted that experiences of women with refugee backgrounds were compounded by individual factors of SEM, including their gender, race, and elderly status, which interacted to further isolate them within their communities.

Systemic and Political Barriers

Environmental Level

Policies. Service providers described institutional racism in the form of strict government policies that limit refugee humanitarian intake and serve to separate families as the most enduring challenge and barrier to service use when working with refugee populations. Service providers emphasised feelings of helplessness and powerlessness when working with families under these restrictive policies.

> there's always been a government that had a racist slogan, but it's become vicious now and these are people that know what it's like to be in a war torn country, know what it's like to be in a refugee camp and they are desperate to try and get some family members that are still alive because a lot of them are either displaced, they don't know where they are, or they're dead. So you're looking at a different traumatized group. When you see women you know that are crying of if I still can't get my son here, all you can do is be with them. It's all you can do cos you can't say to them, 'she'll be right, don't worry, your six year old he's lucky he'll go to an orphanage.' You can't. You've just got to be with them. And let them know that they are not alone and let them know that we hear you, we understand you. – Samantha (Social worker)

> We are powerless to do anything even though you report back, you have meetings, nothing really changes and so that's what causes the disadvantage for this group are policies that hinder resettlement and that really hinders them in obtaining services because of these rules that are not helpful to this group at all. – Samantha (Social worker)

Government policies not only determine who comes to Australia, but also significantly impact upon the quality of life of refugees in the resettlement period. One GP described her frustration at the high demand that policies place upon women who arrive in Australia on 204 (women at risk) visas:

> particularly for the 204 group of women. Immigration recognizes you're a woman at risk, you have six children, you are on your own, okay let's bring you to Australia. […] why make that woman then go to school and work? She's got six children she needs to cook and clean for, and they're little children so you know if immigration brings you here knowing you've got all these issues, why then does the department of social services put all this pressure on you? – Emma (GP)

Despite the effort that some service providers invested to attempt to change policies, ultimately service delivery was constrained by the policies of the government in power.

> The part that I find the most disheartening is that I can see what doesn't work which are policies. That's what it is, it's basic policies and I feel really helpless to change it because regardless of how often we meet with government departments, you know regardless of letters, and documentation and everything else instead of seeing improvement in the sector all I am seeing is destruction. . As the years go by I just haven't seen anything that is done that I can say oh my god they've got it right and for this particular group they are finally going to be supported and they are going to be okay. I don't get that sense from the policies out there. I get the sense from the women because they are resilient and they want to survive and they want to be okay but I don't get that from the hierarchy of policy-makers. That is for me my biggest disillusion.
> – Samantha (Social worker)

Not only has the negative effect of restrictive policies been documented in the literature (Silove et al., 2017; Killedar & Harris, 2017), but for service providers it was also obvious anecdotally how government policies regarding immigration directly affected both the mental and physical health of their clients. A major concern was policies making family reunification impossible:

> for example bridging visas, their life is uncertain. They could be deported back home the next minute. […] it's just a limbo. So if those situations were stable and they knew their status, I'm sure mental health and physical health would be less affected. […] It is the trickiest thing, and we don't have an answer for it. They come, they ask for help, we can't do anything it's government agencies, they need to go through their processes to establish your status, and it's just a waiting game unfortunately. It could be month or years and we've seen both. […] It's very unpredictable…[…] The major hurdle is sponsoring and being able to bring families over from back home, that is a major unmet need. - Niki (Bi-Cultural Worker)

> The status of the visa and especially now that the government has made it more tough with the citizenship – that they have to have a significant amount of English language, English comprehension, before they can go ahead and apply and without being a citizen now they are very restricted in applying for their family visa to sponsor their family here, so that's causing a lot of stress. A lot. – Salma (Bi-Cultural Worker)

Given the powerful influence that policy has upon service provision, providers have understandably invented unique ways of working and coping within these structural limitations, as well as finding hope in seemingly hopeless situations:

> Laws are not set in concrete and depending on the governments they come and go, some change a little bit, some don't. […] you've gotta say to them for as long as you live there is hope. So for as long as you look after yourself you have to be ready because for as long as you're here and governments come and go there is hope. I don't know when – you can't give them a time frame. But for as long as you are here with us, your family has hope. […] And that tends to resonate a little bit more and I think it soothes the guilt a little bit. I'm here and they're there. In my own optimism for as long as you're here be ready because there is always hope. – Samantha (Social worker)

Organisational Level

Child protection. Fear that presentation to mental health services could result in judgment about parenting capacity and involvement with child protection services was described as a potential barrier to service use for some community members. Service providers had heard examples of clients being warned that (especially government) services may be making assessments on parenting which could result in children being removed from parents' care.

> It's very interesting; this is one of the first things that you would hear about if you were accepted to come to Australia or to the west in general. People talk with you about the possibility of, and people exaggerate too, "if you're going there be ready that your kids may be taken from you, you know if you shouted

> at them or if you hit them” […] “You can’t discipline your children in Australia, you can’t do this and you can’t do that” – so people come with all this fear – your children can be taken from me you know. – Beth (Case worker)

> People in the past look at you they see how you behave in front of your children, someone will call and report so there comes all that fear that what they can take your children away – Julia (Bi-cultural worker)

Furthermore, service providers suggested that parents from refugee communities might be at higher risk of being reported to child protection, as methods of discipline may have been different in their country of origin to Australia.

> You got us child protection walking into their lives and the way they discipline their children in one context is illegal in our context. So you have to change the thinking which is you know generation upon generation upon generation, suddenly bang, you can’t use physical punishment. – Amy (Senior Social Worker)

Missed opportunity for service provision. Service providers identified that a key service access point for refugee populations is the point of arrival, but often trauma and mental health symptoms do not present at this stage.

> It would have to be picked up right at the point of arrival when people are undergoing those first assessments and I’m not quite sure whether a lot of the you know PTSD, the anxieties are getting picked up at that early stage. People

> sort of tend to start showing the symptoms and then following through, but even then I don't think they are because mental health is so stigmatized. – Amy (Senior Social Worker)

Service providers described services for newly arrived refugees as significantly limited and short-term and noted that they rarely followed up, leaving people unsupported if they did go on to develop symptoms of mental illness.

> When people come in contact with settlement services initially some of the services are very short term and they might do psychosocial rehabilitation but its really tricky to get people on to the next stage into the community so even settlement services they don't often follow up. […] Mental health is something that is intertwined with (practical issues) as well and so once those things are sorted people might be confronted by their PTSD and loss and grief and by that time they might be bereft of services and find it difficult to link in with appropriate services again. – Sarah (Community Worker)

Service providers reported that when refugees first arrive, symptoms of mental illness might present as somatic complaints and may go untreated.

> We often see that people arrive they're really excited and happy, "I'm here", "aren't I lucky" and we do their health checks and we toddle along and then all of a sudden it goes like that (points downwards). And it's often about six months later that often it all comes out. They might have been telling you about their headaches and their pain but it's kind of six months later after than

> honeymoon phase that all the previous stresses and things that happened in the past start to come out. I think that’s very true for Middle-Eastern people, as I said for the Sudanese they’re a little bit different. I think they tend to – we don’t see them. I don’t think I’ve referred many Sudanese people to counseling at all. – Emma (GP)

However, the relationship between symptoms arising earlier or later is not straightforward. One study indicated that recently resettled refugee women presented with high levels of psychiatric symptoms (Schweitzer et al., 2018), whereas other studies with refugee populations have suggested that symptoms may increase over the first 10-12 years of resettlement and then decrease (Tran et al., 2007), peaking around 10-12 months after resettlement, or throughout the second year of resettlement (Beiser, 1988). Service providers in this study reported that it was not uncommon for mental health referrals to arise a year after settlement, once most of the practical concerns were dealt with.

Lack of accessibility. Service providers highlighted challenges that refugee clients face in accessing services at the environmental level. Logistically, in order for many women to access services, service providers reported that their children had to take time off school, as they were required to work as cultural liasons, assisting with interpreting, making appointments, and transport.

> We’ve got lots of women […] who actually can’t get to this service unless their child takes a day off school and brings them here. – Emma (GP)

> Older siblings so they might be teenagers that actually need to take time off to take their older parents in their 40s to appointments. They’re missing out on

> days of school and they're hearing all the stories of trauma through their parents again, worrying about how their parents aren't able to access services without them in confidence whatsoever. […] that's an added barrier and burden that these women are having to deal with – younger women, school aged children, adolescents, young women… - Laura (Social worker)

Furthermore, on top of transportation issues, many women from these communities have young children, who limit their options for services if there are no childcare facilities. Some women have not had educational opportunities and may be illiterate in their first language as well as not speaking English, making navigation of services extremely challenging.

> Lack of childcare and lack of transportation could be a major issue as well, because a lot of women do not drive themselves and some of the women that do have their husbands with them. I think they wouldn't be able to attend the services at the time because their husbands are unable to drop them off to the services. A lot of these women are of the background that is almost illiterate, even in their own language, so it's very hard, it's almost impossible for them to really know their options and to really be able to navigate. […] One of the major issues for the newly arrived Hazara community is the inability to really navigate the services that they really need for support. That navigation and also not knowing that there are supports available – enough support to help them as well – Salma (Bi-Cultural Worker)

Salma described the different levels of the SEM interacting. At the environmental level, a lack of childcare and transport, at the interpersonal level, dependency upon husbands, at the organizational level, the lack of distribution of relevant translated mental health care information, and at the individual level, difficulties with communication (Taylor & Haintz, 2018).

Expectations of services. A further barrier to service access, or to continued service access, was reported to be a misalignment of expectations and service delivery. Service providers reported that they often sensed disappointment and disillusionment when clients' expectations were not met, especially in regard to acquiring housing, financial assistance, visa status, and family reunification. In some cases, service providers described clients as perceiving them to have more authority and power than they did in reality.

> Thinking that we have all these links and powers in immigration to enable them to have a permanent visa, and that's you know such a protracted painful experience and fundamentally we don't really, we can support them through their emotional journey and help them build coping capacity but in terms of real powers and advocacy type of work it's quite limited, and I think misperceived in the community too in terms of how much we can do and how much of a difference we can make. – Laura (Social worker)

> They think we can write that letter for housing and they'll get a house, that we can write that letter for Centrelink and Job Network will stop bothering them, they think we have a lot of powers, but we do not have many powers. We can fix some things but we can't fix everything. But people they want to be fixed. – Emma (GP)

Furthermore, clients may have expectations that service providers will take time to listen to their story. In reality, healthcare appointments are often brief, and the ability to build trust to disclose sensitive information is limited. A level of continuity of care is often expected that is usually impossible due to limited resources in many services.

> Some of my clients that did go through the mental health organization, they did expect that the support workers would stay with them and really stay with them for a longer period. All clients are designated a specific time limit so once they finish that then they are exited from the service. […] I think they really want the services to be connected with them for a longer while than they are supposed to but every organization has their own limits and policies […] they basically are worried that if they are left alone again […] what if she goes back to her previous mental status again, what about if she is still depression and anxiety again and who does she contact? - Niki (Bi-Cultural Worker)

Discussion

Interviews with service providers suggested that access to mental health services for women from refugee backgrounds may be constrained based on multiple forms of inequality based on migration status, race, culture, age, and gender. Services providers described the ways in which these multiple inequalities interact and have a significant impact upon women's resettlement experiences. Furthermore, these factors operate across the individual, interpersonal, environmental, organisational, and policy levels of the SEM. Levels of the SEM were demonstrated to exist independently, as well as in interactive ways, highlighting the complex, inter-related nature of the barriers for refugee women's access to mental health services in South Australia. Drawing on service providers' accounts, women with refugee backgrounds may find themselves resettled in Australia in a powerless and dependent position, compounded by inequalities when accessing services. Australian immigration policy was discussed as further contributing to women's vulnerability, dependency, and lack of control over their own lives.

Previous literature has highlighted the compounding nature of contextual factors for refugee populations (Rees & Pease, 2007). This was particularly salient in this research, as not only were the levels of SEM reported to interact with each other, but also multiple levels of the SEM were reported to interact, having a compounding effect. For example, a woman may not have access to transport (environmental level), be dependent upon their husband (interpersonal), have low levels of English (individual level), and not have any family in Australia to support her (environmental/policy level).

Aligining with previous literature (Porter & Haslam, 2005; Schweitzer et al., 2018) at the individual level, demographic factors, including gender, race, and age, were reported by service providers to influence women's experiences of isolation and their educational opportunities and experiences. Difficulties with communication interacted with interpersonal factors such as isolation and the organizational factor of lack of accessibility to services. Involvement of interpreters in the provision of mental health care to refugee populations has been deemed integral (Gartley & Due, 2017). Supporting previous literature (Smart et al., 2017), service providers highlighted concerns surrounding providers deeming their patients or clients' English levels as adequate and not using interpreters when they were in fact necessary. This would directly impact upon the quality of service delivery, as well as influence a woman's motivation to return to, or to continue to, seek help in the future. Importantly, these findings may suggest that, although some refugee women require interpreting services well into the resettlement period, the length of time they have lived in a country may be used as a justification that no interpreter is necessary. Further to this, when decisions and assumptions are made regarding women’s level of English, this removes agency and disempowers her, as well as negatively impacts mental health access, care experience, and potentially, mental health outcomes.

Older women were described as a particularly at-risk group, given the difficulties they face learning a new language in a resettlement country, and considering the compounding effects of past trauma on learning capacity (Schmidt, 2019). Dependence upon others for language skills was also described as a gendered experience, with husbands reported as speaking for women regarding appointment-making and transport. Aligning with previous research, service providers expressed their concern that they were mostly seeing men presenting to services, and that women, and in particular Middle-Eastern women, may be significantly isolated from services (Rintoul, 2010). Participants raised concerns that men were the primary points of contact with agencies and sometimes spoke on behalf of women. As a consequence, despite a significant need, women may not present to services. Clearly, the interpersonal factor of isolation interacted with the individual factor of gender.

At the interpersonal level, consistent with previous literature (Silove et al., 2017), service providers identified isolation and stigma surrounding mental health issues as barriers to service use. However, service providers further identified that isolation and stigma surrounding mental health issues interacted. Service providers conceptualized the stigma attached to mental illness as both a cultural issue and a lack of education about available supports. Participants reported that they did not feel as if they were connecting with women in a meaningful way in order to develop the kind of relationships necessary for them to consistently engage with services. Fear about what the community might think of a woman seeking support for mental health issues may result in that woman further isolating herself.

At the environmental and policy level, service providers reported that institutional racism was particularly salient. In particular, participants discussed restrictive government policies such as family reunification. Previous research has highlighted the detrimental effect that restrictive policies can have upon those with refugee backgrounds (Killedar & Harris, 2017; Silove et al., 2017). This study also revealed the detrimental effect that restrictive policies can have upon service providers' morale. The current policies were described as the most enduring barrier for service providers to connect with refugee women, as this was also the barrier that they had the least control over. Service providers described the sense of powerlessness and helplessness that restrictive policies can foster for those who work with these populations. Furthermore, participants reported their disbelief and frustration regarding the government's expectations and conditions they placed upon refugee women, some of whom were sole caregivers for multiple children - for example, presenting to job networks and taking English classes. Service providers also raised concerns regarding a lack of translated resources, reflecting concerns raised in previous literature (Taylor & Haintz, 2018; Simich, Beiser, Stewart & Mwakarimba, 2005; Nicol et al., 2014).

This research shows that barriers to mental health support that are related to social determinants of health for refugee women are interrelated, both between levels and within levels of the SEM. However, the limitations of this research should be acknowledged. Although interviews with participants were in-depth, the small sample size means that results from this study are not necessarily representative of the experiences of service providers more broadly. This study aimed to include service providers from multiple occupations (for example, case workers, social workers, doctors) so as to to present challenges to service provision from multiple perspectives. However, future research should aim to include mental health nurses, psychologists, and bi-cultural workers from more communities.

Recommendations

Due to the complex and interactive nature of the levels of SEM, it is important that the implications and recommendations of this research also be multilayered. However, as acknowledged by Taylor and Haintz (2018), although certain factors exist within a certain level of the SEM, relevant recommendations may not always target the same level. For example, to address isolation at the interpersonal level, there is a need for action and engagement at the policy and organizational levels of the SEM. Further cross-cultural training and education for service providers who work with refugee families may help to equip these workers with the skills necessary to work with this population. Furthermore, bi-cultural workers, especially those who may have refugee backgrounds themselves, were reported to be invaluable when connecting with clients from refugee backgrounds. Increased training of individuals with refugee backgrounds to work in their own communities is essential to bridge this service gap. In regard to stigma, further training in normalizing mental health symptoms when clients do present, as well as psycho-education and mental health literacy education sessions, are recommended.

Further comprehensive efforts should be made at the start of consults or appointments to ascertain whether clients require an interpreter. This is particularly important for mental health care appointments, as much of the content is sensitive, detailed, and complicated (Miller, Martell, Pazdirek, Caruth & Lopez, 2010; Gartley & Due, 2016).

Collaboration between refugee women themselves and service providers to develop translated mental health information in a culturally sensitive and appropriate manner may help women make informed decisions about their own mental health care. Further funding for home visits to refugee women and families, with service providers, bi-cultural workers, and interpreters that includes education and support around transport and attending healthcare appointments may help to connect women with services and develop trust and understanding of the Australian healthcare system (Khamphakdy-Brown et al., 2005). An increase in the accessibility of, length, and availability of English language classes that incorporate information about mental health and the Australian healthcare system would bring women together and reduce their isolation from each other as well as from services. It would also be beneficial if English classes for refugee populations addressed issues that people may experience when learning English due to the effects of trauma (Schmidt, 2019).

As identified by service providers, women with refugee backgrounds face compounding and inter-connected individual, interpersonal, systemic, and political barriers to mental health care. This can leave women disempowered and in a dependent position, compounded by inequalities when accessing services influenced by their gender, culture, age, migration status, and race. Restrictive Australian immigration policy, particularly, contributed to women's vulnerability, dependency, and lack of control over their own lives, as well as demoralising service providers working with this population.

Chapter 9. Discussion

This thesis aimed to explore the following research questions: 1) what resettlement stressors and challenges do women face?; 2) what barriers to help-seeking exist?; 3) what support needs do women have?; with women from the South Sudanese and Afghan refugee communities in South Australia. Consistent with the CBPR approach, my aim for this research was to bring to the forefront the voices of women with refugee backgrounds concerning mental health care in Australia.

Overall, resettlement stressors and challenges, support needs, and barriers to help-seeking were identified throughout the studies. Initially, my research questions focused heavily on conceptualisations of mental illness and barriers to help-seeking. Throughout the research process and working with community leaders and key informants, it became obvious that participants prioritised speaking about their resettlement challenges and stressors, as these were of a higher importance for most participants than accessing mental health care services.

In this concluding chapter I synthesize the findings presented in this thesis and formulate and explore implications for practice and mental health care policy.

9.1 Key findings

Overall, this project emphasised how culture, migration, and gender influenced women with refugee backgrounds' experiences of resettlement and access to mental health services. Women prioritised practical concerns and resettlement challenges and stressors. Racism and discrimination were highlighted as concerns in both groups – Afghan women discussed overt experiences of discrimination, whereas South Sudanese women discussed the detrimental impact of overt racism - specifically, the negative depictions of their community in the media. Service providers identified institutional racism and restrictive migration polices as concerns for their clients. Domestic violence was identified as a key concern for women within both communities, as well as husbands blocking access to services or impeding their wives from forming social connections. Women from both groups reported a general preference for seeking help from social support networks in comparison to formal services. These findings will be discussed in detail.

9.1.1 Resettlement stressors

In regard to the first research question, women from both groups faced resettlement stressors including language and communication difficulties, domestic violence, racism and discrimination, and negotiating changing gender roles; these were often prioritised over mental health issues. Aligning with previous literature involving refugees from war-affected countries (Bogic et al., 2015), results from the interviews with both South Sudanese and Afghan women suggested that mental health issues could persevere years after resettlement. This is probably influenced by the many resettlement stressors reported by participants, including domestic violence, difficulties finding employment, and stigma surrounding mental health issues.

In relation to the second research question, women from the Afghan community more clearly described barriers to help-seeking, whereas women from the South Sudanese community spoke more about resettlement stressors and practical concerns. For women from the South Sudanese community, the mean length of time spent in Australia was 13 years, while for Afghan women it was 6.8 years. Previous research suggests that mental health issues such as depression and anxiety can increase over time spent in resettlement countries for refugee populations (Uribe Guajardo, Slewa-Younan, Smith, Eagar & Stone, 2016; Giacco, Laxham & Priebe, 2018; Schweitzer et al., 2006). Resettlement stressors, including financial difficulties, employment, housing issues, social integration into Australian society (Flatau, Colic-Peisker, Bauskis, Maginn & Buergelt, 2014), and ongoing stress caused by acculturation (Khawaja & Milner, 2012) have been shown to remain constant stressors over time. This difference in time spent in Australia may have influenced the stressors reported by participants as well as barriers to help-seeking and service access. Furthermore, the recent negative portrayals of South Sudanese youth in the mainstream Australian media and the recent death by suicide of South Sudanese youth within the community (as reported to me by a community leader and one of the initial reasons I was approached to conduct research with this community) may have influenced women's concerns raised in interviews.

Aligning with previous research conducted with older refugees (Slewa-Younan et al., 2016; Slade & Borovnik, 2018; Kirmayer et al., 2011), older women from both communities were reported to be more vulnerable and most disadvantaged in terms of mental health service access. Older women were reported to be more isolated and encountered more difficulties with language and communication. Furthermore, participants suggested that some older women may have been internalizing societal stigma relating to mental health care as a system of meaning that then influenced their reported low levels of help-seeking behaviour (Kleinman, 1980). For example, for fear of social disapproval, of not being perceived as fulfilling their family or gender role, or of their disclosures reflecting poorly on their family's reputation, a woman may choose not to seek help from services.

In relation to research question two, service providers identified barriers to help-seeking for women that existed at the individual, interpersonal, environmental, organisational, and policy levels. Application of the SEM revealed that barriers at different levels interacted and had a compounding effect upon the level of accessibility of mental health services for women with refugee backgrounds. These barriers were described as being complex and inter-related. Aligning with results from both the Afghan and South Sudanese communities, service providers highlighted racism and discrimination, stigma, isolation, language and communication, gendered roles, and differences in conceptualisation of mental health as barriers to help-seeking.

9.1.2 Domestic violence

Domestic violence emerged as an unexpected problem throughout the interviews in both studies including women from Afghanistan and South Sudan. Domestic violence is a phenomenon that affects all cultural and faith groups (Devried et al., 2013). However, due to the significant levels of reported stigma surrounding mental health issues and family violence among Afghan women, affected women in this community were reluctant to seek help from services.

Domestic violence was also identified by South Sudanese women as a resettlement stressor, as well as a barrier to help-seeking. In terms of help-seeking, women from refugee backgrounds face complex intersecting factors that are relevant to experiences of domestic violence, including migration pathways, traumatic pre-migration experiences, and social isolation, as well as resettlement stressors in their new host country (El-Murr, 2018). Previous experiences as well as cultural beliefs around privacy, gender, and social roles may work to silence women and reduce their likelihood of presenting to services. Adding to this, women from refugee backgrounds more generally face overlapping barriers to accessing support for experiences of domestic violence, including language and communication barriers, limited knowledge of systems, rights, laws and services, and lack of cultural safety when accessing services (Ghafournia, 2011).

In addition to threats posed by domestic violence, husbands were perceived more generally as potential barriers to help-seeking by both groups of women. Previous research has identified that husbands can act as gatekeepers to health care for Afghan women by attending appointments with them so that women do not feel comfortable disclosing certain information (Rintoul, 2010). In this research, women from the Afghan community reported that a spouse would most likely perceive a woman seeking help for mental health concerns as a negative reflection upon them and their relationship, or their family life. Research conducted with South Sudanese populations has highlighted husbands' desire to control their wives in relation to finances and social interactions and networks (Khawaja & Milner, 2012). Consistently, within the South Sudanese group, participants identified that men sometimes acted as gatekeepers to services as well as preventing them from forming social connections. These examples reflect the wider theme of established gender roles for men and women within these communities. Women described these traditional gender roles persisting following resettlement, consistent with previous research with such communities (Khawaja & Milner, 2012; Hebbani et al., 2010; Rintoul, 2010; Tempany, 2008). Furthermore, service providers voiced their concerns that they were seeing more men than women presenting to services, despite the literature suggesting that women from refugee backgrounds may face significant and unique resettlement stressors.

Despite such concerns over gender roles and domestic violence, many of the complexities associated with women from refugee backgrounds experiencing domestic violence are neglected in Australian domestic violence policy (Ghafournia & Eastel, 2018). In particular, the intersection of gender with race, ethnicity, and migration status embedded in women's experiences of domestic violence exacerbates their marginalization and invisibility and impedes their right to necessary protection. Indeed, oppression is often exacerbated for women who experience domestic violence, depending upon their position in terms of the intersections of a particular race or ethnicity, gender, and migration status (Sokoloff & Pratt, 2005; Sokologg & Dupont, 2005).

Most policies addressing domestic violence in Australia have failed to consider women from refugee or CALD backgrounds' experiences through an intersectional lens (Sokoloff & Dupont, 2005; Ghafournia & Eastel, 2018). Frequently, the focus is on culture, without consideration that women's oppression is not only derived from their cultural background, but also stems from mainstream structural or systemic factors such as racism, discrimination, and gaps in policy (Volpp, 2011). Unfortunately, marginalized women from minority groups are often invisible in most policies addressing domestic violence (Burman & Chantler, 2005; Nixon & Humphreys, 2010; Ghafournia & Eastel, 2018).

One way forward for service provision and inclusive policy for women from refugee backgrounds and communities experiencing domestic violence is taking an approach which is more intersectional. This would encourage service providers and policy makers to surpass the individual categories of migration, race, and gender that are already common in policies. It would then allow the consideration of the impact of different systems of oppression, including racism and sexism (Hankivsky & Cormier, 2009) and lessen the effect of policies focusing on or privileging one inequality over another (Ferree, 2009).

For women in this study, experiences of domestic violence worked as a predisposing factor for help seeking (Andersen, 1995) resulting in women being more reluctant to seek help or access services, especially due to the stigma and shame attached to these experiences.

In regard to research question three, it is necessary for service providers to understand that women from refugee backgrounds face multiple barriers to service use, including domestic violence, and that these experiences may also be compounded by other systemic and structural intersections of oppression, including racism, sexism, and migration status.

9.1.3 Experiences of racism and discrimination

Racism and discrimination were issues identified by both groups of women. In regard to institutional racism, service providers discussed how restrictive migration and government policies constrained their service delivery. Women from the Afghan community raised concerns that negative depictions of “Muslims” in the Australian media impacted upon their everyday lives and service experiences. Women from the South Sudanese community spoke about overt experiences of racism and racism as a barrier to employment and service access.

Significantly and unexpectedly, they also raised concerns regarding the negative media representations of young people from their community in Australia.

South Sudanese women highlighted the detrimental impact upon their wellbeing due to these negative public portrayals of their community. Women expressed particular concern about the increased surveillance and policing of their community based on the negative behaviour of a minority of young people. However, they also identified that the negative depictions that they often observed were not representative of their collective identity, and voiced their apprehension about how they were being portrayed to the wider community. The impact upon their wellbeing included feelings of “shame” and consistently worrying about the younger people within their networks. Given that South Sudan is a collectivist culture, the significant impact that these reports have on women may be due to the importance of the community’s role in raising and educating children, or their sense of responsibility as mothers.

This study highlights the importance of the consideration of how these kinds of negative depictions have the power to affect marginalised communities and perpetuate sentiments of feeling unwelcome, or not belonging within resettlement countries. Media and political discourse generally depict South Sudanese youth associated with violence and “gangs” with a lack of nuanced representation. As mentioned, racially and politically charged comments from those in power, including political leaders and radio commentators, reflect deep-seated institutional racism in Australian society (Baak, 2018; Due, 2008). Ultimately, there needs to be an end to systemic racism in the Australian media and broader public discourse in order to see improvements in mental health outcomes and wellbeing for marginalised groups such as refugee communities. Such changes in media discourse require adherence to ethical journalistic standards (Baak, 2011; McMaster, 2001; Marlowe, 2013) as well as changes to current political agendas which frequently function to exploit communities that are already vulnerable.

Women from the Afghan community discussed the impact of negative media portrayals of “Muslims” upon their community. Notably the interivews were conducted close to the time of the March 2017 Westminster attack in London which was described in the media as “Islamist-related terrorism” (Glenday, 2017). Importantly, women associated experiences of racism to their religion (Islam). These accounts align with growing body of literature regarding the the role of unconscious bias in the negative stereotyping of Muslims as “terrorists” and white privilige of avoiding terrorist labels (Corbin, 2017; Felix & Lee, 2007; Gerges, 2003; Legewie, 2013).

Studies have also shown that when terror attacks are perpetrated by Muslims they receive significantly more attention and news coverage than when terror attacks are perpetrated by non-Muslims (Kearns, Betus & Lemieux, 2017). The media has contributed to the construction of the stereotype of “Muslim terrorists” with some outlets prematurely and mistakenly naming “terrorists” as “Muslim” ahead of confirmation – for example, in the Quebec mosque shooting in 2017 (O’Connor, 2017).

Overall, attacks perpetrated by whites are less likely to be labeled terrorism, and perpetrators are more likely to be referred to as “mass shooters”, whilst Arab-Americans are more likely to be labelled as “terrorists” (D’Orazio & Salehyan, 2018). These media representations that construct false narratives such as “all Muslims are terrorists” play a crucial role in government propaganda and political agendas (Corbin, 2017) and evidently have significant ramifications for groups such as the Afghan community.

Previous research has indicated that for people with refugee backgrounds from Afghanistan, perceived discrimination was associated with higher distress. Furthermore, it has been shown to compound and exacerbate stresses associated with other pre- and post-migration stressors (Alemi & Stempel, 2018).

Overcoming racism is no simple feat, as systemic racism serves a deeper function and has been ingrained in Australian history and culture and reflected in laws and policies ever since colonisation. Since invasion, Australia has constructed an identity as a "white Anglo-Celtic nation" (Batrouney & Goldlust, 2005), reinforced by the Immigration Restriction Act 1901 and the White Australia policy (Jupp, 2002). Accordingly, Aboriginal Australians have consistently been positioned as "black, object, inferior and other" (Moreton-Robinson, 2003). Similarly, for people with African heritage who live in Australia, being "visibility different" significantly impacts upon their everyday lives (Australian Human Rights Commission, 2010). As noted by Wearing (2012, p. 26):

> If you walk along any street in Australia as a black African refugee or Australian Aboriginal you would be noticed, gazed upon, defined and summed up from within certain White socio-cultural constructions and judgements about who you are. These constructions rely upon a history and social context of racist and discriminatory assumptions built into Australian culture and society.

The same could be said for women who wear a hijab or religious clothing. Evidently, belonging in Australia continues to be racialized, and migration and visa status play a role in that racialization and marginalization. Being a "refugee" or even "former refugee" also has implications on how people from Afghanistan and South Sudan are perceived (Baak, 2019). Through representations in the media, refugees who resettle or arrive in Australia seeking asylum are often constructed as different, deviant, or a threat to the "Australian nation and national identity" (Baak, 2011; McMaster, 2001).

Women from the South Sudanese community argued that the way in which they were depicted in the media was not representative of their collective identity. They described in detail the detrimental effect upon their community as well as their own wellbeing. This study outlined the need to listen to the often unheard voices of women from the South Sudanese community about the impact that these wider public discourses were having on their mental health and wellbeing.

Overall, the negative experiences of women during resettlement aligns with the fact that women who are non-white and labelled with their migration status are consistently repressed in Australian society. These experiences are rarely heard, as the discourse is dominated by those in positions of power, who are usually white. In this sense, postcolonial feminsism is a useful and necessary theoretical tool to examine the consistent repression and representation of women with refugee backgrounds who are non-white.

9.1.4 "Informal" help-seeking preference

Both groups reported a general preference for seeking help from social support networks in comparison to formal services, aligning with previous literature with refugee communities in resettlement countries (Simich, Beiser & Mawani, 2003; Stewart, 2014).

In the current study, participants from both groups generally described their experiences of seeking help from social support as helpful. Indeed, social support may include coping and healing strategies that may be deemed as "informal" according to outsiders or researchers, but may be considered formal healing strategies within communities themselves. These experiences of social support within communities were often reported to be with other women who also shared the collective experience of coming from a refugee background and negotiating resettlement.

Accordingly, and in relation to research question three, it is important for these social supports and community-based healing strategies to be taken seriously and supported. There is a growing body of literature regarding community-based psychosocial supports, including peer support or mentoring programs, trauma-informed psychotherapy group programs, psychoeducation and health programs, and physical activity and sports-based programs (Slewa-Younan, Blignault, Renzaho & Dohery, 2018). A recent example of this is a support group for newly arrived women with refugee backgrounds developed by Settlement Services International Women at Risk Committee (Settlement Services International, 2016). This group involves an eight-week Families in Cultural Transitions program that covers the areas of family, money, children, gender, trauma, and young people in the Australian context. The group is facilitated by bi-cultural workers from the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

Given that social connections were reported as strong resources for mental health support and coping, women who are blocked from forming or maintaining these may be at a heightened risk for poor mental health or general wellbeing. Accordingly, there is a clear need for programs that work with men concerning norms around relationships (for example, Ismail, 2018), changes in gender and social roles, and legal rights regarding women. Some programs already exist in Australia, including an Action-Research project "Building Links Empowering South Sudanese (BLESS)" designed by the South Sudanese community, and Catholic Care and Toowoomba's Refugee and Migrant Support (TRAMS) in Queensland (ANROWS, 2019). This latter project integrates community-based primary prevention activities that allow the community to respond to family violence, culturally appropriate early intervention, and culturally sensitive approaches to crisis support.

Clearly, there is a need for these types of culturally sensitive and community-led projects with specific refugee communities in South Australia. In South Australia, the "ASK Maria Project" initiated by the Women's Legal Service has recently completed the data-collection stage (Settlement Council of Australia, 2019). Four information and data-gathering sessions were held in regional areas in South Australia with CALD women to collate women's concerns and better understand needs, as well as provide information about legal rights and how to access support services. The second stage of this project will involve creation of an online interactive resource (Settlement Council of Australia, 2019).

Aligning with previous research (Khawaja et al., 2008; Schweitzer et al., 2007), religion and spirituality were described as coping and healing strategies that women would turn to in difficult times. Many women identified supports that already existed within their communities, such as women's groups, attending mosque or church, and community events.

Generally, higher levels of social support have often been correlated with lower use of mental health services (Faccincani, et al. 1990; Fleury et al. 2012; Lasebikan et al., 2012; Pescosolido et al. 1998; Maulik et al., 2009; Sherbourne, 1988). It is well established that a more holistic approach to mental health care, including home visits, psychoeducation, support and advocacy, and English classes may benefit women from refugee backgrounds in general (Murray & Skull, 2005; Khamphakdy-Brown et al., 2006).

Given the concerns raised by South Sudanese participants, women from this community may benefit from more easily accessible and free English classes, culturally sensitive domestic violence assistance, and women's health information seminars. Given that informal supports were reported by women as their overall preference, these should be embraced by government and support services. For example, English language classes could work as pathways to social inclusion and increased social support - identified by participants as most helpful. Additionally, English classes could also serve as a medium for the delivery of information and discussion about formal support options, if required.

9.1.5 Language and communication

In regard to the first research question, language and communication difficulties were identified as a resettlement challenge. Women from both groups reported difficulties that they encountered in attending English classes, including lack of transportation, lack of childcare, and lack of time - as this was often taken up by competing demands and priorities. When women did attend classes, they often found it difficult to concentrate, as they frequently worried about relatives overseas, or sometimes even reported somatic complaints, including headaches. Recent research has revealed the impact that traumatic experiences can have upon learning English for refugee populations (Schmidt, 2019). For example, intrusive memories of traumatic events can cause distraction, and an attempt to repress these memories interferes with capacity to learn. Furthermore, sleep patterns are also disturbed and interrupted by trauma, increasing the likelihood that students will attend class exhausted (Schmidt, 2019). These findings suggest that English classes for migrant and refugee populations need to be trauma-informed and flexible in their teaching styles.

In relation to the third research question, given the competing demands of women from both communities, it is likely that outreach English language classes may be more effective. English classes that are gender-segregated may be more appropriate, given the frequent gender-segregated practices (Gondek et al., 2015; Felsman, 2016) of both of these communities, especially that of the Afghan Hazara women. Classes that incorporate subjects such as family violence support, and legal rights, as well as mental health support and psychoeducation, in a safe and supportive environment could be a helpful and a non-threatening way of providing such information. In addition, funding for transportation to and from English classes or community centres for women’s information groups would assist and facilitate women attending such services (Andersen, 1995).

Aligning with previous literature, and in relation to the second research question, language and communication was listed as a barrier to help-seeking for both groups (Cheng, Vasi, Wahidi & Russel, 2015; Bellamy et al., 2015; Riggs et al., 2012; Sheikh-Mohammed et al., 2006). In addition to acting as a barrier for help-seeking, lack of English proficiency has also been identified as a barrier to resilience in refugee populations (Hutchinson & Dorsett, 2012). English language issues, especially in countries such as Australia, may indirectly impact upon individuals’ job and housing opportunities and inclusion in Australian society more generally (Schweitzer et al., 2007). The inability to express oneself in the language of a resettlement country can have significant implications for mental health and wellbeing, and can leave people feeling powerless, disadvantaged, and disheartened in regard to service engagement or other aspects of integration such as social inclusion (Shakespeare-Finch & Wickham, 2009).

Importantly, some service providers voiced their concerns that some women who presented to services may not be receiving the necessary option of having an interpreter provided for them. In some cases, service providers reported occasions when the length of time a woman had lived in Australia was used as justification that they did not need an interpreter.

Age has also been seen as playing a role with regard to language and communication, with older women reporting experiencing greater barriers to language and communication in both groups, as well as being noted by service providers. Generally, younger people learn the language of resettlement countries faster than older family members (Reedy, 2007). As such, and aligning with reports from interviews with both groups, children often take on the role of communicator or cultural broker within their family. This can place extra pressure on the relationship between parent and child, as well as result in intergenerational tension (Reedy, 2007).

Language is bound up with culture in interconnected and complex ways (Kramsch & Widdowson, 1998). As such, when young people learn a resettlement language quickly, they may also take on certain aspects of the resettlement country’s dominant culture, further widening any intergenerational gap that may exist within communities.

9.1.6 Mental health

In relation to the second research question, women from both communities identified the fact that a level of stigma still existed in relation to mental health issues. This was consistent with previous literature stating that for those from collectivist cultures, displaying obvious signs of mental illness can reflect poorly upon people's families (Kirmayer et al., 2011). Women from both communities expressed their reservations about discussing personal topics such as marital problems, children, and family life, as these were deemed to be kept within the family. These issues are also related to the general lack of trust in services and issues surrounding confidentiality.

Women expressed that they were worried that other community members would discover that they were seeking help for mental health issues and that they would subsequently be at risk for social disapproval. These findings could also be associated with the collectivist backgrounds of women from both communities. For individuals from collectivist cultures, family and social relationships and their self-identity is developed within the context of their community, and seeking support through these connections is common (Brewer & Chen, 2007). Women in this research were concerned about the impact of their mental health issues or their personal disclosures to services, which may be salient due to their collectivist cultural attributions.

Women from the Afghan community may present to mental health services with differences in symptomology. Aligning with previous literature (Alemi, Weller, Montgomery & James, 2016) women from the Afghan community reported somatic symptoms associated with distress, including headaches.

Women from both groups, had different cultural conceptualizations (Kleinman, 1980) of "mental health" which may be interpreted as low mental health literacy and may also reinforce an individualistic, Western bio-medical approach. For example, Western notions of mental illness that pathologize human experiences and place less emphasis upon the importance, inter-connectedness, and influence of familial and social relationships may make little sense in the context of the lives of many women from refugee backgrounds from Afghanistan and South Sudan.

In answer to the second research question, these differences in conceptualizations may also subsequently result in low levels of help-seeking or access to services if women perceive them as unhelpful or irrelevant. As such, formal access to services that involves clinical settings and adherence to an individualistic, bio-medical model of mental health care may not be the way forward for servicing communities such as those that are represented in this thesis. The bio-medical concept of mental health literacy is derived from physical health literacy that focuses upon increasing patient knowledge about physical health, illnesses, and treatments (Hewitt & Hewitt, 2012).

Similarly, mental health literacy often focuses upon individual psychopathology and its treatment, with its components centering on recognition, knowledge, and attitudes (Ashfield, Macdonald, Francis & Smith, 2017). This individualistic, problem-oriented approach risks the de-contextualization of human experience, ignoring the wider social, economic, and political factors that many people from refugee backgrounds face. As Kleinman (1980) has argued, the biomedical model of mental illness does not consider people from culturally and linguistically diverse backgrounds' explanations and different ways of thinking about mental health and wellbeing.

Evidently, without a concept of mental health that incorporates contextual factors, includes collectivist cultures, and that is more community-based, some women from refugee backgrounds may find speaking about mental health issues to be a low priority, as it ignores their more imminent stressors.

In regard to the third research question, Nadeau and Measham (2006) suggest working with clients, family members, and cultural brokers to develop a shared understanding of the issue. Indeed, a more ethno-medical model that takes into consideration cross-cultural models of mental illness may be more appropriate (Kleinman, 1980). Furthermore, a situational approach to mental health that takes into consideration contextual factors and places less emphasis on labelling and the presumption of an illness or disorder may be more effective (Ashfield et al., 2017). This approach may be more helpful because it encompasses normalizing and contextualizing human distress, promoting language and definitions of mental health that preserve people's dignity, and subsequently lobbies government and industry at a systemic level to address broader issues, including policy change to promote wellbeing at a population level (Ashfield et al., 2017). Furthermore, in the context of the current findings, this kind of approach would consider how factors such as age, gender, culture, race, and migration status impact upon women's resettlement experiences as well as presenting mental health issues.

Consistent with the finding that most people with refugee backgrounds do not experience significant mental disorders, the women in this study demonstrated significant strength and resilience. In this context, resilience, instead of being an essentialist, individualistic concept, is more likely to be dynamic, contextual, and fluid (Pulvirenti & Mason, 2011). Indeed, this may be a more helpful way of conceptualising resilience, especially for those with refugee experiences from more collectivist cultures.

Some literature suggests that resilience is underpinned by a dynamic process that is constructed through everyday processes including challenges as well as opportunity (Lenette et al., 2012). As such, resettlement experiences and government policies are particularly important for women from refugee backgrounds, as they determine the stressors and opportunities that can directly influence the development of resilience and their overall wellbeing.

The results from interviews conducted with service providers overall triangulated with the results from both the Afghan and South Sudanese communities with regard to mental health. However, there were some important differences in perspectives, especially regarding the perception of stressors for South Sudanese community leaders and service providers. In interviews conducted with community leaders and community members from the South Sudanese community, participants identified that although they had been living in Australia for over five to ten years, women in their community were facing ongoing challenges that affected their mental health. However, service providers often indicated that they did not typically refer many South Sudanese clients to counselling due to a perception that they were socially organised, and more likely to "be more vocal" and "take action in what is happening in their lives" than women from Afghan backgrounds.

Given the difference in reports from members from the South Sudanese community and service providers working with this population, future research should further explore these differences in perceptions, particularly since they may represent a gap in service provision and follow-up for this group of women.

9.2 Limitations of the current research

The small and diverse sample size of all groups, including South Sudanese community members and leaders, Afghan community members, and service providers means that some results may not be representative of the experiences of the wider communities under study. Furthermore, in terms of mental health experiences, there were no psychologists or psychiatrists interviewed as service providers.

Service providers from community-based organisations were chosen to be interviewed due to existing connections, to gather community perspectives, and because these organisations were reported by community members as places that they had engaged with previously. In order to achieve a more nuanced representation of women from refugee backgrounds' challenges regarding help-seeking for mental health services, more service providers from the mental health and medical sectors would be required.

It proved difficult to find female community leaders within the Afghan group. While multiple participants were significantly involved with their community, they did not identify themselves as leaders. When asked who the leaders were in the community, it was reported that they were men, and as an outsider to the community, it was difficult to get in touch with those mentioned.

These difficulties in identifying female leaders also reflect the results of a national survey conducted in Afghanistan by Promundo and UN Women (The United Nations equality agency) (ABC, 2019), involving 2000 respondents. Two-thirds of the men who participated thought that women had too many rights, and young men were even more reluctant than elders to see women given any more freedom. Furthermore, one in three Afghan women surveyed reported that women are "too emotional" to be leaders (ABC, 2019). However, it should be noted that this survey was conducted in Afghanistan, so cannot necessarily be generalized to resettled communities in Australia. Overall, though, it may be that the concept of female community leaders, as identified within the South Sudanese community, is not as salient within the Afghan community, at least in South Australia. On the other hand, I may have not been able to identify women who identified themselves as leaders simply due to the fact that I was an outsider to the community.

Language was another limitation to the studies with women from refugee backgrounds. I did not speak the primary language of any of the women who participated in interviews, and the interviews were conducted in English. Interpreters were offered to all participants, but women either reported that they did not need one, or, as was the case for two women who did have lower levels of English, declined and had their daughters interpret for them instead.

This use of family members may have been problematic in that the women may have felt uncomfortable discussing certain topics with a family member interpreting for them, and in particular a daughter. On the other hand, the same may have been true with the use of a formal interpreter, and issues around interpreting have been documented previously (Gartley & Due, 2016). For example, Gartley and Due (2016) discuss challenges with interpreters, including concerns around confidentiality and anonymity, particularly in smaller communities where participants may know the interpreter personally. In addition, there is potential for judgmental attitudes on behalf of the interpreter, difficulties in conveying meaning, time constraints, lack of training for interpreters, and variability in the professionalism of interpreters.

However, Gartley and Due (2016) have ultimately argued that interpreters are a necessity, with participants reporting that interpreters increased effective communication, promoted stronger therapeutic alliances in mental health settings, and could have unique cultural insights. The use of interpreters is an ongoing issue for research with this population. For future research, establishing rapport, building trust, and practising reflexivity may all help to offset the challenges associated with language.

As noted in Chapter 4, “member checking” is generally viewed as an important step in adding to the rigour of qualitative studies, as it gives participants an opportunity to decide whether the researchers “got it right” (Braun & Clarke, 2013). It can also mean that participants play a more active role in the research process. However, there have been some critiques of this process - for example, that participants’ experiences are captured only at specific times, and that if a participant refuses to engage in member-checking, there is often no way of discovering why (Birt, Scott, Cavers, Campbell & Walter, 2016).

Instead of “member-checking”, I chose to allow time and space to meet with participants to reflect upon the data and initial interpretations of their interview. This method, deemed “member reflections”, was proposed by Tracy and Hinrichs (2017) and involves researchers sharing preliminary findings with participants and making note of their reactions to themes and issues, while allowing opportunities for questions, critique, collaboration, and feedback. In the current research, six participants responded to emails and text messages about their interviews and initial themes identified through analysis. Only two participants agreed to meet and check the transcripts and initial interpretations. Other participants initially responded to emails and text messages, but did not answer the question as to whether or not they felt they were represented accurately. Upon reflection, the method of communication (emailing and sending text messages) may have been problematic. Initially phoning participants to organise a meeting time could have alleviated issues with English and communication and also elicited more responses.

It may have been beneficial to include an explanation on the participant information sheet outlining the importance of member-reflections, and that participation in the study involved two parts: both the interview and verification of the analysis. To address issues regarding perceived authority and power dynamics between researcher and participant, instructions could have been given when sending the emails for member-checking. These instructions could have emphasized that the participant is considered “the expert” regarding their own experiences, and that the researcher required thorough feedback to fully understand the participants’ points of view.

For future research, it would be helpful for community partners to be part of the research team and recruitment process, as this would build trust in the project, may result in more participants, and may ensure that the research is relevant to the lives of communities (Hanza et al., 2016). Furthermore, this would have alleviated the cultural and language barriers that I faced during recruitment. Community partners possess a nuanced understanding of the language and culture of each of the study populations, increasing the cultural sensitivity of the project. Community partners could also work as advocates for the study and may decrease hesitation by participants about taking part (Hanza et al., 2016).

Additionally, multiple contacts with the potential research participants, instead of a one-off phone call, email, and then meeting, would have been more appropriate. Disseminating study information to a participant on multiple occasions may have also been less overwhelming for them. It would be ideal if recruitment were done by a community partner in a face-to-face setting by a person who spoke the same language. Involving community partners in the research team would align with a CBPR approach, make the checking of data and the dissemination of results more culturally sensitive, and may alleviate some of the barriers that I faced in this process as an outsider to the communities.

Another limitation was the lack of opportunity and scope for an in-depth analysis in regard to the salient theme of racism that arose throughout interviews. In order to begin to challenge any form of oppression, one must begin by looking at a society in its totality. There are deep-seated reasons behind why marginalised groups are depicted in negative ways in the media and public discourse more generally, and in order for there to be change there first must be an analysis of their function.

Ultimately, we cannot separate issues of racism from issues of class and a critique of capital. Racism helps to create, reproduce and reinforce a wide range of hierarchies that are rooted in class domination (Hudis, 2019). Although outside the scope of this thesis, this important analysis is a necessary step in order to critically analyse and challenge the way that these communities are being represented by the media, as well as who controls the media perpetuating this racism.

Kleinman’s Explanatory Model (1978, 1980) model was used as an interpretive lens that guided analysis. Kleinman’s explanation of social realities helped me to think about the data critically and consider how individuals, dependant on their cultural backgrounds, may internalize social realities as systems of meanings and norms, and this can then govern behaviour and interaction within interpersonal environments. When exploring the differences between professional help-seeking and ‘informal help-seeking’ I used Kleinman’s sectors of the health-care system to conceptualize participant’s coping strategies. Primarily, I used Kleinman’s Model to explore differences in cultural conceptualisations of mental health. However, although some differences in the way that participants conceptualised mental illness were identified, it proved difficult to thoroughly explore this subject within interviews. This topic may have been more suited to an ethnographic, anthropological study.

Andersen’s Model of Health Service Utilization (1973) conceptualized service use access as a result of decisions made by the individual that are constrained by their position in society, the accessibility and the availability of health services. Although Andersen’s Model has recently been adapted to include factors relevant to immigrants (Kao, 2009) including environmental factors such as health policy, overall, the model focuses upon individual-level factors that influence service use (Derose, Gresenz & Ringel, 2011; Due, Aldam & Ziersch, 2020). Furthermore, Andersen’s model as not been used as frequently in research with refugee and asylum seeker populations (Due, Aldam & Ziersch, 2020). For participants in the current research, structural, systemic and political factors were significantly important and so a model that encompassed wider systemic factors was necessary. Previous research has also highlighted that Andersen’s model does not consider predictors as interacting and rather lists them as having separate effects (Gochman, 1997). Again, in this research factors had an interacting effect, and the impact of predictors was different according to factors such as age, gender, migration status and race.

9.3 Limitations to using a CBPR approach

The use of a CBPR framework encouraged me to acknowledge and honour participants' concerns and priorities as the most important, instead of focusing solely on the initial and perhaps less relevant research agenda of help-seeking. As such, instead of only focusing upon producing "evidence" in line with the agenda of help-seeking for mental health services, the research was also oriented towards listening to, and working with, community members. Overall, participants' concerns from both the Afghan and South Sudanese groups were largely collective and community-based reinforcing the relevance of using a CBPR approach for this study.

However, there were several limitations and ethical dilemmas encountered throughout the process of taking a CBPR approach. As this was a PhD project, there were also limitations on the degree to which I could follow a true CBPR approach in which the community and participants would own the data and determine its complete analysis (Holkup, Tripp-Reimer, Salois, & Weinert, 2004).

There were also challenges involved in the multiple roles of researcher, academic and activist. Participants viewed me in various ways during the data collection phase, including as an ally, a friend, an outsider, someone who could facilitate change, as well as an individual or worker from an institution. As such, I needed to maintain a high degree of transparency and make it clear that the data that I was collecting was for a PhD project, and how I would ultimately benefit from the project as well. However, it is possible to hold a dual role of activist and academic, especially in participatory research methods (Flood, Martin & Dreher, 2013).

The combination of activism and academic work can be challenging due to the pressures within the academic world that discourage social action and are at times contradictory to social action research (Flood et al., 2013). Although some argue that "valid" research should be value-free (Flood et al., 2013), critical and community psychology challenges the scientific norms that exclude values from psychology (Prilleltensky, 2001). Hartley et al. (2013) argue that there is an ethical imperative for academics and researchers to bear witness and give voice to groups such as asylum seekers due to the fact that they are often removed or sanctioned from the public view. “Bearing witness” has been defined as listening to and observing the experiences of others and then taking action in response (Cody, 2001). It was similarly important for me to bear witness to the experiences of the participants (women with refugee backgrounds) in the current research, as these are groups that are often unheard and out of public view. Regular supervision with my PhD supervisors who both pursue similar work was invaluable to maintaining my reflective practice, momentum, and willpower, as well as negotiating these challenges.

Throughout the thesis the research evolved from a theoretical standpoint toward an applied CBPR approach. Postcolonial feminism allowed me to understand how social injustices contribute to resettlement stressors as well as inaccessibility of services for women with refugee backgrounds. The theory informed my choice to focus on women and to include voices of women who were not white, as per the critiques of the first two waves of the feminist movement (McEwan, 2001).

Throughout the interview guides, I incorporated questions that addressed gendered experiences like domestic violence, as well as questions relating to racism and discrimination. During analysis I centred the women’s experiences (Wachter & Snyder, 2018; Anderson, 2000), and fundamentally my aim was to improve mental health services (O’Mahony & Donnelly, 2010). Overall, my priority was to have an applied, participatory framework (CBPR), as this was most appropriate and ethical for working with refugee populations. This involved honouring what participants prioritised and voiced as their most important concerns. Consequently, the research became more applied, as the stressors were practical concerns. As such, postcolonial feminist theory was not directly referred to in my main studies, but the ways in which it is relevant in a broader sense is reflected upon during the discussion.

In all qualitative research, especially those with vulnerable or minority populations, it is important to determine for whom and for what purpose the research is conducted (Phipps, 2017). This reflects Gramsci's notion of the "organic intellectual": a social agent who has an allegiance to a hegemonic class and is responsible for the formulation and spreading of 'organic ideologies' (see Bates, 1975). As discovered by Collie et al. (2010), social change can be a confronting and contentious issue in communities that place a high value on preserving social and cultural norms and values that differ from those of the resettlement society. They have suggested that a participatory approach that is flexible and adaptive is more likely to be effective.

Accordingly, for the studies with both the women from Afghanistan and South Sudan, the interview questions were reviewed and modified to reflect what was most important for the participants, which resulted in less of a focus on help-seeking for mental health services. The focus of interviews was changed due to participants prioritising concerns related to resettlement challenges and stressors rather than help-seeking. Furthermore, due to the salience of topics such as experiences of racism and domestic violence, questions relating to these issues were added to interview guides following consultation with community leaders. This highlights the importance of participatory research approaches in which approaches and methods are reviewed and community needs are prioritised.

9.4 Recommendations

9.4.1 Inclusive public policy

At the population level, promoting positive mental health and wellbeing whilst decreasing stigma for women with refugee backgrounds requires building inclusive public policy and creating supportive environments. As such, interventions must involve multiple sectors to address the social determinants of health and mental health for women from refugee backgrounds. Acknowledging this, there must be change through adjustments of policy and programs with the aim of improving mental health and wellbeing for women from refugee backgrounds. Training and organisational change programs would be effective in preventing inequities if they focused on cultural competence and increased understanding and awareness of how racism and discrimination are manifested within health care systems.

Such interventions would require both “bottom up” actions by the community and the involvement of community leaders, as well as a “top down” commitment from policy makers. Given the concerns that were raised that women may be experiencing significant stressors but no longer receiving support following arrival, there is a need for more comprehensive follow-up and continuity of care rather than short-term services.

9.4.2 Domestic violence. There is a need for service providers to understand that women from refugee backgrounds face multiple barriers to service use, including domestic violence, and that these experiences may also be compounded by other systemic and structural intersections of oppression, including racism, sexism, and migration status.

Social supports and community-based healing strategies should be considered in any interventions for these communities, including peer mentoring, trauma-informed psychotherapy group programs, psychoeducation and health programs, and physical activity and sports-based programs. Within these programs and interventions, a situational approach to mental health that considers contextual factors, and has less emphasis on labelling and diagnosing mental illness, may be more useful.

There is also a need for programs that target men and that concern norms around relationships, power, and control. These programs could focus on changes in gender and social roles and legal rights regarding women.

An intersectionality approach to policy and service provision regarding domestic violence experienced by women with refugee backrounds would encourage consideration of the impact of different systems of oppression, including racism and sexism.

9.4.3 Culturally responsive care for women

Bi-cultural workers and workers with their own lived experiences have been reported as invaluable assets to refugee services. To ensure that services are culturally sensitive, there should be an increase in the training of individuals with refugee backgrounds to work in their own communities.

In regard to mental health support, in contrast to a bio-medical approach, a situational approach to mental health care that considers contextual factors, and works with clients, family members, and cultural brokers to develop a shared understanding may be more appropriate.

9.4.4 Language and communication

At the service provision level, it is necessary to always check if a woman requires an interpreter, and not to make assumptions based on the length of time spent in Australia. Women from both the Afghan and South Sudanese community would benefit from more easily-accessible or outreach English language classes that are culturally appropriate and perhaps gender-segregated, culturally sensitive domestic violence assistance, and women’s health information seminars.

English classes need to be trauma-informed, and teachers or tutors should be cognisant of the difficulties that some women may experience in learning a new language later in life following displacement, migration, and resettlement.

Classes should also incorporate subjects such as family violence support and legislation information, as well as mental health support in a safe and supportive environment.

For future research, the use of community partners who are part of the research team would assist in the recruitment of participants, as well as building trust and increasing community collaboration.

9.4.5 Considering social determinants of health in mental health care

Given the interacting levels of SEM in relation to women with refugee backgrounds' resettlement experiences, it is essential to consider social determinants of health when working with refugee populations. Women from refugee backgrounds may experience multi-layered barriers to mental health care. Thus, all levels of the SEM should be considered and addressed when attempting to alleviate these barriers and making decisions regarding policy.

9.5 Conclusion

This thesis explored the resettlement experiences of women from two refugee communities in South Australia. Factors such as gender and culture in the resettlement period in which differential power relationships between men and women can be more pronounced than ever were considered. The resettlement period can be a stressful time where women are faced with re-establishing their lives in a foreign country, loved ones are often separated, and familiar social and gendered roles are renegotiated.

My research indicates that women with refugee backgrounds experience many of the same hardships as men, but also face gender-specific forms of pre-migration violence and post-resettlement challenges and stressors. Overall, when women arrive in Australia they may experience a sense of relief due to their new-found physical safety, but mental health issues can remain a hidden but serious issue for some. There has been a strong focus on conceptualising refugees as "traumatised" and pathologizing symptoms of trauma. However, many women from refugee backgrounds find strength and resilience in their informal social and support networks, as this needs to be acknowledged and built upon in formal service provision.

Overall, the results of all four studies highlighted the complex intersections between gender, race, and refugee status faced by women from the South Sudanese and Afghan communities. These intersections create multiple challenges to resettlement, empowerment, and belonging within the broader Australian community. Reports from women from both communities triangulated with reports from service providers and described the way in which racism, patriarchy, economic disadvantages, and refugee status (even years after resettlement) created layers of inequality that structured the relative positions of women and men in their community and the broader Australian society.

Within both communities, strong "informal" supports were already being utilised, including religious practices and social support. Within the South Sudanese community, female leaders were already working to unite the community in order to discuss the concerns raised in this study. The results of these studies indicate that community action needs to be further supported by the government with resources and funding in order to empower communities to address these self-identified issues.

Through the use of a postcolonial feminist perspective, analysis was raised to a broader level of conceptualisation, one that encompassed and examined how multifaceted socioeconomic, historica,l and political factors interacted with race, class, and gender to influence women's resettlement experiences. The impact, complexities, and relationships between the effect of historical and pre-migration experiences, together with the present socioeconomic, political, and environmental factors, influenced women's experiences and, in some instances, behaviours and choices regarding help-seeking and service access.

Appendices

Appendix A: Recruitment fliers for community members

Researchers from the University of Adelaide would like to know:

How do you think and talk about mental health? How do you seek help?

You are being invited to participate if you:

- Came to Australia as a refugee or an asylum seeker
- Are over 18 and female
- Arrived in Australia OVER 3 months ago
- Are from the **South Sudanese** or **Afghan** community in South Australia

**If you do not speak English we would still love to talk with you - we can arrange an interpreter for you*

What is the project about?
The project involves interviews with women who have a refugee background from South Sudan or Afghanistan. We will ask you about issues in your community and how people seek help. We will also ask you about how people in your community think and talk about mental health issues and how you think services could be improved. *All interviews are voluntary and confidential.*
This project is being conducted by Rose Burford-Rice as part of her PhD project in the School of Psychology at the University of Adelaide. (**HREC Approval Number:** H-2016-130)

What will I be asked to do?
You will be asked to participate in a face to face interview at a location convenient for you or over the phone, which will last approximately 1 hour. You will receive a $20 shopping voucher for your participation.

If you are interested in participating, or for more information, please contact:
Rose: rose.burford-rice@adelaide.edu.au

Clemence: clemence.due@adelaide.edu.au

Appendix B: Participation information sheet for community members

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Exploring concepts of mental health and help-seeking in refugee and asylum seeker women: a South Australian study

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2016-130
PRINCIPAL INVESTIGATOR: Dr. Clemence Due
STUDENT RESEARCHER: Rose Burford-Rice
STUDENT'S DEGREE: PhD/Masters of Clinical Psychology

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

This project aims to consider what you think are important issues in your community, how people in your community seek help from each other and services, and how you think services could be improved.

The project involves interviews with people who are asylum seekers or refugees. As part of the interview, we will ask you about issues in your community and how people seek help. We will also ask you about how people in your community think and talk about mental health issues.

Who is undertaking the project?

This project is being conducted by Clemence Due, Martha Augoustinos, Linley Denson and Rose Burford-Rice

This research will form the basis for the degree of PhD/Masters of Clinical Psychology for Rose at the University of Adelaide under the supervision of Clemence Due, Martha Augoustinos and Linley Denson.

Who is being invited to participate?

You are being invited to participate if you:

- Came to Australia as a refugee or an asylum seeker
- Are over 18 and female
- Arrived in Australia OVER 3 months ago
- Are from the South Sudanese or Afghan community in South Australia
- Have a competent level of English, Dari or Dinka proficiency*

**If you do not have a competent level of English proficiency we would still love to speak with you - we can arrange an interpreter for you*

What will I be asked to do?
You will be asked to participate in an interview which will take about 1 hour. We will conduct the interview face to face at a location convenient for you, or over the phone if you prefer. If you would like to meet for the interview, we can come to a location convenient for you, such as your house, a park, or café, or we can do the interview at the University of Adelaide.

Are there any risks associated with participating in this project?
We recognize that you may feel some distress when you talk about issues in your community or your own experiences. In order to help you if you do feel distress, we will give you a list of the contact details of organizations that can provide some support. We will also do a follow-up call if you are distressed after the interview to see how you are going. You should also know that the researchers are obliged to report any instances of child abuse under mandatory reporting requirements.

What are the benefits of the research project?
You will receive a $20 shopping voucher for your participation. While there are no other direct benefits to you in participating we hope that the research findings will increase understandings of community concerns and service experiences for refugees and asylum seekers in Australia.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time. We can withdraw your data anytime up until submission of Rose's thesis.

What will happen to my information?
The interview will be recorded and transcribed by the researcher. We will not use your name in the transcriptions and publications will not contain any information that could identify you in any way. You will be able to read your interview transcript and request changes if you would like to. Only the researchers will have access to the data obtained in the project, and data will be stored for 5 years on a password protected computer and then deleted. If you are interested in the results of the project you will be able to access a report summarizing the main findings. The findings will be included in journal papers as part of Rose's PhD.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (H-2016-130). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. Contact the Human Research Ethics Committee's Secretariat on phone +61 8 8313 6028 or by email to hrec@adelaide.edu.au. if you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I have questions or want to participate, what do I do?

If you are interested in participating, please contact Rose (rose.burford-rice@adelaide.edu.au), or Clemence (clemence.due@adelaide.edu.au or 8313 6096) to ask questions or organize a time for an interview.

Yours sincerely,
Dr. Clemence Due
Clemence.due@adelaide.edu.au
8313 6096

Ms. Rose Burford-Rice
Rose.burford-rice@adelaide.edu.au

Dr. Linley Denson
Prof Martha Augoustinos

Appendix C: Participation information sheet for service providers

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Exploring concepts of mental health and help-seeking in refugee and asylum seeker women: a South Australian study

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2016-130
PRINCIPAL INVESTIGATOR: Dr. Clemence Due
STUDENT RESEARCHER: Rose Burford-Rice
STUDENT'S DEGREE: PhD/Master of Clinical Psychology

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?

This project aims to consider barriers and enablers to help-seeking behaviours for refugee and asylum seeker women from Afghanistan and South Sudan, what works well when working with this population, and how you think services could be improved.

The project involves interviews with mental health service providers who work specifically with female refugees and asylum seekers from Afghanistan and South Sudan. As part of the interview, we will ask you about your experiences working with this population, specifically what you perceive to be barriers and enablers to help-seeking behaviors for your clients. We will also discuss issues such as stigma surrounding help-seeking for mental health issues within refugee and asylum seeker communities.

Who is undertaking the project?

This project is being conducted by Clemence Due, Martha Augoustions, Linley Denson and Rose Burford-Rice
This research will form the basis for the degree of PhD/Masters of Clinical Psychology at the University of Adelaide under the supervision of Clemence Due, Martha Augoustinos and Linley Denson.

Who is being invited to participate?

You are being invited to participate if you:

- Are a mental health service provider
- Work or have worked (in the last 5 years) with South Sudanese or Afghan women with refugee backgrounds

What will I be asked to do?

You will be asked to participate in an interview which will take about 1 hour. We can conduct the interview either face to face or over the phone, whichever you would prefer. If you would like to meet for the interview, we can come to a location convenient for you, such as your place of work, your house, or do the interview in an office at the University of Adelaide.

Are there any risks associated with participating in this project?
We recognize that there is a possible risk of emotional distress when you talk about your experiences working with this vulnerable population. In order to assist you in the event that you may experience some distress you will be provided with a list of the contact details of organizations that can provide some support.

What are the benefits of the research project?
While there are no other direct benefits to you in participating we hope that the research findings will increase understandings of experiences of service provision and barriers and enablers to help-seeking with refugees and asylum seekers.

Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time. We can withdraw your data anytime up until submission of Rose's thesis.

What will happen to my information?
The interview will be recorded and transcribed by the researcher. We will not use your name in the transcriptions and publications will not contain any information that could identify you in any way. You will be able to read your interview transcript and request changes if you would like to. Only the researchers will have access to the data obtained in the project, and data will be stored for 5 years on a password protected computer and then deleted. If you are interested in the results of the project you will be able to access a report summarizing the main findings. The findings will be included in journal papers as part of Rose's PhD.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (H-2016-130). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. Contact the Human Research Ethics Committee's Secretariat on phone +61 8 8313 6028 or by email to hrec@adelaide.edu.au. if you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I have questions or want to participate, what do I do?
If you are interested in participating, please contact Rose (rose.burford-rice@adelaide.edu.au, or Clemence (clemence.due@adelaide.edu.au or 8313 6096) to ask questions or organize a time for an interview.

Yours sincerely,
Dr. Clemence Due
Clemence.due@adelaide.edu.au
8313 6096
Ms. Rose Burford-Rice
rose.burford-rice@adelaide.edu.au

Dr. Linley Denson
Prof. Martha Augoustino

Appendix D: Complaints and support sheet

The University of Adelaide Human Research Ethics Committee (HREC)

This document is for people who are participants in a research project.

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPAINTS PROCEDURE

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project Title:	Exploring concepts of mental health and help-seeking with women from refugee backgrounds: a South Australian study
Investigators:	Clemence Due, Martha Augoustinos, Linley Denson, Rose Burford-Rice
Approval Number:	H-2016-130

The Human Research Ethics Committee monitors all the research projects which it has approved. The committee considers it important that people participating in approved projects have an independent and confidential reporting mechanism which they can use if they have any worries or complaints about that research.

This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (see http://www.nhmrc.gov.au/publications/synopses/e72syn.htm)

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

Name:	**Dr. Clemence Due, Lecturer and Researcher, The University of Adelaide**
Contact:	**Phone: (08) 8313 6096 Email: clemence.due@adelaide.edu.au**

2. If you wish to discuss with an independent person matters related to:
   - making a complaint, or
   - raising concerns on the conduct of the project, or
   - the University policy on research involving human participants, or
   - your rights as a participant,

Please contact the convener of the Subcommittee for Human Research in the School of Psychology, Dr. Paul Delfabbro (Tel: 08 8313 4963).

APPENDIX E

Support organisations that may be able to assist you if you experience any distress during the “Exploring concepts of mental health and help-seeking in refugees and asylum seekers: a South Australian study” **project**

1. Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS)

   The Migrant Health Service can help with mental health needs in person.
   Phone: 8206 8900
   Address: 81 Angas Street Adelaide

2. Migrant Health Service

   The Migrant Health Service can help with mental health needs in person.
   Phone: 8237 3900
   Address: 21 Market Street Adelaide

3. Lifeline

   Lifeline is a telephone support service, so you can talk with someone on the telephone if you are feeling distressed or upset.
   Phone: 13 11 14
   Website: https://www.lifeline.org.au/

   If you cannot speak English well, or feel more comfortable speaking in another language, please call the Translating and Interpreting Service on 13 14 50 and ask them to call Lifeline for you on 13 11 14.

4. Assistance and Crisis Intervention Service

   The assessment and crisis intervention service can help in a mental health emergency.
   Phone: 13 14 65

Appendix E: Consent form

THE UNIVERSITY of ADELAIDE

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Exploring concepts of mental health and help-seeking in refugee and asylum seeker women: a South Australian study
Ethics Approval Number:	H-2016-130

2. I have had the project fully explained to my satisfaction by the research worker. My consent is given freely.

3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

4. Although I understand the purpose of the research project, it has also been explained that involvement may not be of any benefit to me.

5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged. I understand I have the opportunity to read over the transcript of my interview and delete any text which may identify me, and this will not be used in any publications.

6. I understand that I am free to withdraw from the project at any time.

7. I agree to the interview being audio recorded:

   Yes ☐ No ☐

8. I would like a summary of the study's results emailed to me upon its completion:

   Yes ☐ No ☐

9. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: ______________________ Signature: ________________________ Date: __________

Researcher/Witness to complete:

I have described the nature of the research to ____

(print name of participant)

and in my opinion she/he understood the explanation.

Signature: ___________________ Position: _________________________ Date: __________

Appendix F: Interview guide for community members

Interview Guide (community members):

What do you think are some of the difficulties that women face in your community?

What do you understand about mental health?

– How has your experience as a refugee/asylum seeker influenced that?

How much/well do you think women/people in your community understand mental health?

- Do you think that people think about mental health differently here in Australia than they did in Afghanistan/South Sudan?

When women in your community feel unhappy how do they get help?

What sort of support do they get from the community?

What do you think it is like for a woman to talk about how they are feeling in your community?

If you felt unhappy who would you go to, or where would you go to get help?

What kind of things might stop women from getting help in your community?

- How do you think we could help these women?

How do people in your community think about women who are feeling unhappy?

Have you, or any women or girls you know ever had any help from mental health services? - Were you happy with the help?

How do you think these services could be improved to help women in your community?

Do you think racism is an issue for women in your community?

- Would this stop you from asking for or looking for help?

Do you think your life now is very different to what it would have been back in your country?

- How does it feel to think about this?

What have you found has helped you get through the hard times in your life? What keeps you strong?

- How important was your religion when things were difficult in your life?
- Do you think this is similar for other women in your community?

What are some of the positive experiences in your community?

Is there anything else that you would like to tell us?

Appendix G: Interview guide for service providers

Interview Guide for Service Providers

What proportion of your female clients do you estimate are of a refugee background and from Afghanistan or South Sudan?

For what kind of reasons do you see these clients?

Do the needs of these clients typically differ from other clients from different cultural backgrounds?

Do you think different communities experience different challenges?

Do you notice any particular or unique ways in which your clients from Afghanistan and South Sudan think and talk about mental health issues?

Is the pattern of service utilisation by Afghan/South Sudanese clients different to that of other clients? If so, in what way? Are there patterns?

What do you perceive to be barriers that your female clients from these communities face to seek help for mental health issues?

What do you perceive to be enablers for your female clients from these communities to seek help for mental health issues?

Do you think that young women face different barriers to accessing services to older women from these communities?

What expectations do you think Afghan/South Sudanese female clients have of your service or organisation?

Do you think that there are any unmet needs for your female Afghan/South Sudanese clients?

What challenges do you face working with your Afghan/South Sudanese female clients? What seems to work and what does not?

What strengths do you see in your Afghan/South Sudanese clients?

How do you think services for these women could be improved?

Appendix H: Thank you letter

Dear ***,

On behalf of the University of Adelaide, School of Psychology and the members of our research team, I would like to thank you for participating in the research study – ‘Exploring concepts of mental health and help-seeking in refugee and asylum seeker women: a South Australian study’.

I really appreciate the time that you spent answering my questions and sharing your experiences, despite your other commitments.

I wish you all the best for your future.

Many thanks,
Rosie Burford-Rice

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Appendix I: The research questions and purpose behind the interview guides for service providers and women from refugee backgrounds from both the South Sudanese and Afghan communities.

Research Question	Question	Population	Interview Guide
What resettlement challenges and stressors do women from this community face?	What are the resettlement challenges for women in this community?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	What do you think are some of the difficulties that women face in your community?
What support needs do community members have, and how can they be taken up by service providers and policy?	What community-based supports exist, and how do women access support?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	When women in your community feel unhappy how do they get help? What sort of support do they get from the community?
What barriers to help-seeking currently exist in the community?	What barriers to help-seeking might a woman face?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	What kind of things might stop women from getting help in your community?
How do community members conceptualise and represent mental health and wellbeing?	How do women conceptualise mental health?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	What do you understand about mental health? How much/well do you think women/people in your community understand mental health? Do you think that people think about mental health differently here in Australia than they did in Afghanistan/South Sudan?
How do community members conceptualise and represent mental health and wellbeing?	Does stigma exist within the community regarding mental health issues?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	What do you think it would be like for a woman to talk about how they are feeling in your community? How do women in your community think about women who are feeling unhappy? (prompts: e.g is there gossip, people talking about them?)

What resettlement challenges and stressors do women from this community face?	Do you think racism is an issue faced by women in your community?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	Do you think racism is an issue for women in your community? Would this stop you from asking for help?
What support needs do community members have, and how can they be taken up by service providers and policy?	How could services for women be improved in your community?	Women with refugee backgrounds from the Afghan and South Sudanese communities in South Australia.	Have you or any women or girls you know ever had any help from mental health services? Were you happy with this help? How do you think these services could be improved to help women in your community?

Appendix J: The research questions and purpose behind the interview guides for service providers and women from refugee backgrounds from both the South Sudanese and Afghan communities.

Research Question	Question	Population	Interview Guide
What resettlement challenges and stressors do women from this community face?	What big issues do women face in their community?	Service providers working with women from refugee backgrounds.	What do you think is the biggest issue that your female clients face?
What barriers to help-seeking currently exist in the community?	What are the main barriers that refugee women face to access services?	Service providers working with women from refugee backgrounds.	What do you perceive to be barriers that your female clients face to seek help for mental health issues?
What barriers to help-seeking currently exist in the community?	What are the main enablers and facilitators for refugee women to access services?	Service providers working with women from refugee backgrounds.	What do you perceive to be enablers and facilitators for your female clients to seek help for mental health issues?
What barriers to help-seeking currently exist in the community?	Are there differences in barriers to help-seeking in regards to age?	Service providers working with women from refugee backgrounds.	Do you think that young women face different barriers to accessing services to older women from these communities?
What support needs do community members have, and how can they be taken up by service providers and policy?	What expectations do clients have of available services?	Service providers working with women from refugee backgrounds.	What expectations do you think Afghan/South Sudanese female clients have of your service or organisation?
To explore the challenges that service providers face when working with women from refugee backgrounds.	What are the biggest challenges for service providers who work with refugee women?	Service providers working with women from refugee backgrounds.	What challenges do you face working with your female clients?
What support needs do community members have, and how can they be taken up by service providers and policy?	How could services be improved for these women ?	Service providers working with women from refugee backgrounds.	How do you think services could be improved?

Appendix K: Research report prepared for the Afghan community

Help-seeking for mental health services among afghan women from refugee backgrounds

Summary of research findings

The project

This study involved interviews with eleven Afghan Hazara women with refugee backgrounds in Adelaide, South Australia. Thematic analysis was used to analyse the data and identify themes within interviews. Here is a summary of the main findings.

Barriers to help-seeking

Stigma

- Expressing personal problems was reported as bad for women's reputation or social status as well as that of her family
- Women reported not wanting to cause stress for their children if they talked about their mental health
- Women might choose to remain silent to avoid social consequences

Cultural conceptualisations

- Mental health was often related to physical symptoms like headaches
- Medical treatment was reported as being a preferred treatment for some women rather than talking therapies
- Mental health issues were described by some participants as contagious and that if you had them you would be isolated
- Some younger women reported that views on mental health in their generation was changing and that younger people had more knowledge about mental health services

> *They will think oh if everyone else in the community finds out, what will they say about me? […] our family will have a bad image […] the question is what will people say? […] How will the community react to my condition, or to my health issues – Azadah (18 years)*

Domestic violence

- Women related mental health issues to domestic violence that had occurred in Afghanistan
- Women described experiences of domestic violence as something that many women were expected to endure and remain silent about
- Women reported that seeking help for domestic violence was seen negatively by the community

> *if a woman has been through all domestic violence and she has raised her voice then people will say something about her” – Parisa (30 years)*

Husband as Gatekeeper

- Some women described husbands as people who would stop their wives from seeking help for mental health issues
- Women reported that older men in the community were more likely than younger men to stop their partners or wives from seeking help for mental health issues.

Language and communication difficulties

- Women reported that mental health issues often stopped them from learning English
- Some older women reported having headaches, thinking about their past, and worrying about family members, which made it difficult to concentrate during English classes

Ways women sought help

- Women reported a preference for talking with their friends instead of accessing professional help if they experienced mental health issues
- Some women reported that religion was something that they turned to when they were experiencing difficult times
- However, one participant highlighted that it was still important for women in her community to access professional help

> *they find their friend or woman like herself and talk together and remove the bad events in their mind or anything that bad effect in their memory – Rana (20 years)*

Recommendations

- Female-only education sessions and English classes that involve domestic violence related information
- Outreach education and mental health teams to service isolated women
- Potentially incorporating mental health information into religious practices
- Mental health services that embrace protective social support networks

If you would like to know more about the research, please contact: Rose Burford-Rice rose.burford-rice@adelaide.edu.au or Clemence Due clemence.due@adelaide.edu.au

Appendix L: Research report prepared for the South Sudanese community

Resettlement stressors and challenges for South sudanese women with refugee backgrounds

Summary of research findings

The project

This study involved interviews with nine community members from the South Sudanese community who lived in Adelaide, South Australia. In interviews, participants discussed resettlement stressors and challenges. Thematic analysis was used to analyse the data and identify themes within interviews. Here is a summary of the main findings.

Resettlement stressors

> *When you live together with family it doesn't happen all the time to be sad. […] But here, it's sad is more. You thinking about your background, your family in Africa. – Hope (30-40 years)*

Family separation

- Separation from family members caused emotional distress and also financial strain for resettled families as they often sent back money to their families

Social isolation

- Some women reported feeling isolated if they were one of the only members of their ethnic group in Adelaide or were finding it hard to make new connections in the community

> *I don't have a lot of people, or connected with a lot of Australians. […] I came here alone […] I've gone through all this stress on my own – Leah (25-30 years)*

Social determinants of health

- Housing, employment and social isolation were all listed as causing resettlement stress, especially for women with large families

<u>Factors that affect mental health and help-seeking</u>

Cultural conceptualisations of mental health and stigma

- Participants reported about the ways in which some people conceptualised mental illness to be associated with witchcraft or being cursed
- Privacy was also reported to be highly valued, and for some women mental health issues were expected to stay within the family

Lack of trust

- Some women reported that they needed a reason to trust someone and experienced some fear when disclosing personal problems to professionals

Racism

- Participants reported that the negative representations of young people from the South Sudanese community in the media was detrimental for community members' mental health
- Women indicated that racism was a barrier for some women to seek help for mental health

> *There's a lot racism that's going on because of what young people are doing. Especially the South Sudanese you hear the thing that they are doing is not good, and they're out there causing issues and that kinda comes back to us again like 'oh you're Sudanese, South Sudanese' straight away you know? [...] It's coming back to the actual community – Mary (18-25 years)*

Control and power

- Differences in gender roles in Australia was reported to cause tension within some families, especially when a woman's role began to change.
- Family breakdown was reported as a risk if a woman stepped outside of her expected role as this could be perceived as women challenging men's control and power

Domestic Violence

- Participants related the change in social, cultural and gender roles to experiences of family violence
- Some women explained that domestic violence was often addressed within families and within the community

Husband as gatekeeper

- Participants described how husbands could sometimes act as barriers to help-seeking

> *If you are a married woman they're very strict –you can't go out, only something that your family knows or your husband. [...] Most of the times the struggle is to look for jobs because you have to look after kids [...] you only go to community parties, you can't go out with friends –Chloe (25-30 years)*

Recommendations

- Female-only education sessions and English classes that involve domestic violence related information
- Outreach education and mental health teams to service isolated women

Mental health services that embrace protective social support networks

If you would like to know more about the research, please contact: Rose Burford-Rice rose.burford-rice@adelaide.edu.au or Clemence Due clemence.due@adelaide.edu.au

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